Kansas
Department of Health and Environment
Division of Health Care Finance

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Notification of KanCare HCBS Changes and Updates

I. Consumer Information

Consumer Name:			Select Waiver Type
KanCare ID:	SSN:	Case #:	DOB:
☐ Change for Consumer	Address:		
☐ Change for Responsible Person	Phone:		

II. KanCare Information Changes (to be completed by Eligibility Staff)

☐	Approval status: Select Approval Status	HCBS Waiver Type: Select Waiver Type	
☐	Review status: Select status	Review Effective date :	Next Review date:
☐	Client Obligation Change	Amount $	Effective date:
		$	Effective date:
☐	KanCare Case Closure	Effective date:	Reason for closure: Select HCBS Closure Reason
☐	HCBS Ends	Effective date:	Reason for closure: Select HCBS Closure Reason
☐	Other:		

Comments:

Agency of person completing form: Select Agency of person completing section

Name of Person Completing form:

Email address of Submitter: | Date:

III. HCBS Change (to be completed by Assessor, MCO, or HCBS Manager)

☐	Service type: Select Service Type		
☐	Service Review Status: Service Review Status		Effective Date:
☐	Level of Care waiver change: Select Service Type		Effective Date:
☐	Monthly Cost of Care Changes to:	$	Effective Date:
☐	Terminate: Select Termination Service Type	Effective Date:	Reason: Select HCBS Closure Reason
☐	Medical Bills for Client Obligation (bills attached)		
☐	Entered Nursing Facility	Date Entered:	

Facility Name and Address:

Length of stay: Select length of stay

☐ Other:

Comments:

Agency of person completing form: Select Agency of person completing section

Name of Person Completing form:

Email address of Submitter: | Date: