KANSAS DEPARTMENT ON AGING & DISABILITY SERVICES – CUSTOMER SERVICE WORKSHEET

Date: _____

Customer Name:	**Address:**	**City**	**Zip**
County	**Phone #**		**KAMIS ID#**
Emergency Contact	**Relationship**	**Phone #**	**Alt. Phone #**

UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Service Code:	Provider: Service Code:	Provider: Service Code:	Informals/ Non-KDADS Admin
	Bathing/Grooming ☐ Total Assist (4) ☐ Physical Assist (3) ☐ Supervise (oversight) (2) ☐ Customer chooses lower level or N/A Specify: ☐ Type: / ☐ Oral Hygiene/ ☐ Hair Care/ ☐ Skin Care/ ☐ Shaving/ ☐ Other				
	Dressing/Undressing ☐ Total Assist (4) ☐ Physical Assist (3) ☐ Supervise (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Prosthesis, specify:				
	Toileting ☐ Total Assist (4) ☐ Physical Assist (includes pericare) (3) ☐ Supervise (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Special Needs: ☐Commode/ ☐Bedpan/ ☐Urinal/ ☐ Incontinence Mgmt/ ☐ Ostomy(HMA)/ ☐ Catheter Care(HMA)/ ☐ Other				
	Transfer (non-bathing or toileting transfers) ☐ Total Assist (4) ☐ Physical Assist (3) ☐ Supervise (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Special Needs: ☐ Assistive devices for transfers/ ☐ Other (specify)				

KANSAS DEPARTMENT ON AGING & DISABILITY SERVICES – CUSTOMER SERVICE WORKSHEET

					Date: _____
UAI Code	**Activities of Daily Living/ Instrumental Activities of Daily Living**	**Provider: Service Code:**	**Provider: Service Code:**	**Provider: Service Code:**	**Informals/ Non-KDADS Admin**
	Walking/Mobility ☐ Total Assist (bedfast) (4) ☐ Range of Motion (HMA) ☐ Physical Assist (3) ☐ Supervise (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Assistive Device(s): ☐ Wheelchair/ ☐ Cane/ ☐ Walker/ ☐ Other (specify)				
	Eating ☐ Total Assist (feed) (4) ☐ Physical Assist (includes cutting food) (3) ☐ Supervise (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Special Nutrition: ☐ Tube Feed (HMA)/ ☐ Other				
	Meal Preparation Specify: Breakfast/ Lunch/ Supper/ Snack ☐ Total Assist: prepare and serve meal (4) ☐ Partial Assistance w/ meal prep. (3) ☐ Supervision (oversight/cueing) (2) ☐ Customer chooses lower level or N/A Specify: ☐ Special Diet, type ☐ Future Meals/ ☐Lives in congregate/family setting.				
	Shopping ☐ Total Assist (unable to shop) (4) ☐ Physical Assist (accompany) (3) ☐ *Supervise (oversight/cuing) *Informal only** (2) ☐ Customer chooses lower level or N/A Specify: ☐ Groceries/ ☐ Medication Pick-up/ ☐ Hygiene/Medical Supplies				
	Money Management ☐ *Total Assist *Informal only** (4) ☐ Physical Assist (3) ☐ Supervise (remind/oversight) (2) ☐ Customer choose lower level or N/A				

KANSAS DEPARTMENT ON AGING & DISABILITY SERVICES – CUSTOMER SERVICE WORKSHEET

					Date: _____
UAI Code	**Activities of Daily Living/ Instrumental Activities of Daily Living**	**Provider: Service Code:**	**Provider: Service Code:**	**Provider: Service Code:**	**Informals/ Non-KDADS Admin**
	Transportation ☐ Total Assist (4) ☐ Physical Assist (3) ☐ Supervise (2) ☐ Customer choose lower level or N/A Accompanying to Medical Appointments (specify frequency) *Other, such as: to shop and social activities (*Informal only*)*				
	Telephone Usage (*Informal only*)				
	Laundry/Housekeeping ☐ Total Assist (4) ☐ Physical Assist (3) ☐ Supervise (2) ☐ Customer chooses lower level or N/A **Laundry** ☐ Specify: ☐ In home or apt. ☐ In the apt. complex ☐ Outside home or apt. complex **Cleaning (non-chore tasks)** ☐ Bathroom/ ☐ Kitchen/ ☐ Bedroom/ ☐ Vacuum/ ☐ Scrub Floors / ☐ Commode/ ☐ Change linens/ ☐ Remove Trash/ ☐ Dust/ ☐ Other				
	Management of Medications/Treatments ☐ Total Assist (w/ med. admin. & performing treatments, HMA) (4) ☐ Physical Assist (w/ med. Admin. & performing treatments, HMA) (3) Supervise (2): Specify: ☐Oversight/Cueing ☐Medication Set-up ☐ Customer chooses lower level or N/A ☐ Other, specify:				
	Specify days and frequency:	Days: Units Per	Days: Units Per	Days: Units Per	

☐ **Check if supplemental page attached.** ☐ **Check if more than one Customer Service Worksheet attached.**

CUSTOMER OR REPRESENTATIVE SIGNATURE_____DATE_____