**Kansas Department for Aging and Disability Services Standard Intake & Information Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PSA:** |  | | | | **Interviewer:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | **Intake Type:** | | | | | | | | | | | | | | | | **CARE** | | | | | | | | | | | | | | | | | **In-Home Services** | | | | | | | | | | | | | | | |
| **Intake Relate to:** | | | | | | | | | | | FE | | | | | | | | PD | | | | | | | | | | | | | TBI | | | | | | | | | | | | | OAA | | | | | | | | | | | | | | | | SCA | | | | | | | | | | | | | Other: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intake Source:** | | | | | | | | | | | 3160 | | | | | | | | | | | | Telephone –  Customer | | | | | | | | | | | | | | | | | | | Telephone –  Family | | | | | | | | | | | | | | | | | | | | | | | | Telephone –  Provider | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **CUSTOMER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Customer Name**: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Birth Date**: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | Age: | | | | | | | |  | | | | | | | | |
| Social Security # | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | KAMIS #: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Gender: | | | | | | | | | | | | | | Female  Other | | | | | | | | | | | | | | | | | | Male | | | | | | | | | |
| Marital Status: | | | | | | | | | Single | | | | | | | | | | | | | | | | Married | | | | | | | | | | | | | | | | | | | | | | Widowed | | | | | | | | | | | | | | | | | | | | | Divorced | | | | | | | | | | | | | | | | | | | | | | Veteran: | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | No | | | | | |
| Spouse Name: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Spouse Birth Date: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has a medical card: | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | | | | | If yes, #: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Applied for HCBS/Medicaid: | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | | | | | When (date): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | Approved for Social Security Disability: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | No |
| On the I/DD waiver or waiting list: | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | | | | | SSD Approval pending  Physical Disability Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Race**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hispanic or Latino | | | | | | | | | | | | | | | | | Not Hispanic or Latino | | | | | | | | | | | | | | | | | | | | | | | | | | | | | White Non-Hispanic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Black or African American | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethnicity Missing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | White Hispanic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Native Hawaiian or Other Pacific Islander | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interpreter Needed: | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | No | | | | | | | | | | | | | | | American Indian/Alaskan Native | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reporting some other race | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, specify language: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Asian | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reporting 2 or more races | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDRESS INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | *Street* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *City* | | | | | | | | | | | | | | | | | | | | | | | | | | | *County* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *State* | | | | | | | | | | | | | | | | *Zip* | | | | | | | |
| **Phone:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Email: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ASSOCIATE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does the customer have a legal guardian?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | | | | No | | | | | | | | | | | | | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency Contact: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Email: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Phone (alternate): | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | *Street* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *City* | | | | | | | | | | | | | | | | | | | | | | | | | | | *County* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *State* | | | | | | | | | | | | | | | | *Zip* | | | | | | | |
| Emergency Contact Living with Customer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | No | | | | | | | | | | | | | Emergency Contact Primary Caregiver: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | No | | | | |
| **CUSTOMER’S CURRENT LOCATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Home** | | | | | | | | | | **Nursing Facility** | | | | | | | | | | | | | | | | | | | **Hospital** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Prison** | | | | | | | | | | | | | | | | **Other**: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Facility or Hospital – complete name and address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Admission Date: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | Expected Discharge Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Name: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Less Than 30 Day Admission: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | No | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Emergency Admission: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | No | | | | | | |
| *Street* | |  | | | | | | | | | | | *City* | | | | | | | | | *State* | | | | | | | | | | | | | | *Zip* | | | | | | | | | | | | | *Phone* | | | | | | | | | | | | | Terminal Illness or Coma Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | No | | | | | | |
| **PASRR (Required for CARE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does customer have a history of MI or ID/DD or related condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | No | | | | | | | If Yes, which: | | | | | | | | | | | | | | | MI | | | | | | | | | | ID/DD | | | | | | | | | | | | | | | | Related condition | | | | | | | | | | | | | | |
| Is a CMHC involved? | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | No | | | | | | | | | | | | | | | | | | Is a CDDO involved? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Case Manager Name: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | Case Manager Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Agency Name/Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **NEEDS (CHECK IF APPLICABLE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **RISK FACTORS (CHECK IF APPLICABLE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bathing | | | | | | | | | | | | | | | | | | | | | | | | | | | Shopping | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Animals in or around home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Infectious Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dressing | | | | | | | | | | | | | | | | | | | | | | | | | | | Toileting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Bladder/Incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Lives Alone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eating | | | | | | | | | | | | | | | | | | | | | | | | | | | Transfer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Criminal Record | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Memory/Difficulty | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Laundry/Housekeeping | | | | | | | | | | | | | | | | | | | | | | | | | | | Transportation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Depression | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Neglect, Abuse, Exploitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Management of Meds/Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | Use of Telephone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Falls, Unsteadiness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Support, Caregiver not available | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Meal Preparation | | | | | | | | | | | | | | | | | | | | | | | | | | | Walking, Mobility | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hearing Impairment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Visual Impairment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Money Management | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is customer aware of the referral? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | Does customer agree to the referral? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | No | | | |
| Referred By: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Most significant concerns / health problems: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current services / providers: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FINANCIAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family Size: | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Income Sources: | | | | | | | | | | | | | | | | | | Customer | | | | | | | | | | | | | | | |  | | | | | | | Spouse | | | | | | | | | | | |  | | | | | | | | | | |
| Assets Above: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | SSA | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
| $10,000 (1 person) | | | | | | | | | | | | | | Yes | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | SSI | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
| $13,500 (2 persons) | | | | | | | | | | | | | | Yes | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
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| **CUSTOMER REFERRAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Assessment | | | | | | | | Assessment Type: | | | | | | | | | | | | | | | | | | | | | HCBS | | | | | | | | | | | | | | | | | | | OAA | | | | | | | | | | | | | | | | | SCA | | | | | | | | | | PACE | | | | | | | | | | | | | | | | Due Date: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| APS/CPS | | | | | | CIL | | | | | | | | | | | | CDDO | | | | | | | | | | | I&A/OC | | | | | | | | | | | | | | | | | | | | | | | | | | Mental Health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **I & A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Information Mailed: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | ***Date*** | | | | | | | | | | | | ***Units*** | | | | | | | | | | | | | | | ***Date*** | | | | | | | | | | | | ***Units*** | |
| Comments: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | |
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