**You must complete all sections marked with an asterisk (\*) to the best of your knowledge.**

**Complete the rest to the best of your ability.**

**\*Section A: Personal Information**

Name: First and last DOB: M/D/Y Primary phone #: Include area code

Medicaid #: Enter # MCO: Choose SSN: Last 4
Address: Street address City, State: City, State Zip code: Enter zip code

Email: Enter email Alternate contact #: Include area code
[ ]  Mailing address is the same as street address
Mailing address: Street Address City, State: City, State Zip Code: Enter zip code

Other Health Insurance (if applicable): Enter text

[ ] Guardian/[ ] Representative? First and last name Phone #: Include area code

Email: Enter email Relationship to participant: Enter text
[ ]  Guardian/Representative address is the same as participant address
Guardian address: Street address City, State: City, State Zip code: Enter zip code

Is this person aware that 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 employed? | [ ]  Yes [ ]  No |
| **\***Do you want to find a job? | [ ]  Yes [ ]  No |
| Have you been employed before? | [ ]  Yes [ ]  No |
| Do you know what type of job you may be interested in? | [ ]  Yes [ ]  No |
| Are you ready to enroll in the program to obtain and maintain employment? | [ ]  Yes [ ]  No |
| **\***Are you receiving any employment services now (other than VR)? | [ ]  Yes [ ]  No |
| **\***If so, what is the source? Enter here |
| Have you received employment services in the past? | [ ]  Yes [ ]  No |
| If so, what was the source (e.g., Voc Rehab, school, employment center, etc.)? Enter here |
| **\***Are you currently receiving any services from Vocational Rehabilitation (VR)? | [ ]  Yes [ ]  No |
| If so, what services are being provided? Enter here |
| ♦ **STEPS will need a release of information to talk to VR. Please contact Sherry Worthington at** **Sherry.Worthington@ks.gov** **or** **785-207-4630 ASAP to complete the release, then contact STEPS once the release is complete.** ♦ |
| **\***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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| … |
| … |
| … |

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| **Section C: Eligibility** |
| **\***Do you have a disability determination from Social Security | [ ]  Yes [ ]  No |
| **\***What is the condition that qualified you for disability? Enter here |
| **\***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 eligible for an HCBS waiver or waitlist? | [ ]  Yes [ ]  No |
| **\***If so, which? | Choose one. |

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| **Section D: Service History and Mini-Assessment** |
| **\***Do you need assistance with personal care needs, such as bathing, dressing, eating, etc.? | [ ]  Yes [ ]  No |
| ♦ Participants with behavioral health conditions will need to be found eligible for a waiver/waitlist in order to be eligible for PA Services ♦ |
| Do you have a person-centered support plan? | [ ]  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 benefit(s) do you receive from SSA? | SSI? $ Amount  | SSDI? $ Amount | Other? $ Amount |
| **\***Do you have resources greater than $15,000? (e.g., retirement plans, burial plans, land, rental property, etc.) | [ ]  Yes [ ]  No |
| Do you receive any VA Benefits? | [ ]  Yes [ ]  No |
| Do you receive any other unearned income? | [ ]  Yes [ ]  No |
| Do you receive 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 |
| **\***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?  | [ ]  Yes [ ]  No |
| If so, what are they and where are they from? … |

Form completed by: First and last name and role

Date: Enter a date

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| **‼** **For Program Use Only (Do not write in this space) ‼** |
| **Areas to Assess** | **Provisional Service Plan Info** | **Other Notes** |
| [ ]  Pre-Voc Skills | [ ]  PAS | Identified a CSC?  | [ ]  Yes | [ ]  No |  | Other notes |
| [ ]  Independent Living Skills | * [ ]  Enhanced Services
 | *CSC Contact info* |
| [ ]  Transportation | * [ ]  Home Delivered Meals
 | Agency:  | If applicable |
|  | Name: | If applicable |
|  | * [ ]  PERS
 | Phone/email: | If applicable |
|  | * [ ]  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** |
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