

Kansas Department for Aging and Disability Services

Options Counseling Form

\*\* - Indicates fields in the section are required

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| \*\*Session Date:  |       | \*\*KAMIS ID: |       | \*\*Time: start: |       | end : |       |
| \*\*Options Counselor: |       |
| **\*\*CUSTOMER INFORMATION** |
| First: |       | M.I.: |       |
| Last: |       | Nickname: |       |
| Birth Date  |       |       |       |  | Social Security #: |       |
|  | Month | Day | Year |  |  |
| Marital Status: | [ ]  Single | [ ]  Married | [ ]  Widowed | [ ]  Divorced |
|  |  |  |  |  |
| Gender: | [ ]  Female | [ ]  Male |  |
|  |  |  |
| Veteran?  | [ ]  Yes | [ ]  No |
| Spouse of Veteran? | [ ]  Yes | [ ]  No |
| Receives Veteran Benefits? | [ ]  Yes | [ ]  No |
| **Primary Language:** | Speaks | Reads | Understands Orally | **Ethnicity:** |
| Arabic | [ ]  | [ ]  | [ ]  | [ ]  Hispanic or Latino |
| Chinese | [ ]  | [ ]  | [ ]  | [ ]  Not Hispanic or Latino |
| English | [ ]  | [ ]  | [ ]  | [ ]  Ethnicity Missing |
| French | [ ]  | [ ]  | [ ]  |  |
| German | [ ]  | [ ]  | [ ]  | **Race:** |
| Hindi | [ ]  | [ ]  | [ ]  | [ ]  White Non-Hispanic |
| Pilipino | [ ]  | [ ]  | [ ]  | [ ]  White Hispanic |
| Sign | [ ]  | [ ]  | [ ]  | [ ]  American Indian/Alaskan Native |
| Spanish | [ ]  | [ ]  | [ ]  | [ ]  Asian |
| Tagalog | [ ]  | [ ]  | [ ]  | [ ]  Black or African American |
| Urdu | [ ]  | [ ]  | [ ]  | [ ]  Native Hawaiian or Other Pacific Islander |
| Vietnamese | [ ]  | [ ]  | [ ]  | [ ]  Reporting some other race |
| Other: |       | [ ]  Reporting 2 or more races |
| Interpreter Needed | [ ]  Yes | [ ]  No |  |
| **\*\*ADDRESS INFORMATION** |
| **Residence Address**  |  | Customer’s home is: | [ ]  Rural  | [ ]  Urban |
| Street Address: |       |
| City: |       | County: |       | State: |       | Zip: |       |
| Phone: |       | Phone (alternate): |       |
| **ASSOCIATE INFORMATION** |
| **Emergency or alternative contact:** | Relationship: |       |
| First Name: |       | Last Name: |       |
| Street Address: |       |
| City: |       | County: |       | State: |       | Zip: |       |
| Phone: |       | Phone (alternate): |       |
|  |
| **Legal Guardian:** | Relationship: |       |
| First Name: |       | Last Name: |       |
| Street Address: |       |
| City: |       | County: |       | State: |       | Zip: |       |
| Phone: |       | Phone (alternate): |       |
|  |
| **DPOA:** | Relationship: |       |
| First Name: |       | Last Name: |       |
| Street Address: |       |
| City: |       | County: |       | State: |       | Zip: |       |
| Phone: |       | Phone (alternate): |       |
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| Options Counseling Form |
| Customer:  |       |
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| **\*\*SESSION DETAILS** |
| **Referral Source To Options Counseling:**  |
| ADRC Call Center | [ ]  ADRC Website | [ ]  Brochure | [ ]  Caregiver |
| [ ]  CTO | [ ]  Family Member | [ ]  Friend – Neighbor | [ ]  Hospital |
| [ ]  MFP | [ ]  Nursing Facility | [ ]  Other Website | [ ]  Self |
| [ ]  Social Service Agency |  |  |
| **Contact Method:** |
| [ ]  Phone | [ ]  In Person | [ ]  E-Mail | [ ]  FAX |
| [ ]  Mail | [ ]  Other |  |
| **If Contact Method is In Person - Location:**  |
| [ ]  ADRC | [ ]  Customer’s Residence | [ ]  Community Center | [ ]  Hospital |
| [ ]  NF / Institution | [ ]  Other Location |  |
| **Current Living Arrangement:** |
| [ ]  Apartment | [ ]  Condominium | [ ]  Assisted Living | [ ]  Boarding Care Home |
| [ ]  Duplex | [ ]  Home Plus | [ ]  Homeless | [ ]  House |
| [ ]  Townhouse | [ ]  Mobile Home | [ ]  Nursing Home | [ ]  Residential Health Care |
| [ ]  Other |  |  |
| **Customer Lives With:** | [ ]  Alone | [ ]  Family | [ ]  Non-Relative |
|  | [ ]  Not Disclosed | [ ]  Spouse  |
| **Customer's Disability: (All Ages)** |
| [ ]  Dementia | [ ]  MR / DD / ID | [ ]  Mental Illness | [ ]  Multiple Disabilities |
| [ ]  No Disabilities | [ ]  Physically Disabled | [ ]  Traumatic Brain Injury | [ ]  Unknown |
| [ ]  Unspecified Disabilities  |  |  |  |
| **Current Medicaid Program:** |
| [ ]  Autism | [ ]  FE | [ ]  MH | [ ]  MR / DD | [ ]  NF / ACH | [ ]  PACE |
| [ ]  PD | [ ]  TA | [ ]  TBI | [ ]  Not Currently Enrolled | [ ]  Other |
| Medicaid Card ID (not required): |       |  |  |  |
|  |  |  |  |  |
| **Most important challenge / issue for the customer at this time.** (Reason for this Options Counseling Session): |
| [ ]  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 and/or Supplies |
| [ ]  In Home Services | [ ]  KanCare Mailings |
| [ ]  KanCare Options | [ ]  Legal Assistance |
| [ ]  Long Term Care Options | [ ]  Medicaid Application Information |
| [ ]  Medicaid Assistance | [ ]  Medicaid Denial |
| [ ]  Medicare/SHICK | [ ]  Medication Management |
| [ ]  NF / ACH Placement Options | [ ]  Nutrition Support |
| [ ]  Other | [ ]  Peer Support |
| [ ]  Private Pay Options | [ ]  Rehabilitation (including vision and hearing) |
| [ ]  Respite | [ ]  Substance Abuse |
| [ ]  Transition | [ ]  Transportation |
| [ ]  Veteran's Services |  |
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| Options Counseling Form |
| Customer: |       |
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| **\*\*SESSION DETAILS** (continued) |
| What is important to the Customer:(Values, Needs, Goals)  |       |
|  |
| What has the Customer tried previously to meet their identified need(s): (optional) |       |
|  |  |
| What is the Customer’s Desired Outcome for this Session:  |       |
|  |
| **Options Discussed:**  |
| [ ]  Informal Support Options | [ ]  KanCare Plan Options | [ ]  Medicaid Long Term Care Options |
| [ ]  Long Term Care Options | [ ]  PACE Options | [ ]  Private Pay Long Term Care Options |
|  |
| Customer requested risks and benefits of each option? | [ ]  Yes | [ ]  No |
| Number of Session Attendees (other than customer): |       |
| The Session Attendance Sheet (page 4) must be uploaded with KAMIS |  |
| **FOLLOW-UP INFORMATION** |
| \*\* Follow-Up Needed: | [ ]  Yes | [ ]  No | Proposed Follow-Up Date: |       |
| Follow-Up Completed: | [ ]  Yes | [ ]  No | Follow-Up Completed Date: |       |
| Follow-Up Assigned To: |       |
| Time Spent on Follow-Up (total): |       |
|  |  |
| Follow-Up Note:  |       |
|  |  |

Action / Referral Information

|  |  |
| --- | --- |
| **Customer Name:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Action Type**(Action/Referral/ Information) | **Action / Referral Date** | **Detail of Action or Referral** | **Action To Be Performed By** | **Action Goal or Referral Date** | **Completed** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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Option Counseling Attendee Listing

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| --- | --- | --- | --- |
| **Customer Name:** |       | **Date:** |       |
| **NAME** | **RELATIONSHIP** | **PHONE** |
|       |       |       |
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