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

**Complete the rest 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 #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Mailing address is the same as street address
*Mailing Address:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City, State:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Zip code:* \_\_\_\_\_\_\_\_\_\_

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

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

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

[ ]  Guardian/Representative address is the same as participant address
*Guard/Rep 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** **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 |
|  |  |
|  |
| **Section B: Employment Continued** |
| 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 |

|  |  |
| --- | --- |
| **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 beeligible 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 |
|  |
|  |
| **Section E: Public Benefits Continued** |
| 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* |
| * [ ]  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** |