

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

ES-3161  
Rev. 7-02

**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)**

<input type="checkbox"/> Review Complete:	<input type="checkbox"/> Approved / Denied	<input type="checkbox"/> Working Healthy - Temporary Unemployment Plan Needed.
Eff Date: _____	Next Review: _____	Date Last Employed _____
<input type="checkbox"/> HCBS Obligation Change:	\$ _____ Eff: _____	Reason for Unemployment _____
	\$ _____ Eff: _____	
<input type="checkbox"/> Medicaid Case Close Eff:	_____	Reason: _____
<input type="checkbox"/> HCBS Client Employed (possible Working Healthy eligible):		
<input type="checkbox"/> Other:	_____	
Comments:	_____	

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

<input type="checkbox"/> HCBS Services Review:	Approved / Denied _____	Effective Date: _____
<input type="checkbox"/> Level of Care Waiver Change To:	_____	Effective Date: _____
<input type="checkbox"/> Monthly Cost of Services Change To: \$	_____	Effective Date: _____
<input type="checkbox"/> HCBS Services Terminated - Effective Date:	_____	Reason: _____
<input type="checkbox"/> Medical Bills for Obligation (Bills Attached)		
<input type="checkbox"/> NF Entrance: Date Entered: _____	Facility: _____	Anticipated Length of Stay _____
Check one: <input type="checkbox"/> HCBS-Covered Respite	<input type="checkbox"/> Temporary Care	<input type="checkbox"/> Permanent/Undetermined
<input type="checkbox"/> Other:	_____	
Comments:	_____	

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

Temporary Unemployment Plan Info:	<input type="checkbox"/> Client Failed to Comply, Reason _____	<input type="checkbox"/> Plan Developed
Premium Repayment:	<input type="checkbox"/> Agreement Signed, Date Received _____	
Other:	_____	
Comments:	_____	

\_\_\_\_\_  
EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE  YES  NO ATTACHMENTS:

\_\_\_\_\_  
CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE