**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? | |
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|  | |
| ♦ **STEPS will need a release of information to talk to VR. Please contact Mary Corbett at** [**Mary.Corbett@ks.gov**](mailto:mary.corbett@ks.gov?subject=STEPS%20Program%20Release) **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** | |