P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
FAX: 800-498-12554

Notification of KanCare, HCBS/MFP Changes and Updates

I. CONSUMER INFORMATION

Consumer Name: ____________________

Case Number (if known): ____________________ KanCare ID No: ____________________

Address Change (if applicable): ____________________

Responsible Person or Contact Change (if applicable): ____________________

II. KANCARE INFORMATION CHANGES (to be completed by eligibility staff)

☐ Approval Status: Select

☐ Review Complete

Review Effective Date: ____________ Next Review Due: ____________

☐ HCBS/MFP Client Obligation Type: Select Client Obligation Changes: $ ________ Effective Date: ____________

$ ________ Effective Date: ____________

☐ KanCare Case Closed Effective: ____________ Reason for closure: Select

☐ HCBS Ends Effective: ____________

☐ HCBS/MFP Select

☐ Other: ____________________

Comments: ____________________

Completed by Date

III. HCBS/MFP CHANGE (to be completed by ADRC, MCO, HCBS Manager, or IDD Manager)

☐ Service Type: Select ☐ Service Review Status: Select Effective Date: ____________

☐ Level of Care Waiver Change: Select Effective Date: ____________

☐ Monthly Cost of Care Changes To: $ ________ Effective Date: ____________

☐ Terminated Service Type Select Effective Date: ____________ Reason for HCBS closure: Select

☐ Medical Bills For Client Obligation (bills attached)

☐ Entered Nursing Facility: Date Entered: ____________ Facility: ____________

Anticipated Length of Stay: ____________ Stay is: Select

☐ Other: ____________________

Comments: ____________________

Completed by Select Date

Completed by Select Date

Attachments: ☐ Yes ☐ No