**Kansas Department for Aging and Disability Services**

**ADRC Information, Referral and Assistance Form**

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| --- | --- |
| Date:  |       |
| **CONTACT INFORMATION** |
| First Name: |       | Last Name: |       | Age: |     |
| Street Address: |       |
| City: |       | County: |       | State: |       | Zip: |       |
| Phone: |       | E-Mail: |       |
| Notes:       |
| **CONTACT CATEGORIES** |
| Calls Purpose: | [ ]  Assistance  | [ ]  Dropped Call | [ ]  Hang-Up | [ ]  Information | [ ]  Referral |
| Caller Type: | [ ]  Caregiver | [ ]  Customer | [ ]  Family | [ ]  Other | [ ]  Potential Customer | [ ]  Professional |
| Need Relates To:  | [ ]  Aging | [ ]  Dementia |
| [ ]  MR / DD/ ID | [ ]  Mental Health | [ ]  Multiple Disabilities |
| [ ]  No Disabilities | [ ]  Physically Disabled | [ ]  Traumatic Brain Injury |
| [ ]  Unknown | [ ]  Unspecified Disabilities |
| **PROGRAM TYPE** |
| [ ]  OAA IIIB | [ ]  OAA II E | [ ]  Medicaid | [ ]  Non-Medicaid / Non-OAA |
| **NEEDS** |
| As Customer tells their story, mark all of the following major need(s) that apply: |
| [ ]  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 / Supplies |
| [ ]  In Home Services | [ ]  KanCare Mailings | [ ]  KanCare Options |
| [ ]  Legal Assistance | [ ]  Long Term Care Options | [ ]  Medicaid App. Info. |
| [ ]  Medicaid Assistance | [ ]  Medicaid Denial | [ ]  Medicare/SHICK |
| [ ]  Medication Management | [ ]  NF / ACH Placement Options | [ ]  Nutrition Support |
| [ ]  Other | [ ]  Peer Support | [ ]  Private Pay Options |
| [ ]  Rehabilitation (vision and hearing) | [ ]  Respite | [ ]  Substance Abuse |
| [ ]  Transportation | [ ]  Transition | [ ]  Veteran's Services |
| During caller's identification of needs, did any of the following issues arise?(These are not questions to be asked, but rather themes to listen for as the client tells their story.) |
| [ ]  Abuse, Neglect, Exploitation | [ ]  Change in Living Arrangement |
| [ ]  Complex / unstable Medical or Mental Health | [ ]  Dementia / Confusion / Cognitive Impairment |
| [ ]  History of Falls | [ ]  Hospitalization(s) or Nursing Home(s) stays |
| [ ]  Limited Finances | [ ]  Limited Informal Supports |
| [ ]  Medication Management | [ ]  On Waiting List for Public Services |
| [ ]  Situational Changes/Caregiver |  |
| **CONTACT RESOLUTION** |
| After completing call, mark any of the following major referral(s) categories that apply: |
| [ ]  Crisis Intervention | [ ]  KanCare | [ ]  Local AAA |
| [ ]  Local CDDO | [ ]  Local CIL | [ ]  Local CMHC |
| [ ]  No Referral | [ ]  Public Funded Program (includes Medicaid) | [ ]  Specific Community Service(s) |
| Referred for Options Counseling To: |       |
|  |