



Kansas Department for Aging and Disability Services

Options Counseling Form

** - Indicates fields in the section are required

**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
Arabic			
Chinese			
English			
French			
German			
Hindi			
Pilipino			
Sign			
Spanish			
Tagalog			
Urdu			
Vietnamese			
Other:			

Interpreter Needed Yes No

Ethnicity:
 Hispanic or Latino
 Not Hispanic or Latino
 Ethnicity Missing

Race:
 White Non-Hispanic
 White Hispanic
 American Indian/Alaskan Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 Reporting some other race
 Reporting 2 or more races

**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): _____

Options Counseling Form

Customer: _____

****SESSION DETAILS****Referral Source To Options Counseling:**

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> ADRC Call Center | <input type="checkbox"/> ADRC Website | <input type="checkbox"/> Brochure | <input type="checkbox"/> Caregiver |
| <input type="checkbox"/> CTO | <input type="checkbox"/> Family Member | <input type="checkbox"/> Friend – Neighbor | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> MFP | <input type="checkbox"/> Nursing Facility | <input type="checkbox"/> Other Website | <input type="checkbox"/> Self |
| <input type="checkbox"/> Social Service Agency | | | |

Contact Method:

- | | | | |
|--------------------------------|------------------------------------|---------------------------------|------------------------------|
| <input type="checkbox"/> Phone | <input type="checkbox"/> In Person | <input type="checkbox"/> E-Mail | <input type="checkbox"/> FAX |
| <input type="checkbox"/> Mail | <input type="checkbox"/> Other | | |

If Contact Method is In Person - Location:

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> ADRC | <input type="checkbox"/> Customer's Residence | <input type="checkbox"/> Community Center | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> NF / Institution | <input type="checkbox"/> Other Location | | |

Current Living Arrangement:

- | | | | |
|------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Apartment | <input type="checkbox"/> Condominium | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Boarding Care Home |
| <input type="checkbox"/> Duplex | <input type="checkbox"/> Home Plus | <input type="checkbox"/> Homeless | <input type="checkbox"/> House |
| <input type="checkbox"/> Townhouse | <input type="checkbox"/> Mobile Home | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Residential Health Care |
| <input type="checkbox"/> Other | | | |

Customer Lives With:

- | | | |
|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Family | <input type="checkbox"/> Non-Relative |
| <input type="checkbox"/> Not Disclosed | <input type="checkbox"/> Spouse | |

Customer's Disability: (All Ages)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dementia | <input type="checkbox"/> MR / DD / ID | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Multiple Disabilities |
| <input type="checkbox"/> No Disabilities | <input type="checkbox"/> Physically Disabled | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Unspecified Disabilities | | | |

Current Medicaid Program:

- | | | | | | |
|---------------------------------|-----------------------------|------------------------------|---|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Autism | <input type="checkbox"/> FE | <input type="checkbox"/> MH | <input type="checkbox"/> MR / DD | <input type="checkbox"/> NF / ACH | <input type="checkbox"/> PACE |
| <input type="checkbox"/> PD | <input type="checkbox"/> TA | <input type="checkbox"/> TBI | <input type="checkbox"/> Not Currently Enrolled | <input type="checkbox"/> Other | |

Medicaid Card ID (not required): _____

Most important challenge / issue for the customer at this time. (Reason for this Options Counseling Session):

- | | |
|---|--|
| <input type="checkbox"/> Abuse/Neglect/Exploitation | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> CARE | <input type="checkbox"/> Caregiver Support |
| <input type="checkbox"/> Cognitive/Mental Health | <input type="checkbox"/> Crisis Intervention |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Employment/Ticket to Work |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Financial Management Service (FMS) |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Housing and/or Supplies |
| <input type="checkbox"/> In Home Services | <input type="checkbox"/> KanCare Mailings |
| <input type="checkbox"/> KanCare Options | <input type="checkbox"/> Legal Assistance |
| <input type="checkbox"/> Long Term Care Options | <input type="checkbox"/> Medicaid Application Information |
| <input type="checkbox"/> Medicaid Assistance | <input type="checkbox"/> Medicaid Denial |
| <input type="checkbox"/> Medicare/SHICK | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> NF / ACH Placement Options | <input type="checkbox"/> Nutrition Support |
| <input type="checkbox"/> Other | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Private Pay Options | <input type="checkbox"/> Rehabilitation (including vision and hearing) |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Transition | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Veteran's Services | |

Options Counseling Form

Customer: _____

****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:
