

**NOTIFICATION OF HCBS OR WORKING HEALTHY SERVICES
REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION**

TO: _____ **FROM:** _____

I. CONSUMER INFORMATION:

Name: _____ Medicaid ID No: _____
Address: _____
Phone: _____ SSN: _____ Date of Birth: _____
Responsible Person/Contact: _____ Home Phone: _____
Address: _____ Work Phone: _____

II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist or Social Worker)

Working Healthy Referral Eligibility Information HCBS Referral

EES Specialist: _____ Phone: _____
Address: _____ Fax: _____
Medicaid Application: Date: _____ Case #: _____
Status: Pending
 Non-HCBS Approval (check one) Medical Card Spenddown Amount QMB/LMB Only
 Working Healthy Approval, effective date _____ Premium(s): _____
 Denial/Ineligible
 HCBS Approved, effective date _____ HCBS Obligation: _____ Month: _____
Next Review Date: _____ HCBS Obligation: _____ Month: _____
Comments: _____

III. HCBS INFORMATION: (to be completed by Case Manager/IL Counselor)

Medicaid Referral Service Information

Case Manager: _____ Phone: _____
Address: _____ Fax: _____
Waiver: FE PD MR/DD SED HI
Assessment Date: _____ Waiver/LOC Threshold Met? Yes No Request Withdrawn Yes No
Chooses HCBS: Yes, Date: _____ No Placed on Waiting List: Yes, Date: _____ No
Effective Date of HCBS Services: _____ Monthly Cost (excluding average acute care costs): _____
Comments: _____

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

Benefits Specialist: _____ Phone: _____
Chooses Working Healthy: No Yes, date _____
Premium Discussed No Yes, Willing To Pay Prior Medical Premium No Yes Current Premium No Yes
Comments: _____

EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE YES NO
ATTACHMENTS

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE