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| **I. INDIVIDUAL’S INFORMATION (Completed by MCO)****INSTITUTION TRANSITION EVALUTATION OF NEED** State of KansasKANSAS DEPARTMENT FOR AGING & DISABILITY Services08/17 |
| Name: |       | KanCare ID No.:      |
| SSN: |       | Date of Birth: |       |  |
| Institution/Nursing Facility Name and Address:                   |
| Institution/Nursing Facility Phone Number:      Institution/Nursing Facility Admission Date:       Institution/Nursing Facility Anticipated Discharge Date:        |
| Individual’s New Address (after transition):            Responsible Person/Contact:       Contact Phone #      Responsible Person/Contact Address:              |
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| Applicant MCO |  |  |

 | Select  |  |
| Choose HCBS: [ ] Yes [ ] No **HCBS Program Type: Choose an item.** If Yes, Choice Date:        |
| TBI/PD Documented Condition:       Please attach documentation  |  |  |
| Comments:       |
| Signature of Person Completing Section        | Date Sent:       |  |  |
| **II. HCBS PROGRAM ELIGIBILITY INFORMATION**  |
| Waiver Program Manager: |       |  |
|  |  |  |  |
| Applicant MCO Choice: | Select | Type of Assessment Select.Date of Assessment:        | ADL/IADL/Tier LevelScore:       |
| HCBS Program Type: | Select On Waiting List: [ ] Yes [ ] No If Yes, Date Removed:       |
| Program Threshold Met: | [ ] Yes [ ] No Services Request Withdrawn: [ ] Yes [ ] No |  |
|  |  |  |  |  |  |
| **HCBS Program Type: Choose an item.** [ ] Approved [ ] Denied |  Effective Date:      |
| Comments: |       |
|       |       |
| Signature of Waiver Program Manager Completing Section |  | Date Sent |

Attachments: [ ] Yes [ ] No