STATE OF KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH CARE FINANCE

# NOTIFICATION OF HCBS, MFP, WH OR WORK SERVICES REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION

ES-3160
Rev. 01-13

**TO:** ____________________ **FROM:** ____________________

## I. CONSUMER INFORMATION

Name: ____________________ KanCare ID No.: ____________ Date of Birth: ________

Address: ____________________ Phone:: ____________ SSN: ____________

Responsible Person/Contact: ____________________ Home Phone: ____________

Address: ____________________ Work Phone: ____________

## II. ELIGIBILITY INFORMATION (to be completed by DCF eligibility staff)

____ HCBS Referral ____ HCBS Assessment Only ____ Working Healthy Referral ____ WORK Referral ____ Eligibility Information

DCF Eligibility Worker: ____________________ Phone: ____________

Address: ____________________ Fax Number: ____________

KanCare Application: Date Received: ____________ Case Number: ____________

Application Status:

____ Pending ____ Denial/Ineligible ____ Non-HCBS Approval – Type of Coverage: ____________

____ Working Healthy Approval: Effective Date: ____________ Premium Amount: ____________

____ WORK Approval: Effective Date: ____________

____ HCBS Approval: Effective Date: ____________ HCBS Client Obligation: ____________ Month: ________

Next Review Date: ____________ HCBS Client Obligation: ____________ Month: ________

Comments: ____________________

## III. HCBS/MFP/WORK INFORMATION (to be completed by ADRC, Program Manager, or Case Manager)

____ KanCare Referral ____ Service Information: ____ HCBS ____ MFP ____ Working Healthy/WORK

HCBS/MFP/WORK Contact Completing Referral: ____________________ Phone: ____________

Address: ____________________ Fax Number: ____________

Applicant MCO Choice: ____ Amerigroup ____ Sunflower ____ United ____ None Applicant Requests PACE Referral: ____ Yes ____ No

HCBS/MFP Waiver Type: ____________ Placed on Waiting List: ____ Yes ____ No If Yes, Date: ____________

HCBS/MFP Waiver Threshold Met: ____ Yes ____ No HCBS/MFP Services Request Withdrawn: ____ Yes ____ No

Chooses HCBS/MFP: ____ Yes ____ No If Yes, Choice Date: ____________ Estimated Monthly Cost of Care: ____________

Effective Date of HCBS/MFP Services (approved by Program Manager, Case Manager, or other Authority): ____________

WORK Service: ____ Approved ____ Denied Start Date: ____________

Comments: ____________________

## IV. WORKING HEALTHY INFORMATION (to be completed by Benefit Specialist)

Benefit Specialist: ____________________ Phone: ____________

Chooses Working Healthy: ____ Yes ____ No If Yes, Date: ____________

Premium Discussed: ____ Yes ____ No Willing To Pay Premium: For Prior Months: ____ Yes ____ No For Current Month(s): ____ Yes ____ No

Comments: ____________________

____________________ Attachments: ____ Yes ____ No

DCF Eligibility Worker Signature Date

____________________

HCBS/MFP/Working Healthy/WORK Authorized Agent Signature Date