**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: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 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 | | | |
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