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HCBS/MFP Waiver Threshold Met: ☐ Yes ☐ No HCBS/MFP Services Request Withdrawn: ☐ Yes ☐ No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