

Notification of HCBS Service: Referral/ Initial Eligibility/ Assessment/ Service Information

I. Consumer Information			
Name:		KanCare ID #:	
Address:			
Phone:	SSN:	Date of Birth:	
Responsible Person/Contact:		Phone:	
Address:			
Initiated By:	Name:	Date Sent:	
Reason for 3160:		HCBS Program Type:	

II. HCBS Program Eligibility Information (Functional Eligibility Assessor)			
Person Completing Section:		Office Phone:	
Address:		Office Fax:	
Applicant MCO choice:			
HCBS Program Type:		Assessment Date:	
Program Threshold Met:	Yes	No	Services Request Withdrawn: Yes No
Submitted to KDADS Date:			
Comments:			
Medicaid App in Progress:	Yes	No	Assisted By: If Other:
Person Completing Section:		Date:	

III. KDADS Program Manager (KDADS Program Manager Approval Required)			
Program Manager:		Office Phone:	
HCBS Program Type:	Approved	Denied	Waitlisted Effective Date:
Comments:			
Person Completing Section:		Date Sent:	

IV. MCO Information		
MCO:	Estimated Cost of Care:	Anticipated Start Date:
If transition, new address:		
Comments:		
Person Completing Section:		Date Sent:

V. Eligibility Information			
Eligibility Worker:		Office Phone:	
HCBS Program Type:	Approved	Denied	Waitlisted Effective Date:
Comments:			
Eligibility Worker:		Date Completed:	

Form Returned upon eligibility completion to	MCO:	KDADS:	Assessor:	DCF:
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