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| **I. INDIVIDUAL’S INFORMATION (Completed by MCO)**  **INSTITUTION TRANSITION EVALUTATION OF NEED**  State of Kansas  KANSAS DEPARTMENT FOR AGING &  DISABILITY Services  08/17 | | | | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | 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 Level  Score: | | | | | |
| HCBS Program Type: | | | | | | | Select On Waiting List: Yes No If Yes, Date Removed: | | | | | | | | | | | | | | | | | |
| Program Threshold Met: | | | | | | | | | Yes No Services Request Withdrawn: Yes No | | | | | | | | | | | | | | |  |
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| **HCBS Program Type: Choose an item.** Approved Denied | | | | | | | | | | | | | | Effective Date: | | | | | | | | | | |
| Comments: | | | |  | | | | | | | | | | | | | | | | | | | | |
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| Signature of Waiver Program Manager Completing Section | | | | | | | | | | | | | | | |  | | | | Date Sent | | | | |

Attachments: Yes No