

**NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES
CHANGES / UPDATES**

ES-3161
Rev. 7-07

TO: Local SRS EES Worker **FROM:** FES / Autism Specialist
ADDRESS: 500 Van Buren **ADDRESS:** 003 Sugar Pie Lane
Topek, Ks 66611 Lawrence, Ks. 66047

I. CONSUMER INFORMATION:

Name: John Smith
Case Number (If Known): _____ Medicaid ID #: 001002003004
Address Change: N/A Date: N/A
Responsible Person or Alternate Contact Change: Mrs. Smith Date: 02/15/2009

II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)

Review Complete: Approved / Denied Working Healthy/WORK - Temporary Unemployment Plan Needed.
Eff Date: _____ Next Review: _____ Date Last Employed: _____
 HCBS Obligation Change: \$ _____ Eff: _____ Reason for Unemployment _____
\$ _____ Eff: _____
 Medicaid Case Close Eff: _____ Reason: _____
 HCBS Client Employed (possible Working Healthy/WORK eligible):
 Other: _____
Comments: _____

III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)

HCBS/WORK Services Review: Approved/Denied approved or denied Effective Date: _____ Month of the initial assessment _____
 Level of Care Waiver Change To: _____ Transfer from one waiver to another _____ Effective Date: _____ Agreed upon date of transfer _____
 Monthly Cost of Services Change To: \$ _____ Effective Date: _____
 HCBS/WORK Services Terminated -Effective Date: _____ Last day of services _____ Reason: Met service limits/ moved
 Medical Bills for Obligation (Bills Attached)
 NF Entrance: Date Entered: _____ Facility: _____ Anticipated Length of Stay _____
Check one: HCBS-Covered Respite Temporary Care Permanent/Undetermined
 Other: Autism Specialist information
Comments: _____

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

Temporary Unemployment Plan Info: Client Failed to Comply, Reason _____ Plan Developed _____
Premium Repayment: Agreement Signed, Date Received _____
Other: _____
Comments: _____

YES NO

EES SPECIALIST/SOCIAL WORKER SIGNATURE _____ DATE _____ ATTACHMENTS: _____

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE _____ DATE _____