**Sections and questions marked with an asterisk (\*) must be completed to the best of your ability.**

*Please use a separate piece of paper, if necessary, to fully answer any question(s).*

**\*Section A: Personal Information**

*Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *DOB:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Primary phone #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Medicaid #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *MCO:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *SSN (last 4):* \_\_\_\_\_\_\_
*Address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Zip code:* \_\_\_\_\_\_\_\_\_\_

*Email:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Alternate contact #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Check here if the mailing address is the same as the street address
*Mailing Address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Zip code:* \_\_\_\_\_\_\_\_\_\_

*Other Health Insurance (if applicable):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] *Guardian /* [ ] *Representative* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Guard/Rep* *Phone #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Email:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Relationship to participant:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Check here if the Guardian/Representative street or mailing address is the same as the participant address
*Guard/Rep address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ *Zip code:* \_\_\_\_\_\_\_\_\_

Does the person know they are being referred to the STEPS program? [ ]  Yes [ ]  No

**As STEPS is a person-centered program, the person being referred (and/or their guardian) must be involved**

**in the referral process.**

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| **Section B: Employment** |
| **\***Are you currently working? | [ ]  Yes [ ]  No |
| **\***Do you want to find a job? | [ ]  Yes [ ]  No |
| Have you worked in the past? | [ ]  Yes [ ]  No |
| Do you know what type of job you may be interested in? | [ ]  Yes [ ]  No |
| **\***Are there any concerns about self-preservation skills and/or otherwise maintaining safety at work? | [ ]  Yes [ ]  No |
| **\***If so, could these be improved with training? | [ ]  Yes [ ]  No |
| Are you ready to enroll in the program to find and keep a job? | [ ]  Yes [ ]  No |
| **\***Are you getting any employment services now (do not include VR)? | [ ]  Yes [ ]  No |
| **\***If so, who are those services from? |
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|  |
| Have you had employment services in the past? | [ ]  Yes [ ]  No |
| If so, who were those from (e.g., Voc Rehab, school, employment center, etc.)? |
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|  |
| **\***Are you currently receiving any services from Vocational Rehabilitation (VR)? | [ ]  Yes [ ]  No |
| If so, what services are being provided? |
|  |
|  |
| ♦ **STEPS will need a release of information to talk to VR. Please contact Mary Corbett at** **Mary.Corbett@ks.gov** **or** **785-368-7112 ASAP to complete the release, then contact STEPS once the release is complete.** ♦ |

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| **Section B: Employment (continued)** |
| **\***Is transportation a barrier to employment? | [ ]  Yes [ ]  No |
| List any other barriers you know of that you want to overcome to find a job. |
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| **Section C: Eligibility** |
| **\***Do you have a disability determination from Social Security (SSA)? | [ ]  Yes [ ]  No |
| **\***What is the condition that qualified you for disability? Use this space to write in your disability -> |
| **\***Do you have a behavioral health diagnosis as your primary disability?  | [ ]  Yes [ ]  No |
| **\***If so, which | [ ]  Schizophrenia | [ ]  Bipolar/major depression | [ ]  Psychosis NOS | [ ]  PTSD |
| [ ]  Delusional disorders | [ ]  Obsessive-Compulsive Disorder | [ ]  Personality Disorders | [ ]  Substance Use Disorder (SUD)/co-occurring SUD |
| **\***Are you getting any services from a Community Mental Health Center? | [ ]  Yes [ ]  No |
| **\***Are you on an HCBS waiver or waitlist? | [ ]  Yes [ ]  No |
|  **\***If so, which one?  | [ ]  BI Waiver | [ ]  IDD Waiver | [ ]  IDD Waitlist | [ ]  PD Waiver | [ ]  PD Waitlist |

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| **Section D: Service History and Mini-Assessment** |
| **\***Do you need help with personal care needs, like bathing, dressing, eating, etc. (includes prompting)? | [ ]  Yes [ ]  No |
| ♦ **Participants with only a behavioral health condition will need to meet functional criteria in order to be eligible for PAS** ♦ |
| Do you have a current person-centered support plan or have you had one in the past? | [ ]  Yes [ ]  No |
| Do you have any employment goals listed in your support plan? | [ ]  Yes [ ]  No |
| **\***Do you currently have any kind of case manager? | [ ]  Yes [ ]  No |
| **\***If so, what is their contact information? (Agency, Name, phone and/or email) |
|  |
|  |
| Is this the person who referred you to STEPS? | [ ]  Yes [ ]  No |
| If not, who referred you and what is their contact information? (Agency, Name, phone and/or email) |
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| **Section E: Public Benefits** |
| **\***What cash benefit(s) do you get from Social Security? | SSI? $ | SSDI? $ | Other? $ |
| **\***Do you have resources greater than $15,000 (e.g., retirement plans, burial plans, land, rental property, etc.) | [ ]  Yes [ ]  No |
| Do you get any VA cash benefits? | [ ]  Yes [ ]  No |
| Do you get any other unearned income? | [ ]  Yes [ ]  No |
| Do you get SNAP? (Food stamps) | [ ]  Yes [ ]  No |
| Do you apply for Low Income Energy Assistance Program (LIEAP) each year? | [ ]  Yes [ ]  No |
| Do you live in subsidized housing? (Section 8, Housing Authority, etc.) | [ ]  Yes [ ]  No |

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| **Section E: Public Benefits (continued)** |
| **\***Do you worry about being able to pay your bills? | [ ]  Yes [ ]  No |
| **\***Do you have any current legal problems? | [ ]  Yes [ ]  No |
| **\***If so, what are they? (select all that apply) | [ ]  On probation | [ ]  On parole | [ ]  Has arrest(s) |

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| **Section F: Wrap-up** |
| Have you received any other types of supports or is there any other information that you would like to provide? | [ ]  Yes [ ]  No |
| Please provide any additional information: |
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|  |
|  |

Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name and role

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| **‼** **For Program Use Only (Do not write in this box) ‼** |
| **Areas to Assess** | **Provisional Service Plan Info** | **Other Notes** |
| [ ]  Pre-Voc Skills | [ ]  PAS | Identified a CSC?  | [ ]  Yes | [ ]  No |  |
| [ ]  Independent Living Skills | * [ ]  Enhanced Services
 | *CSC Contact info* |
| * [ ]  Home Delivered Meals
 | Agency:  |  |
| [ ]  Transportation | Name: |  |
|  | * [ ]  PERS
 | Phone/email: |  |
|  | * [ ]  Medication Management System
 | If no CSC, the MCO should assist the participant to locate a CSC. A list of approved providers can be found on the STEPS website: <https://kancare.ks.gov/consumers/working-healthy/steps> |
|  |
| **\*MCO Assessors: Please use this as a guide for what to cover in the initial STEPS Services Assessment** |