

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

***Section A: Personal Information**

Name: _____ DOB: _____ Primary Phone #: _____

Medicaid #: _____ MCO: _____ SSN: _____

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: _____

Guardian or Representative? Name: _____ Phone #: _____

Email: _____ Relationship to referral: _____

Check here if the Guardian/Representative street or mailing address is the same as referral address

Guardian/Rep Address: _____

City, State: _____ Zip Code: _____

***Does the person (and/or their guardian) 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.

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

*Are there any concerns about self-preservation skills and/or otherwise maintaining safety at work? Describe. 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?

Have you had employment services in the past? Yes No

*If so, who were those from (e.g., Voc Rehab, school, employment center, etc.)?

*Are you currently getting any services from Vocational Rehabilitation (VR)? Yes No

*If so, what services are you getting?

♦ 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. ♦

*Is transportation a barrier to working? Yes No

*Do you have an unrestricted driver's license? Yes No

List any other barriers you know of that you want to overcome to find a job.

Section C: Eligibility

*Do you have a disability determination from Social Security (SSA)? Yes No

*What is the condition that qualified you for disability?

Section C: Eligibility (continued)

*Do you have a behavioral health diagnosis? Yes No

*If so, which: Schizophrenia Bipolar/major depression Psychosis NOS
 Delusional disorders Obsessive-Compulsive Disorder PTSD
 Substance Use Disorder (SUD)/co-occurring SUD Personality Disorders

*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? _____

Section D: Service History

*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 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/did 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? _____

Is this the person who referred you to STEPS? Yes No

*If not, who referred you and what is their contact information? _____

Section E: Public Benefits

*What cash benefit(s) do you get from Social Security? SSI? SSDI? Other? Yes No

*Do you have resources greater than \$15,000? (e.g., retirement plans, burial plans, land, 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

*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)

Section F: Wrap-up

Have you had any other supports or is there any other information you would like to share? Yes No

Please provide any additional information: _____

Who completed form: _____

Date: _____

Support & Training for Employing People Successfully (STEPS) Referral Form – Fill and Submit

!! For STEPS Program Manager Use Only (Do not write in this box) !!

Meets program criteria: Behavioral Health HCBS waiver/waitlist SSDI (or Title II) SSI (or Title 19)

Areas to Assess	Provisional Service Plan Info	Other Notes
<input type="checkbox"/> Pre-Voc Skills <input type="checkbox"/> PAS <input type="checkbox"/> Independent Living Skills <input type="checkbox"/> Enhanced Services <input type="checkbox"/> Transportation <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> <input type="checkbox"/> PERS <input type="checkbox"/> <input type="checkbox"/> Medication Management System <p>*MCO Assessors: Please use this as a guide for what to cover in the initial STEPS Services Assessment</p>	Identified a CSC? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>CSC Contact info</i> Agency: _____ Name: _____ Phone/email: _____ 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://www.kancare.ks.gov/providers/programs/working-healthy/steps-providers	