**KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES**

**NOTICE OF ACTION**

**PROGRAM:**  
- ☐ Older Americans Act  
- ☐ Senior Care Act

**Date of Notice:**

**TO:**

**FROM:**

**Agency:**

**Attention:**

**Phone:**

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of Units (Specify Per Day or Week)</th>
<th>Self Dir. Y/N?</th>
<th>Provider Name</th>
<th>Dates of Service From</th>
<th>To</th>
<th>Provider Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

☐ Customer Service Worksheet Attached

**Copay:** %  

**Paid To:**

**Comments, Message, or Explanation of Action:**

☐ Effective _____, your services and/or plan of care are being implemented as identified above;

☐ Or other:

**cc:**

Regulatory Reference(s): KDADS FSM _____

You may contact your case manager at the phone number above.

Please carefully read the Customer Rights and Responsibilities with this NOA.

**Case Manager Signature:** ____________________________  

**Date:** ______

KDOA 904 (11/15)