**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 |  |  |  |  |
|  | Total |  | + |  | = |  |
| **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: |  |  |  |  |  |  |
|  |  |  |  |  |  |