

NOTIFICATION OF HCBS OR WORKING HEALTHY SERVICES REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION

TO: Local SRS EES worker FROM: Functional Eligibility Specialist

I. CONSUMER INFORMATION:

Name: Annie Sue Jones Medicaid ID No: 001000000000
Address: 1111 High St, Somewhere, Kansas 666612
Phone: 785-233-0000 SSN: 000-00-0000 Date of Birth: 06/19/06
Responsible Person/Contact: Mrs. Jones Home Phone: 785-233-0000
Address: Same as above Work Phone: _____

II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist or Social Worker)

Working Healthy Referral WORK Referral Eligibility Information HCBS Referral

EES Specialist: _____ Phone: _____

Address: _____ Fax: _____

Medicaid Application: Date: _____ Case #: _____

Status: Pending Denial/Ineligible
 Non-HCBS Approval (check one) Medical Card Spenddown Amount QMB/LMB Only
 Working Healthy Approval, effective date _____ Premium(s): _____
 WORK approval, effective date _____
 HCBS Approved, effective date _____ HCBS Obligation: _____ Month: _____

Next Review Date: _____ HCBS Obligation: _____ Month: _____

Comments: _____

III. HCBS INFORMATION: (to be completed by Case Manager/IL Counselor)

Medicaid Referral Service Information

Case Manager/ILC: Functional Eligibility Specialist Phone: 785-233-0001

Address: Sugar Plum St., Topeka, KS 66612 Fax: 785233-0002

HCBS Waiver Type: Autism Placed on Waiting List: Yes, Date: _____ No

Waiver/LOC Threshold Met? Yes No Request Withdrawn Yes No

Chooses HCBS: Yes, Date: 04/01/09 No Monthly Cost (excluding average acute care costs): _____

Effective Date of HCBS Services (Approved By Program Manager or Other Authority): 04/01/09

WORK Service: Approved Denied Start Date: _____

Comments: Autism Specialist contact information. If an Autism Specialist is still unknown at this time put in Autism Program Manager's information

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

Benefits Specialist: _____ Phone: _____

Chooses Working Healthy: No Yes, date _____

Premium Discussed No Yes, Willing To Pay Prior Medical Premium No Yes Current Premium No Yes

Comments: _____

ELIGIBILITY WORKER SIGNATURE	DATE	ATTACHMENTS
<u>Functional Eligibility Specialist</u>	<u>04/01/09</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO
HCBS AUTHORIZED AGENT SIGNATURE	DATE	

