This form is required before you can be approved to start providing STEPS CSC services. This form is also required annually to provide updated contact information and your twelve hours of standardized training in order to continue to be approved to provide STEPS CSC services.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CSC Name: | | | | |  | | | | | | | | | |
| Agency Name: | | | | |  | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | |
| City, State: | | | | |  | | | | | | | Zip: | |  |
| Telephone Number(s): | | | | | | |  | | | | | | | |
| E-mail address: | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **List of counties that you serve:** | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| All CSCs need to have a backup identified in case of urgent matters regarding members.  Please indicate a backup person or supervisor who STEPS should contact regarding members  if you are out of the office. | | | | | | | | | | | | | | |
|  | | | **Name and contact information of a back-up person when you are unavailable. Backup should have at least the same qualifications as a STEPS CSC:** | | | | | | | | | | | |
|  | | | Name of Contact: | | | | |  | | | | | | |
|  | | | Telephone Number: | | | | |  | | | | | | |
|  | | | E-mail address: | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | **Name and contact information of your supervisor:** | | | | | | | | | | | |
|  | | | Name of Supervisor: | | | | |  | | | | | | |
|  | | | Telephone Number: | | | | |  | | | | | | |
|  | | | E-mail address: | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | |
| **Populations served:** | | | | | | | | | | | | | | |
| Intellectual/ Developmental Disability | | | | | | | | | Physical Disability | | Brain Injury | | | Behavioral Health |
|  | | | | | | | | | | | | | | |
| **Choose at least one of the following:** | | | | | | | | | | | | | | |
|  | | Do you have a minimum of six months experience with a disability as recognized by the Rehabilitation Act of 1973? | | | | | | | | | | |
|  | | Do you have a minimum of one-year professional experience providing direct services, including case management (working directly with people with a variety of disabilities) and have completed at least twelve hours of standardized training annually? | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Please provide the following information (for new CSCs only):** | | | | | | | | | | | | | | |
|  | | | Have you completed the *STEPS* orientation training? | | | | | | Date of training: | | |  | |

**Please provide the following information (for existing CSCs only):**

As part of CSC qualifications for the STEPS program, CSCs must complete at least twelve hours of case management training annually.

| **Name of Training** | **Brief Description of Training** | **Date of Training** | **Number of Hours Received** |
| --- | --- | --- | --- |
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As a STEPS Community Service Coordinator, you are required to participate in all state mandated STEPS and community service coordinator trainings to ensure proficiency of the program and services rules, regulations, policies, and procedures set for by the KDHE.

If at any time you are unable to continue providing *STEPS CSC* support for a *STEPS* participant, you must notify the *STEPS* Program Manager in writing two weeks prior to ending CSC support. You must also notify in writing both the participant and the participants MCO Case Manager/Care Coordinator prior to ending CSC support. It will be your responsibility to assist the participants you serve to locate a new CSC prior to ending CSC support.

**By signing this form, you certify that the above is accurate and true.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Printed name of CSC |  |  |
|  |  |  |
|  |  |  |
| CSC Signature |  | Date |