

NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES
CHANGES / UPDATES

ES-3161
Rev. 7-07

TO: _____ FROM: _____
ADDRESS: _____ ADDRESS: _____

I. CONSUMER INFORMATION:

Name: _____
Case Number (If Known): _____ Medicaid ID #: _____
Address Change: _____ Date: _____
Responsible Person or Alternate Contact Change: _____ Date: _____

II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)

Review Complete: Approved / Denied Working Healthy/WORK - Temporary Unemployment Plan Needed.

Eff Date: _____ Next Review: _____ Date Last Employed _____

HCBS Obligation Change: \$ _____ Eff: _____ Reason for Unemployment _____
\$ _____ Eff: _____

Medicaid Case Close Eff: _____ Reason: _____

HCBS Client Employed (possible Working Healthy/WORK eligible):

Other: _____

Comments: _____

III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)

HCBS/WORK Services Review: Approved/Denied _____ Effective Date: _____

Level of Care Waiver Change To: _____ Effective Date: _____

Monthly Cost of Services Change To: \$ _____ Effective Date: _____

HCBS/WORK Services Terminated -Effective Date: _____ Reason: _____

Medical Bills for Obligation (Bills Attached)

NF Entrance: Date Entered: _____ Facility: _____ Anticipated Length of Stay _____

Check one: HCBS-Covered Respite Temporary Care Permanent/Undetermined

Other: _____

Comments: _____

IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)

Temporary Unemployment Plan Info: Client Failed to Comply, Reason Plan Developed

Premium Repayment: Agreement Signed, Date Received _____

Other: _____

Comments: _____

 YES NO
EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE ATTACHMENTS:

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE