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

NOTIFICATION OF KANCARE/HCBS/MFP/WH/WORK SERVICES CHANGES/UPDATES

ES-3161
Rev. 01-13

TO: ____________________ **FROM:** ____________________

ADDRESS: ____________________ **ADDRESS:** ____________________

____________________ ____________________

I. CONSUMER INFORMATION

Name: ____________________

Case Number (if known): ____________ KanCare ID No.: ____________

Address Change: ____________________ Date: ____________

Responsible Person or Contact Change: ____________________ Date: ____________

II. KANCARE INFORMATION CHANGES (to be completed by DCF eligibility staff)

____ Review Complete: ____ Approved/Denied ____ Working Healthy/WORK – Temporary Unemployment Plan Needed

Review Effective Date: ____________ Next Review Due:: ____________ Date Last Employed: ____________

____ HCBS/MFP Client Obligation Change: $ ________ Effective: ____________ Reason For Unemployment: ____________

$ ________ Effective: ____________ ____________________

____ KanCare Case Closed Effective: ____________ Reason For Closure: ____________________

____ HCBS/MFP Client Employed – Possible Working Healthy/WORK Eligibility

____ Other: ____________________

Comments: ____________________

III. HCBS/MFP/WORK SERVICE CHANGES (to be completed by Case Manager or WORK Manager)

____ HCBS/MFP/WORK Services Review Complete: ____ Approved ____ Denied Effective Date: ____________

____ Level of Care Waiver Change To: ____________ Effective Date: ____________

____ Monthly Cost of Care Change To: $ ____________ Effective Date: ____________

____ HCBS/MFP/WORK Services Terminated: Effective Date: ____________ Reason: ____________________

____ Medical Bills For Client Obligation (bills attached)

____ Entered Nursing Facility: Date Entered: ____________ Facility: ____________________

Anticipated Length of Stay: ____________ Stay is: ____ HCBS Covered Respite Care ____ Temporary Care ____ Permanent/Undetermined

____ Other: ____________________

Comments: ____________________

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

____ Temporary Unemployment Plan Information: ____ Plan Developed ____ Client Failed to Comply – Reason: ____________________

____ Premium Repayment: ____ Agreement Signed – Date Received: ____________

____ Other: ____________________

Comments: ____________________

____________________ Attachments: ____ Yes ____ No

DCF Eligibility Worker Signature Date

____

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