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:
Address:			Phone:
Responsible Person Name:			Phone:

II. KanCare information Changed (to be completed by Eligibility Staff)

☐ **Reinstatement**	Effective Date:		Select HCBS Service type:	
☐ **Client Obligation**	Amount:		Effective Date:	
	Amount:		Effective Date:	
☐ **KanCare Case Closure**	Effective Date:	Select Closure Reason:		
☐ **HCBS ends**	Effective Date:	Select 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)

☐ **Reinstatement**	Effective date:	Select Service Type:	
☐ **Monthly cost of care**	Amount:	Effective Date:	
☐ **Terminate**	Effective Date:	Select Closure Reason:	
☐ **Entered Nursing Facility**	Date Entered:		

Facility Name:

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:**