STATE OF KANSAS
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
ECONOMIC & EMPLOYMENT SUPPORT

NOTIFICATION OF HCBS OR WORKING HEALTHY SERVICES REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION

ES-3160
Rev. 05-07

TO: _____ **FROM:** _____

I. CONSUMER INFORMATION:

Name: _____ Medicaid ID No: _____

Address: _____

Phone: _____ SSN: _____ Date of Birth: _____

Responsible Person/Contact: _____ Home Phone: _____

Address: _____ Work Phone: _____

II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist or Social Worker)

☐ Working Healthy Referral ☐ Eligibility Information ☐ HCBS Referral

EES Specialist: _____ Phone: _____

Address: _____ Fax: _____

Medicaid Application: Date: _____ Case #: _____

Status:
- ☐ Pending
- ☐ Non-HCBS Approval (check one) ☐ Medical Card ☐ Spenddown Amount _____ ☐ QMB/LMB Only
- ☐ Working Healthy Approval, effective date _____ Premium(s): _____
- ☐ Denial/Ineligible
- ☐ HCBS Approved, effective date _____ HCBS Obligation: _____ Month: _____

Next Review Date: _____ HCBS Obligation: _____ Month: _____

Comments: _____

III. HCBS INFORMATION: (to be completed by Case Manager/IL Counselor)

☐ Medicaid Referral ☐ Service Information

Case Manager/ILC: _____ Phone: _____

Address: _____ Fax: _____

HCBS Waiver Type: _____ Placed on Waiting List: ☐ Yes, Date: _____ ☐ No

Waiver/LOC Threshold Met? ☐ Yes ☐ No Request Withdrawn ☐ Yes ☐ No

Chooses HCBS: ☐ Yes, Date: _____ ☐ No Monthly Cost (excluding average acute care costs): _____

Effective Date of HCBS Services (Approved By Program Manager or Other Authority): _____

Comments: _____

4. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)

Benefits Specialist: _____ Phone: _____

Chooses Working Healthy: ☐ No ☐ Yes, date _____

Premium Discussed ☐ No ☐ Yes, Willing To Pay Prior Medical Premium ☐ No ☐ Yes Current Premium ☐ No ☐ Yes

Comments: _____

☐ **YES** ☐ **NO**

_____
ELIGIBILITY WORKER SIGNATURE DATE **ATTACHMENTS**

_____
HCBS AUTHORIZED AGENT SIGNATURE DATE