Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
FAX: 844-264-6285

Notification of KanCare HCBS Changes and Update

I. Consumer Information

Consumer Name:			Select waiver type
KanCare ID:	SSN:	Case #:	D.O.B.:
☐ **Change for Consumer**	Address:		
☐ **Change for Responsible person**	Name:		Phone:

II. KanCare Information Changes (to be completed by Eligibility Staff)

☐ **Reinstatement**	Effective date:	Select HCBS Waiver Type
☐ **Client Obligation Changes**	Amount	Effective date:
	Amount	Effective date:
☐ **KanCare Case Closure**	Effective date:	Select Closure Reason
☐ **HCBS Ends**	Effective date:	Select Closure Reason

Other:

Comments:

Agency of person completing form: Select Agency of person completing section

Name of person completing form:

Email address of submitter: **Date:**

III. HCBS Change (to be completed by Assessor, MCO, or HCBS Manager)

☐ **Reinstatement**	Effective date:	Select Service Type
☐ **Monthly cost of care changes**	Amount	Effective date:
☐ **Terminate**	Effective date:	Select Closure Reason
☐ **Entered Nursing Facility/PRTF**	Date entered:	

Facility Name:

And address:

Length of stay: Select Type of Stay

Other:

Comments:

Agency of person completing form: Select Agency of person completing section

Name of person completing form:

Email address of submitter: **Date:**