**Notification of KanCare HCBS/MFP Changes and Updates**

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| **I. Consumer Information** |
| Consumer Name: |  | KanCare ID:  |       |
| Case # (if known) |       | SSN: |       | DOB: |       |
| Address Change (if Applicable): |       |
| Responsible Person or Contact Change (if applicable): |       |
|  |
| **II. KANCARE INFORMATION CHANGES (to be completed by eligibility staff)** |
| [ ]  Approval Status:  |  |
| [ ]  Review Complete | Review Effective Date: |       | Next Review Due: |       |
| [ ]  HCBS/MFP Client Obligation Type:  | Client Obligation Changes: | $      | Effective Date: |       |
|  |  | $      | Effective Date: |       |
| [ ]  KanCare Case Closed Effective: |       | Reason for closure: |       |
| [ ]  HCBS Ends Effective: |       |  |  |
| [ ]  HCBS/MFP  |  |  |  |
| [ ]  Other: |       |
| Comments |       |
| Individual Completing Agency Type:  |   | Organization Name (other than state):  |       |
| Email address of submitter: |       |  |
|       |       |
| Signature of Person Completing Section | Date |
|  |  |
| **III. HCBS/MFP CHANGE (to be completed by ADRC, MCO, or HCBS Manager)** |
| [ ]  Service Type:  |  | [ ]  Service Review Status: |  | Effective Date: |       |
| [ ]  Level of Care Waiver Change:  | Effective Date: |       |
| [ ]  Monthly Cost of Care Changes To: | $      |  | Effective Date: |       |
| [ ]  Terminated Service Type |  | Effective Date: |       | Reason for HCBS Closure: |  |
| [ ]  Medical Bills For Client Obligation (bills attached) |
| [ ]  Entered Nursing Facility: | Date Entered: |       | Facility: |       |
|  Anticipated Length of Stay: |       | Stay is:  |  |
| [ ]  Other: |       |
| Comments: |       |
| Individual Completing Agency Type:  |  | Organization Name (other than state):  |       |
|       |       |
| Signature of Person Completing Section | Date |
|  |  |
|  | Attachments: [ ]  Yes [ ]  No |