



NOTIFICATION OF KANCARE HCBS SERVICES
REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICE INFORMATION

I. CONSUMER INFORMATION

Name: KanCare ID No.:
Address:
Phone: SSN: Date of Birth:
Responsible Person/Contact Home Phone:
Address: Work Phone:
Form Initiated By: Name: Date Sent:
Reason for 3160: HCBS Program Type:

II. HCBS PROGRAM ELIGIBILITY INFORMATION (Functional Eligibility Assessor)

Person Completing Section: Office Phone:
Address: Office Fax:
Applicant MCO Choice: Applicant Requesting PACE Referral: Yes No
HCBS Program Type: Placed on Waiting List: Yes No If Yes, Date:
Program Threshold Met: Yes No Services Request Withdrawn: Yes No
Choose HCBS: Yes No If Yes, Choice Date:
Comments:
Medicaid App in Progress Assistance by: If Other:
Signature Person Completing Section Date Sent

III. KDADS PROGRAM MANAGER APPROVAL/DENIAL (IDD/PD/BI/AU/SED)

Program Manager Approval Required: Yes No (If Yes, section must be completed by Program Manager)
Program Manager Office Phone:
HCBS Program Type: Approved Denied Effective Date:
Comments:
Signature of Person Completing Section Date Sent

IV. MCO INFORMATION

MCO: Estimated Cost of Care: Anticipated Start Date:
If Transition, New Address:
Comments:
Signature of Person Completing Section Date Sent

V. ELIGIBILITY INFORMATION

Eligibility Worker: Office Phone:
KanCare Application Received: Case Number: App. Status:
Approval Type: Effective Date:
Estimated Cost of Care: HCBS Client Obligation: Month:
Next Review Date: HCBS Client Obligation: Month:
Comments:
Eligibility Worker Signature Date Complete

Form Returned upon eligibility completion to: MCO KDADS Assessor DCF

Attachments: Yes No