KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
III-E CAREGIVER ASSESSMENT PLAN **KAMIS ID #** _____

I. INTAKE
Interviewer _____ PSA _____ Date of Assessment _____ ☐ Initial ☐ Reassessment

II. CAREGIVER CATEGORY
☐ Caregiver (Complete Sec. III, V, VI, and VII)
☐ Older Relative: ☐ Caring for child(ren) < 19 years of age (Complete Sec. III, IV, and VII)
☐ Caring for disabled adult(s) 19-59 years of age (Complete Sec. III, IV, VI, and VII)

III. CAREGIVER INFORMATION
Name (First, Middle, Last) _____ DOB _____ SSN _____ ☐ Male ☐ Female ☐ Other
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White
Income below poverty level? ☐ Yes ☐ No
Address _____ City _____ County _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____

IV. CAREGIVER for Child(ren) or Disabled Adult(s):
Number of children cared for: Number of disabled adults cared for:
Relationship to Child(ren)/Disabled Adult(s) ☐ Grandparent ☐ Elderly Relative ☐ Elderly Non-relative ☐ Parent

V. CAREGIVER for Adult - Relationship to Recipient: ☐ Husband ☐ Wife ☐ Domestic partner, including civil union
☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Sister ☐ Brother ☐ Other relative ☐ Non-relative

VI. ADULT CARE RECIPIENT #1 INFORMATION:
Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult 19-59
Name (First, Middle, Last) _____ DOB _____ Recipient SSN _____ ☐ Male ☐ Female ☐ Other
Address _____ City _____ County _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____

ADLS
☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfer ☐ Walking/Mobility ☐ Eating

IADLS
☐ Meal Preparation ☐ Shopping ☐ Money Management ☐ Transportation ☐ Use of Telephone ☐ Laundry/Housekeeping ☐ Medication Mgmt/Treatment

VII. CAREGIVER SERVICE PLAN

Recipient No.	Service Code	Provider Name	Units	Per	Total Units	Start Date	End Date	Discharge Code

VIII. ADULT CARE RECIPIENT #2:

CAREGIVER for Adult - Relationship to Recipient: ☐ Husband ☐ Wife ☐ Domestic partner, including civil union ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Other Relative ☐ Non-relative

Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult < 60

ADULT CARE RECIPIENT #2 INFORMATION

☐ Male ☐ Female ☐ Other

Name (First, Middle, Last _____ DOB _____ Recipient SSN _____

Address _____ City _____ County _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

ADLS

☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfer ☐ Walking/Mobility ☐ Eating

IADLS

☐ Meal Preparation ☐ Shopping ☐ Money Management ☐ Transportation ☐ Use of Telephone ☐ Laundry/Housekeeping ☐ Medication Mgmt/Treatment

IX. ADULT CARE RECIPIENT #3:

CAREGIVER for Adult - Relationship to Recipient: ☐ Husband ☐ Wife ☐ Domestic partner, including civil union ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Brother ☐ Sister ☐ Other Relative ☐ Non-relative

Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult < 60

ADULT CARE RECIPIENT #3 INFORMATION

☐ Male ☐ Female ☐ Other

Name (First, Middle, Last _____ DOB _____ Recipient SSN _____

Address _____ City _____ County _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

ADLS

☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfer ☐ Walking/Mobility ☐ Eating

IADLS

☐ Meal Preparation ☐ Shopping ☐ Money Management ☐ Transportation ☐ Use of Telephone ☐ Laundry/Housekeeping ☐ Medication Mgmt/Treatment

X. NOTES:

III-E CAREGIVER ASSESSMENT PLAN
INSTRUCTIONS

GENERAL

- Do not use this form if you are providing "**Public Information**" or **"Assistance - Information & Assistance"** only.
- Complete the entire III-E Caregiver Assessment Plan (CAP) according to the instructions provided below when requesting or providing the following Title III-E Services: Assistance - Case Management; Individual Counseling; Caregiver Training (Individual or Group); Respite; and Supplemental Services.

SECTION I: INTAKE

- Complete ***all*** information in Section I.

SECTION II: CAREGIVER CATEGORY

- Check the funding category for which the applicant is applying. If applying for more than one category, separate forms must be completed.
- Check "Older Relative" if caring for Child/Children < 19 years of age or disabled adult(s) 19 - 59 years of age, regardless of the caregiver's relationship to the child or disabled adult.

SECTION III: CAREGIVER INFORMATION

- Complete ***all*** "Caregiver" information, including a complete address.
- The Ethnicity and Race categories reflect Office of Management and Budget (OMB) requirements. Caregivers are to be asked about their ethnicity and race as two separate questions. The Caregiver should be given the opportunity for self-identification. The Ethnicity and Race categories will be used for data collection purposes only. Poverty status will used for data collection purposes only.

SECTION IV: CAREGIVER FOR CHILD/CHILDREN <19 YEARS OF AGE OR DISABLED ADULT 19-59 YEARS OF AGE

- Complete this section only if "Older Relative" Caregiver Category checked.
- List the total number of qualifying children and total number of qualifying disabled adults being care for in the home. Check all applicable "Relationships" to the child(ren) and disabled adult(s).

SECTION V: CAREGIVER FOR ADULT

- Check the applicable "Relationship". A separate section for each adult care recipient is required.

SECTION VI: ADULT CARE RECIPIENT #1 INFORMATION:

- Complete ***all*** "Adult Care Recipient #1" information.

SECTION VII: CAREGIVER SERVICE PLAN

- Enter Care Recipient No. (e.g. Recipient #1, 2, or 3) for applicable adult or leave column blank if "Older relative caring for child(ren) < 19 years of age" Caregiver;
- Enter Service Code; Provider Name; Units; Per (day or week); Total Units (per month); Service Start Date; and Service End Date.
- Enter a Discharge Code when the Caregiver no longer receives a service.

SECTION VIII: ADULT CARE RECIPIENT #2

- Complete ***all*** "Adult Care Recipient" information for a second adult if two or more adults are care recipients.

SECTION IX: ADULT CARE RECIPIENT #3

- Complete ***all*** "Adult Care Recipient" information for a third adult if three or more adults are care recipients. **(***Additional forms may be used if more than three adults are care recipients.)*

SECTION X: NOTES

- This section is available for the Interviewer to record any information that may be applicable.

Contact the KDADS Family Caregiver Support Program Manager at KDADSOAASCA@ks.gov if you have questions regarding this form.

KAMIS DATA ENTRY REQUIREMENTS

The III-E Caregiver Assessment Plan (CAP) (SS-025) must be entered into KAMIS before the 20th day of the month following the month in which services were provided. The Caregiver Service Plan's Start Date entered into KAMIS allows Caregiver Service providers to be reimbursed effective with this date of service. In addition, the AAA must verify the Group I Services provided and submit through the KAMIS 225 process before the 20th day of the month following the month in which services were provided.

Following is a list of required KAMIS fields:

SECTION I INTAKE:
Interviewer, PSA, Date of Assessment, Initial or Reassessment designation

SECTION II CAREGIVER CATEGORY:
Caregiver or Older Relative
If Older Relative, select caring for child(ren) < 19 years of age or caring for disabled adult(s) 19 - 59 years of age, or both if applicable

SECTION III CAREGIVER INFORMATION:
The following caregiver information must be entered:
Name, date of birth, gender, ethnicity, race, city, county, state, poverty status

SECTION IV OLDER RELATIVE CAREGIVER CATEGORY (Required if "Older Relative" funding checked in Section II):
Number of children and number of disabled adults, if applicable
Relationship to child/children and disabled adult(s), if applicable

SECTION V CAREGIVER for ADULT
Relationship to Recipient

SECTION VI ADULT CARE RECIPIENT #1 (Required if "Caregiver" funding checked in Section II):
Qualifying Care Recipient

SECTION VII CAREGIVER SERVICE PLAN
The following information must be entered to initiate services:
Recipient No., Service Code, Provider Name, Units, Per, Total Units, Start Date, End Date
(Note: The End Date shall be the date the service is to terminate or one year from the Start Date, whichever comes first.) Discharge Code shall be entered when the service is terminated.

SECTION VIII ADULT CARE RECIPIENT #2 (Complete if more than one adult is a care recipient):
Relationship to Recipient
Qualifying Care Recipient

SECTION IX ADULT CARE RECIPIENT #3 (Complete if more than two adults are care recipients):
Relationship to Recipient
Qualifying Care Recipient

SECTION X NOTES:
None