



WORK
Work Opportunities Reward Kansans
Kansas Personal Assistance Program for Employed Persons with Disabilities
Assessment Instrument

Kansas Health Policy Authority
Kansas Working Healthy Program
900 SW Kansas, Suite 900N
Topeka, KS 66612

WORK - Work Opportunities Reward Kansans

Original Assessment Date:	
Revised Assessment Date:	
Assessor Name:	

I. Information Section

Name:	
Street Address:	
City:	
State:	
Zip:	
County:	
SRS Region:	
Email:	
Birth date:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number:	
Medicaid ID Number:	
Home Phone:	
Mobile Phone:	
Numbers of hours of employment each month	
Type of Employment	
Do you work in a setting that is competitive and integrated?	

Friend/Representative (Note: This person may not be a paid provider of PAS)

Name:	
Street Address:	
City:	
State:	
Zip:	
Phone:	

II. Eligibility Section

Note: this section is only to verify that eligibility has been established for Working Healthy.
(Please check yes or no)

		Yes	No
1)	Have you been determined to have a disability by Social Security Standards (SSI or SSDI) or Disability DU?	<input type="checkbox"/>	<input type="checkbox"/>
2)	Are you currently eligible for the Working Healthy Program (Kansas Medicaid Buy-in Program)?	<input type="checkbox"/>	<input type="checkbox"/>
3)	Are you employed (provide proof that you have paid FICA or SECA [self-employment tax])?	<input type="checkbox"/>	<input type="checkbox"/>
4)	Are you a Kansas resident?	<input type="checkbox"/>	<input type="checkbox"/>
5)	Are you 16-64 years of age?	<input type="checkbox"/>	<input type="checkbox"/>

III. Previous Support (Initial Assessment)

(Questions 1-5, criteria for Waiver to WORK Services for initial assessment only)

(Please check yes or no)

		Yes	No
1)	Are you currently using HCBS waiver services?	<input type="checkbox"/>	<input type="checkbox"/>

If “no”, skip to Question 3

2) Which HCBS waiver? (Please check one)

Physical Disability (PD)	<input type="checkbox"/>
Developmental Disability (MR/DD)	<input type="checkbox"/>
Traumatic Brain Injury (HI)	<input type="checkbox"/>

(Please indicate the number of hours)

Hours

3)	If you are currently using Personal Assistance Services, how many hours of Personal Attendant Care services do you currently qualify for?	
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(Please check yes or no)

Yes

No

4)	Are you currently on a waiting list for HCBS waver services?	<input type="checkbox"/>	<input type="checkbox"/>
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If "no", skip to Question 6

5) Which HCBS waiver waiting list? (Please check one)

Physical Disability (PD)	<input type="checkbox"/>
Developmental Disability (MR/DD)	<input type="checkbox"/>
Traumatic Brain Injury (HI)	<input type="checkbox"/>

(Please check yes or no)

Yes

No

6)	Are you currently eligible for but not on a waiver or waiting list?	<input type="checkbox"/>	<input type="checkbox"/>
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If "no", skip to next section

7) Which level of care can be demonstrated? (Please check one)

Physical Disability (PD)	<input type="checkbox"/>
Developmental Disability (MR/DD)	<input type="checkbox"/>
Traumatic Brain Injury (HI)	<input type="checkbox"/>

(Please check yes or no)

Yes

No

8)	Do you currently use life line services?	<input type="checkbox"/>	<input type="checkbox"/>
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IV. Support Assessment for PAS Needs

ADL's (Activities of Daily Living

(Support can be defined as total or partial support from another person, assistance with set-up or prep work for an activity, prompts and verbal guidance (reminders)).

1) Personal hygiene and grooming

- Examples include:
- Bathing
 - Oral Care
 - Hair care
 - Shaving

a) Can you perform this task without support?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Please check one

b) How much time does it take for you to perform this task without support?
(List total number of minutes.)

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c) How do you currently get this done? (Explain in the space below)

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d) What could you do if someone was available to assist you? (Explain in the space below)

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e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.

Brief description:

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	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>

Please check one

Total Weekly hours needed for this activity _____ hours.

Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

2) Dressing

Examples include:

- Personal Care
- Intellectual Support
- Assistive Devices

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

Are any hours of support requested for this task?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

3) Prosthetic and Orthotic Devices

Examples include:

- Assistance in putting on and removing devices
- Maintenance and cleaning devices

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>

Please check one

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>

Please check one

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

4) Toileting

Examples include:

- Empty ostomy/Urine bag
- Establish/maintain toileting schedule

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

Are any hours of support requested for this task?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

5) Medication Management

Examples include:

- Reminders to take medication
- Check compliance
- Assist in taking medications

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

6) Transfer

Examples include:

- Supervision/minimal assistance
- Moderate assistance
- Heavy support/lifting

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

7) Walking/Mobility/Wheelchair Maneuvering

Examples include:

- Special assistive devices
- Supervise/minimal assistance
- Moderate support
- Heavy support and lifting
- Turn and position in chair and/or bed

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please check one
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b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please check one
Are any hours of support requested for this task?			

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

8) Eating

Examples include:

- Remind/Coax to eat
- Assistance to cut food
- Directly feeding

a) Can you perform this task without support?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

9) Meal planning/Preparation/Clean up

Examples include:

- Development of healthy menu
- Safe preparation of foods
- Wash dishes and clean kitchen

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

Are any hours of support requested for this task?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

10) Shopping

Examples include:

- Making list of needed items
- Selection of items needed
- Payment and change for items

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

11) Laundry/Housekeeping

Examples include:

- Laundry
- Cleaning floors and dusting
- Cleaning bathroom
- Remove trash
- Change linens
- Make beds
- Assistive devices

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

12) Transportation (Going from place to place throughout the community)

Examples include:

- Assistance to use public transportation
- Scheduling transportation needs

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please check one
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b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please check one
Are any hours of support requested for this task?			

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

13) Money Management

Examples include:

- Assistance with paying bills
- Using a budget
- Assistance with checking account

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

14) Other

Examples include:

- Service Animal care
- Doctor ordered exercises (weight training or range of motion, etc)
- Life Line
- Lawn Care

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

b) How much time does it take for you to perform this task without support? (List total number of minutes.)

c) How do you currently get this done? (Explain in the space below)

d) What could you do if someone was available to assist you? (Explain in the space below)

e) If support is needed for this task, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are any hours of support requested for this task?	Please check one	

Total Weekly hours needed for this activity _____ hours.
Total Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

Estimated time: 10 minutes – 60 minutes daily

15) Travel Supports

Examples include:

- Assistance to use public transportation
- Scheduling transportation needs

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

b) What supports will allow you to travel to and from work or to meet personal appointments within the work day? (Note: Appointments and travel related to employment are employer's responsibility)

Brief description:

c) If support is needed, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.

Brief description:

Are any hours of support requested for this task?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

Weekly hours needed for this activity _____ hours.

Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

16) Physical Supports in Employment

Examples include:

- Assistance with toileting
- Assistance with meals
- Movement within the workplace
- Assistance with medication needs

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please check one		

b) What supports are necessary to meet personal needs while at work?
Brief description:

c) If support is needed, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

	Yes	No
Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
Please check one		
Weekly hours needed for this activity _____ hours.		
Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)		

17) Cognitive Supports in Employment

Examples include:

- Assistance with accessing/receiving job/task accommodations
- Learning and using specific job skills
- Interacting with employer/supervisor/co-workers
- Completing work related tasks with acceptable speed and quality
- Changing job assignments

a) Can you perform this task without support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

b) What supports are necessary to meet cognitive needs while at work?
Brief description:

c) If support is needed, briefly describe the amount and frequency of support needed and include an estimate of the weekly and monthly hours of support you would need.
Brief description:

Are any hours of support requested for this task?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please check one

Weekly hours needed for this activity _____ hours.
Monthly hours _____ (Weekly hours X 4.33 = Monthly hours)

1) Place of residence

<input type="checkbox"/>	House/Town House
<input type="checkbox"/>	Apartment/Condominium
<input type="checkbox"/>	Duplex
<input type="checkbox"/>	Assisted Living
<input type="checkbox"/>	Congregate/Group Living Facility
<input type="checkbox"/>	Trailer Home
<input type="checkbox"/>	Nursing Facility
<input type="checkbox"/>	Homeless

2) Client's residence is:

<input type="checkbox"/>	Owned (or being purchased)
<input type="checkbox"/>	Rented, private
<input type="checkbox"/>	Rented, subsidized
<input type="checkbox"/>	Rent free (e.g. family, friends)
<input type="checkbox"/>	Other

3) Client's residence location

<input type="checkbox"/>	Rural (less than 20,000)
<input type="checkbox"/>	Town (20,000-100,000)
<input type="checkbox"/>	Urban (greater than 100,000)

4) Do you feel safe inside your home?

yes no
If no, why?

5) Do you feel safe in your neighborhood?

yes no
If no, why?

6) Do you feel safe outside of your neighborhood?

yes no
If no, why?

7) Is there anything inside or outside of your home that you worry about or are uncomfortable about?

yes no
If yes, why?

8) Are there any neglect, abuse or exploitation issues that should be reported to help you?

Primary Diagnosis: _____

9) Does your home have the following? 1. Does not have, 2. Not working, 3. Working (indicate the code that applies).

<input type="checkbox"/>	Electricity
<input type="checkbox"/>	Gas/Propane
<input type="checkbox"/>	Piped water, hot/cold
<input type="checkbox"/>	Air conditioner/fan
<input type="checkbox"/>	Telephone
<input type="checkbox"/>	Laundry facilities
<input type="checkbox"/>	Smoke detector
<input type="checkbox"/>	Carbon monoxide detector
<input type="checkbox"/>	Refrigerator
<input type="checkbox"/>	Stove
<input type="checkbox"/>	Heating system
<input type="checkbox"/>	Flush toilet
<input type="checkbox"/>	Tub/shower
<input type="checkbox"/>	Radio/television
<input type="checkbox"/>	Microwave

10) Are there health or physical safety problems? (Check all that apply)

<input type="checkbox"/>	Dirt/garbage
<input type="checkbox"/>	Furnishings/rugs
<input type="checkbox"/>	House/Basement
<input type="checkbox"/>	Yard/Storage Buildings
<input type="checkbox"/>	Animals/Pets
<input type="checkbox"/>	Poor lighting
<input type="checkbox"/>	Other

11) Do you have any difficulty getting into your home or any room in your home? (Check all that apply)

<input type="checkbox"/>	Entrance(s)
<input type="checkbox"/>	Living/Family Room
<input type="checkbox"/>	Bathing Facility/Tub
<input type="checkbox"/>	Laundry
<input type="checkbox"/>	Bedroom
<input type="checkbox"/>	Toilet Facility
<input type="checkbox"/>	Kitchen
<input type="checkbox"/>	No Difficulty

12) Is this dwelling a suitable candidate for weatherization?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Already completed
<input type="checkbox"/>	Above income guidelines

13) Recommended changes to environment:

Sources of Information: _____
 (Please indicate all that apply)

Health Conditions	Primary Condition	Secondary Condition	Notes
Alcoholism/Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
Alzheimer's Disease, other memory loss conditions	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	
Circulation Problems (Swelling limbs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
GI Tract Problems (ulcer, colitis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Lung/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Missing Limb	<input type="checkbox"/>	<input type="checkbox"/>	
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	
Open Wounds, Bed Sores	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological Disease (such as Parkinson's) or other coordination or mobility problems	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Significant Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Uses Wheelchair, walker, or other aid	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Problems (glaucoma, cataracts, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specific)	<input type="checkbox"/>	<input type="checkbox"/>	

Total hours of support and allocation requested:

Total Number of ADL PAS Hours per week requested Pages 5-12	
Total Number of IADL PAS Hours per week requested Pages 13-18	
Total Number of Employment Related Support Hours per week requested Pages 19-21	
Total monthly number of Personal Assistance Hours per Week Requested	
Total Monthly Hours of Personal Assistance requested (Total Weekly Hours X 4.33)	
Total Monthly hours X \$13.25 = Total Allocation	

The times and activities on this form are estimates of the times and activities necessary to support my independence. I participated in the development of this document, and agree that it reasonably reflects my support needs.

Beneficiary Signature

5/18/10
Date

Additional WORK Services:

Independent Living Counseling Service (Note: This is an optional service and is paid directly to the provider not through the WORK allocation)

IL Counseling Agency Name:	
IL Counselor Name	
Address	
City	
State	
Zip	
Phone	
Email Address	

Assistive Services

What types of Assistive Technology, home modifications or other support services do you currently use to support your independence?
