

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? _____
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- 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	