

HCBS Waiver Integration Workgroup Application

PROPOSED MEMBER INFORMATION

Member Type: Consumer Family- Relationship to consumer: _____
 Provider Other _____

Name: _____ Agency (if applicable): _____

Address: _____

Phone Number: _____ Email: _____

1. Are you currently participating in any other KDADS work groups/committees? Yes No

If yes, what groups/committees? _____

2. Why do you want to be a member of the Waiver Integration Workgroup? _____

3. What do you feel you could contribute to this Workgroup? _____

4. What HCBS program population(s) do represent? _____

5. What type of services do you provide? _____

WORKGROUP INFORMATION

KDADS is exploring different topics that will be critical components of waiver integration. The following focus groups are essential to the waiver integration project:

Please select the preferred focus group:

- | | |
|-----------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Access, Eligibility, & Navigation Team | <input type="checkbox"/> Policy & Regulation Review |
| <input type="checkbox"/> Service Provision & Limitations | <input type="checkbox"/> Education, Training, & Communication |
| <input type="checkbox"/> Provider Qualifications & Licensing | |

I understand that as part of this workgroup:

- I must work productively with a group of peers in a respectful manner
- I have the resources to travel and I am responsible for any expenses accumulated through the workgroup
- I am committed to dedicating the time required to participate in this workgroup and any focus group meetings in addition to this primary workgroup. Workgroup meetings will be held in Topeka, dates and times will follow.

Signature: _____ Date: _____

Please fill out and return to the following email address by **9/23/2015**.

HCBS-KS@kdads.ks.gov, Subject line: Waiver Integration Stakeholder Workgroup

