

Kansas Department for Aging and Disability Services

Options Counseling Form

\*\* - Indicates fields in the section are required

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*\*Session Date: | | | | | |  | | | | | | | | | | \*\*KAMIS ID: | | | | | |  | | | | \*\*Time: start: | | | |  | | | end : | | |  |
| \*\*Options Counselor: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*CUSTOMER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First: | |  | | | | | | | | | | | | | | | | | | | | | M.I.: | | | | | | |  | | | | | | |
| Last: | |  | | | | | | | | | | | | | | | | | | | | | Nickname: | | | | | | |  | | | | | | |
| Birth Date | | | |  | | | | | |  | | | |  | | | | | | |  | | Social Security #: | | | | | | |  | | | | | | |
|  | | | | Month | | | | | | Day | | | | Year | | | | | |  | | | | | | | | | |  | | | | | | |
| Marital Status: | | | | | | | | Single | | | | | | | | | Married | | | | | | | Widowed | | | | | | | Divorced | | | | | |
|  | | | | | | | |  | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | |
| Gender: | | | | | | | | Female | | | | | | | | | Male | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | |  | | | | |
| Veteran? | | | | | | | | | | | | Yes | | | | | | | No | | |
| Spouse of Veteran? | | | | | | | | | | | | Yes | | | | | | | No | | |
| Receives Veteran Benefits? | | | | | | | | | | | | Yes | | | | | | | No | | |
| **Primary Language:** | | | | | | | | Speaks | | | Reads | | | | Understands Orally | | | | | | | **Ethnicity:** | | | | | | | | | | | | | | |
| Arabic | | | | | | | |  | | |  | | | |  | | | | | | | Hispanic or Latino | | | | | | | | | | | | | | |
| Chinese | | | | | | | |  | | |  | | | |  | | | | | | | Not Hispanic or Latino | | | | | | | | | | | | | | |
| English | | | | | | | |  | | |  | | | |  | | | | | | | Ethnicity Missing | | | | | | | | | | | | | | |
| French | | | | | | | |  | | |  | | | |  | | | | | | |  | | | | | | | | | | | | | | |
| German | | | | | | | |  | | |  | | | |  | | | | | | | **Race:** | | | | | | | | | | | | | | |
| Hindi | | | | | | | |  | | |  | | | |  | | | | | | | White Non-Hispanic | | | | | | | | | | | | | | |
| Pilipino | | | | | | | |  | | |  | | | |  | | | | | | | White Hispanic | | | | | | | | | | | | | | |
| Sign | | | | | | | |  | | |  | | | |  | | | | | | | American Indian/Alaskan Native | | | | | | | | | | | | | | |
| Spanish | | | | | | | |  | | |  | | | |  | | | | | | | Asian | | | | | | | | | | | | | | |
| Tagalog | | | | | | | |  | | |  | | | |  | | | | | | | Black or African American | | | | | | | | | | | | | | |
| Urdu | | | | | | | |  | | |  | | | |  | | | | | | | Native Hawaiian or Other Pacific Islander | | | | | | | | | | | | | | |
| Vietnamese | | | | | | | |  | | |  | | | |  | | | | | | | Reporting some other race | | | | | | | | | | | | | | |
| Other: | | | | | | | |  | | | | | | | | | | | | | | Reporting 2 or more races | | | | | | | | | | | | | | |
| Interpreter Needed | | | | | | | Yes | | | | | | | | No | | | | | | |  | | | | | | | | | | | | | | |
| **\*\*ADDRESS INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Residence Address** | | | | | | | | |  | | | | | | | | | | | Customer’s home is: | | | | | | | | | Rural | | | | | Urban | | |
| Street Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | | | | County: | | | | |  | | | | | | | | | | State: |  | | | Zip: | | |  | |
| Phone: | | |  | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | |  | | | | | | | | | |
| **ASSOCIATE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency or alternative contact:** | | | | | | | | | | | | | | | | | | | | Relationship: | | | | |  | | | | | | | | | | | |
| First Name: | | | | |  | | | | | | | | | | | | | | | Last Name: | | | | |  | | | | | | | | | | | |
| Street Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | | | | County: | | | | |  | | | | | | | | | | State: |  | | | Zip: | | |  | |
| Phone: | | |  | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal Guardian:** | | | | | | | | | | | | | | | | | | | | Relationship: | | | | |  | | | | | | | | | | | |
| First Name: | | | | |  | | | | | | | | | | | | | | | Last Name: | | | | |  | | | | | | | | | | | |
| Street Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | | | | County: | | | | |  | | | | | | | | | | State: |  | | | Zip: | | |  | |
| Phone: | | |  | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DPOA:** | | | | | | | | | | | | | | | | | | | | Relationship: | | | | |  | | | | | | | | | | | |
| First Name: | | | | |  | | | | | | | | | | | | | | | Last Name: | | | | |  | | | | | | | | | | | |
| Street Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | | | | County: | | | | |  | | | | | | | | | | State: |  | | | Zip: | | |  | |
| Phone: | | |  | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | |  | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Options Counseling Form | | | | | | | | | | | | | | | | | | | | | | |
| Customer: |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*SESSION DETAILS** | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Source To Options Counseling:** | | | | | | | | | | | | | | | | | | | | | | |
| ADRC Call Center | | | | ADRC Website | | | | | Brochure | | | | | | | | Caregiver | | | | | |
| CTO | | | | Family Member | | | | | Friend – Neighbor | | | | | | | | Hospital | | | | | |
| MFP | | | | Nursing Facility | | | | | Other Website | | | | | | | | Self | | | | | |
| Social Service Agency | | | | | | | | |  | | | | | | | |  | | | | | |
| **Contact Method:** | | | | | | | | | | | | | | | | | | | | | | |
| Phone | | | | In Person | | | | | E-Mail | | | | | | | | FAX | | | | | |
| Mail | | | | Other | | |  | | | | | | | | | | | | | | | |
| **If Contact Method is In Person - Location:** | | | | | | | | | | | | | | | | | | | | | | |
| ADRC | | | | Customer’s Residence | | | | | Community Center | | | | | | | | Hospital | | | | | |
| NF / Institution | | | | Other Location | | | | |  | | | | | | | | | | | | | |
| **Current Living Arrangement:** | | | | | | | | | | | | | | | | | | | | | | |
| Apartment | | | | Condominium | | | | | Assisted Living | | | | | | | | Boarding Care Home | | | | | |
| Duplex | | | | Home Plus | | | | | Homeless | | | | | | | | House | | | | | |
| Townhouse | | | | Mobile Home | | | | | Nursing Home | | | | | | | | Residential Health Care | | | | | |
| Other | |  | | | | | | | | | | | | | | | | |  | | | |
| **Customer Lives With:** | | | | Alone | | | | | Family | | | | | | | | | Non-Relative | | | | |
|  | | | | Not Disclosed | | | | | Spouse | | | | | | | | | | | | | |
| **Customer's Disability: (All Ages)** | | | | | | | | | | | | | | | | | | | | | | |
| Dementia | | | | MR / DD / ID | | | | | Mental Illness | | | | | | | | | Multiple Disabilities | | | | |
| No Disabilities | | | | Physically Disabled | | | | | Traumatic Brain Injury | | | | | | | | | Unknown | | | | |
| Unspecified Disabilities | | | | | | | |  | | | | | |  | | | | | | |  | |
| **Current Medicaid Program:** | | | | | | | | | | | | | | | | | | | | | | |
| Autism | | | FE | | | MH | | | | MR / DD | | | | | NF / ACH | | | | | PACE | | |
| PD | | | TA | | | TBI | | | | Not Currently Enrolled | | | | | | | | | | Other | | |
| Medicaid Card ID (not required): | | | | |  | | | | | | | |  | | |  | | | | | |  |
|  | | | | |  | | | | | | |  | | | |  | | | | | |  |
| **Most important challenge / issue for the customer at this time.** (Reason for this Options Counseling Session): | | | | | | | | | | | | | | | | | | | | | | |
| Abuse/Neglect/Exploitation | | | | | | | | | | | Assistive Technology | | | | | | | | | | | |
| CARE | | | | | | | | | | | Caregiver Support | | | | | | | | | | | |
| Cognitive/Mental Health | | | | | | | | | | | Crisis Intervention | | | | | | | | | | | |
| Durable Medical Equipment | | | | | | | | | | | Employment/Ticket to Work | | | | | | | | | | | |
| Financial Assistance | | | | | | | | | | | Financial Management Service (FMS) | | | | | | | | | | | |
| Hospitalization | | | | | | | | | | | Housing and/or Supplies | | | | | | | | | | | |
| In Home Services | | | | | | | | | | | KanCare Mailings | | | | | | | | | | | |
| KanCare Options | | | | | | | | | | | Legal Assistance | | | | | | | | | | | |
| Long Term Care Options | | | | | | | | | | | Medicaid Application Information | | | | | | | | | | | |
| Medicaid Assistance | | | | | | | | | | | Medicaid Denial | | | | | | | | | | | |
| Medicare/SHICK | | | | | | | | | | | Medication Management | | | | | | | | | | | |
| NF / ACH Placement Options | | | | | | | | | | | Nutrition Support | | | | | | | | | | | |
| Other | | | | | | | | | | | Peer Support | | | | | | | | | | | |
| Private Pay Options | | | | | | | | | | | Rehabilitation (including vision and hearing) | | | | | | | | | | | |
| Respite | | | | | | | | | | | Substance Abuse | | | | | | | | | | | |
| Transition | | | | | | | | | | | Transportation | | | | | | | | | | | |
| Veteran's Services | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Options Counseling Form | | | | | | | | | | | | | | | | | | |
| Customer: |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **\*\*SESSION DETAILS** (continued) | | | | | | | | | | | | | | | | | | |
| What is important to the Customer:  (Values, Needs, Goals) | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| What has the Customer tried previously to meet their identified need(s): (optional) | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | |
| What is the Customer’s Desired Outcome for this Session: | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Options Discussed:** | | | | | | | | | | | | | | | | | |
| Informal Support Options | | | | | | KanCare Plan Options | | | | | | | | | Medicaid Long Term Care Options | | |
| Long Term Care Options | | | | | | | PACE Options | | | | | | | | Private Pay Long Term Care Options | | |
|  | | | | | | | | | | | | | | | | | |
| Customer requested risks and benefits of each option? | | | | | | | | | | | | | Yes | | | No | |
| Number of Session Attendees (other than customer): | | | | | | | | | | |  | | | | | | |
| The Session Attendance Sheet (page 4) must be uploaded with KAMIS | | | | | | | | | | | | | |  | | | |
| **FOLLOW-UP INFORMATION** | | | | | | | | | | | | | | | | | |
| \*\* Follow-Up Needed: | | | | Yes | | | | | | No | | Proposed Follow-Up Date: | | | | |  |
| Follow-Up Completed: | | | | Yes | | | | | | No | | Follow-Up Completed Date: | | | | |  |
| Follow-Up Assigned To: | | | |  | | | | | | | | | | | | | |
| Time Spent on Follow-Up (total): | | | | |  | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | |
| Follow-Up Note: | |  | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | |

Action / Referral Information

|  |  |
| --- | --- |
| **Customer Name:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Action Type**  (Action/Referral/ Information) | **Action / Referral Date** | **Detail of Action or Referral** | **Action To Be Performed By** | **Action Goal or Referral Date** | **Completed** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Option Counseling Attendee Listing

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Customer Name:** |  | | **Date:** |  |
| **NAME** | | **RELATIONSHIP** | **PHONE** | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |