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## Notification of KanCare HCBS Changes and Updates

I. Consumer Information			
Consumer Name:			A-1
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:		HCBS Waiver Type:	
Review status:	Review Effective date :	Next Review date:	
Client Obligation Change	Amount \$	Effective date:	
	\$	Effective date:	
KanCare Case Closure	Effective date:	Reason for closure:	
HCBS Ends	Effective date:	Reason for closure:	
Other:			
Comments:			
Agency of person completing form:			
Name of Person Completing form:			
Email address of Submitter:			Date:
III. HCBS Change (to be completed by Assessor, 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:	
Terminate:	Effective Date:	Reason:	
Medical Bills for Client Obligation (bills attached)			
Entered Nursing Facility	Date Entered:		
Facility Name and Address:			
Length of stay:			
Other:			
Comments:			
Agency of person completing form:			
Name of Person Completing form:			
Email address of Submitter:			Date: