STATE OF KANSAS DEPT FOR CHILDREN AND FAMILIES ECONOMIC & EMPLOYMENT SERVICES

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

ES-3160 Rev. 07-07

| | | | FROM | l: | | | | |
|--|--|---|--|--|--------------------------------------|--------|-----------|------|
| I. CONSUMER INFORM | IATION: | | | | | | | _ |
| Name: | | | | Medicaid ID No: | | | | |
| Address: | | | | | | | | |
| Phone: | | SSN: | | | Date of Birth: | | | |
| Responsible Person/Con | ntact: | | | Home | Phone: | | | |
| Address: | | | | Work | Phone: | | | |
| II. ELIGIBILITY INFO | ORMATION: (to be cor | npleted by EES | Specialist or | Social Worker) | | | | |
| | ealthy Referral | WORK Referr | - | Eligibility Inform | nation | | HCBS Refe | rral |
| EES Specialist: | | | | 0 , | Phone: | | | |
| Address: | | | | | Fax: | | | |
| Medicaio | Application: Date: | | | Case #: | | | | |
| Status: | Pending | Denial/Ineligible | | _ | | | | |
| | Non-HCBS Approval (che | eck one) | Medical Card | Spenddown | Amount | | QMB/LMB | Only |
| | Working Healthy Approva | al, effective date | | | Premium(s): | | | |
| | WORK approval, effective | e date | | | | | | |
| | HCBS Approved, effective | e date | Н | CBS Obligation: | | Month: | | |
| Next Review Date: | <u> </u> | | Н | CBS Obligation: | | Month: | | |
| Comments: | | | | | | | | |
| | | | | | | | | |
| III HCRS INFORMATIO | M: (to be completed by | Caso Managor/II (| Councelor) | | | | | |
| | ON: (to be completed by | | | | | | | |
| Medicaid Refe | erral | | Counselor) ice Information | | Phone: | | | |
| Medicaid Refe Case Manager/ILC: | erral | | | | Phone: | | | |
| Medicaid Refe Case Manager/ILC: Address: | erral | | ice Information | ı Waiting List⁺ | Fax: | | | No |
| Medicaid Refe Case Manager/ILC: Address: HCBS Waiver Type | erral | Servi | ice Information | Waiting List: | Fax: Yes, Date: | | No. | No |
| Medicaid Refe Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh | erral : nold Met? | Servi | ice Information Placed or No Re | equest Withdrawn | Fax: Yes, Date: | | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: | erral | Yes No | Placed or No Re | equest Withdrawn | Fax: Yes, Date: | | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC | erral : nold Met? Yes, Date: CBS Services (Approved E | Yes No | Placed or No Re Monthly C | equest Withdrawn cost (excluding avera | Fax: Yes, Date: | | No No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: | erral : nold Met? Yes, Date: | Yes No | Placed or No Re | equest Withdrawn cost (excluding avera | Fax: Yes, Date: | | No No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: | erral : nold Met? Yes, Date: CBS Services (Approved E | Yes No | Placed or No Re Monthly C | equest Withdrawn cost (excluding avera | Fax: Yes, Date: | | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: | erral : nold Met? Yes, Date: CBS Services (Approved E | Yes No By Program Manag Denied | Placed or No Re Monthly C er or Other Auth | equest Withdrawn cost (excluding avera ority): | Fax: Yes, Date: | | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: | erral : nold Met? Yes, Date: CBS Services (Approved E | Yes No By Program Manag Denied | Placed or No Re Monthly C er or Other Auth | equest Withdrawn cost (excluding avera ority): | Fax: Yes, Date: | | No No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: | erral : nold Met? Yes, Date: CBS Services (Approved E Approved | Yes No By Program Manag Denied | Placed or No Re Monthly C er or Other Auth | equest Withdrawn cost (excluding avera ority): | Fax: Yes, Date: Yeage acute care co | | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: IV. WORKING HEALTH Benefits Specialist: | erral : nold Met? Yes, Date: CBS Services (Approved EApproved) IY INFORMATION (to be Healthy: No | Yes No By Program Manag Denied completed by Ber | Placed or No Re Monthly Cer or Other Auth Start Date | equest Withdrawn Cost (excluding avera ority): | Fax: Yes, Date: Yeage acute care co | sts): | No | No |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: IV. WORKING HEALTH Benefits Specialist: Chooses Working H | erral : nold Met? Yes, Date: CBS Services (Approved EApproved) IY INFORMATION (to be Healthy: No | Yes No By Program Manag Denied completed by Ber Yes, date | Placed or No Re Monthly Cer or Other Auth Start Date | equest Withdrawn Cost (excluding avera ority): | Fax: Yes, Date: Yeage acute care con | sts): | | |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: IV. WORKING HEALTH Benefits Specialist: Chooses Working H Premium Discussed | erral : nold Met? Yes, Date: CBS Services (Approved EApproved) IY INFORMATION (to be Healthy: No | Yes No By Program Manag Denied completed by Ber Yes, date | Placed or No Re Monthly Cer or Other Auth Start Date | equest Withdrawn Cost (excluding avera ority): | Fax: Yes, Date: Yeage acute care con | sts): | No | Yes |
| Medicaid Reference Case Manager/ILC: Address: HCBS Waiver Type Waiver/LOC Thresh Chooses HCBS: Effective Date of HC WORK Service: Comments: IV. WORKING HEALTH Benefits Specialist: Chooses Working H Premium Discussed | erral Yes, Date: CBS Services (Approved E Approved Y INFORMATION (to be Healthy: No Yes | Yes No By Program Manag Denied completed by Ber Yes, date | Placed or No Re Monthly Cer or Other Auth Start Date | equest Withdrawn Cost (excluding avera ority): | Fax: Yes, Date: Yeage acute care con | sts): | | Yes |