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

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

*Email:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Alternate contact #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Mailing address is the same as street address  
*Mailing Address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Zip code:* \_\_\_\_\_\_\_\_\_\_\_\_\_

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

*Guardian/**Representative* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Phone #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Guardian/Representative address is the same as participant address  
*Guard. address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ *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? | |
|  | |
| Have you received employment services in the past? | Yes  No |
| If so, what was the source (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 Sherry Worthington at** [**Sherry.Worthington@ks.gov**](mailto: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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| **Section C: Eligibility** | | | | | | | | | | | | |
| **\***Do you have a disability determination from Social Security | | | | | | | | | | | | Yes  No |
| **\***What is the condition that qualified you for 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 eligible for an HCBS waiver or waitlist? | | | | | | | | | | | | Yes  No |
| **\***If so, which? | | BI | IDD | | PD |  | | | | Waitlist | | Wavier |

|  |  |
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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? $ | | | SSDI? $ | | Other? $ | | |
| **\***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? | |
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Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and role

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **‼** **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 |  |
| Independent Living Skills | * Enhanced Services | *CSC Contact info* | | | | |
| Transportation | * Home Delivered Meals | Agency: |  | | | |
|  | 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** | |
|  | |