ES-3161
Rev. 7-02

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

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 - 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 eligible):
☐ Other: ______________________
Comments: ______________________

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

☐ HCBS Services Review: Approved / Denied __________ Effective Date: __________
☐ Level of Care Waiver Change To: __________ Effective Date: __________
☐ Monthly Cost of Services Change To: $ __________ Effective Date: __________
☐ HCBS 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: ______________________

____
EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE

ATTACHMENTS: ☐ **YES** ☐ **NO**

____
CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE

This form supersedes IM-3161 (1-98)