



Working Healthy
Making health care work

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:	
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?		
2)	Are you currently eligible for the Working Healthy Program (Kansas Medicaid Buy-in Program)?		
3)	Are you employed (provide proof that you have paid FICA or SECA [self-employment tax])?		
4)	Are you a Kansas resident?		
5)	Are you 16-64 years of age?		

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?		

If “no”, skip to Question 3

2) Which HCBS waiver? (Please check one)

Physical Disability (PD)	
Developmental Disability (MR/DD)	
Traumatic Brain Injury (HI)	

(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?		
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If "no", skip to Question 6

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

Physical Disability (PD)	
Developmental Disability (MR/DD)	
Traumatic Brain Injury (HI)	

(Please check yes or no)

Yes

No

6)	Are you currently eligible for but not on a waiver or waiting list?		
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If "no", skip to next section

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

Physical Disability (PD)	
Developmental Disability (MR/DD)	
Traumatic Brain Injury (HI)	

(Please check yes or no)

Yes

No

8)	Do you currently use life line services?		
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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

- | |
|---|
| <p>Examples include:</p> <ul style="list-style-type: none"> • Bathing • Oral Care • Hair care • Shaving |
|---|

	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

2) Dressing

Examples include:

- Personal Care
- Intellectual Support
- 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.
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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?		
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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 No

Are any hours of support requested for this task?		
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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

4) Toileting

Examples include:

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

	Yes	No
a) Can you perform this task without support?		

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?		

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

Yes No

a) Can you perform this task without support?	<input type="checkbox"/>	<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.)

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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:

Yes No

Are any hours of support requested for this task?	<input type="checkbox"/>	<input type="checkbox"/>
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Please check one

Total Weekly hours needed for this activity _____ hours.
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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

	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

9) Meal planning/Preparation/Clean up

Examples include:

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

Yes No

a) Can you perform this task without support?	<input type="checkbox"/>	<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 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

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"/>
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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 No

Are any hours of support requested for this task?	<input type="checkbox"/>	<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

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

Examples include: <ul style="list-style-type: none"> • Assistance to use public transportation • Scheduling transportation needs
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	Yes	No
a) Can you perform this task without support?		

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?		

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

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

Yes

No

a) Can you perform this task without support?	<input type="checkbox"/>	<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

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

15) Travel Supports

Examples include:

- Assistance to use public transportation
- Scheduling transportation needs

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

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:

	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)

16) Physical Supports in Employment

Examples include:

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

	Yes	No
a) Can you perform this task without support?	<input type="checkbox"/>	<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		
Total Weekly hours needed for this activity _____ hours.		
Total 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	No
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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:

	Yes	No
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)

1) Place of residence

House/Town House
Apartment/Condominium
Duplex
Assisted Living
Congregate/Group Living Facility
Trailer Home
Nursing Facility
Homeless

2) Client's residence is:

Owned (or being purchased)
Rented, private
Rented, subsidized
Rent free (e.g. family, friends)
Other

3) Client's residence location

Rural (less than 20,000)
Town (20,000-100,000)
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

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

Primary Diagnosis: _____

Sources of Information: _____

(Please indicate all that apply)

If yes, why?

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

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

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

Dirt/garbage
Furnishings/rugs
House/Basement
Yard/Storage Buildings
Animals/Pets
Poor lighting
Other

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

Entrance(s)
Living/Family Room
Bathing Facility/Tub
Laundry
Bedroom
Toilet Facility
Kitchen
No Difficulty

12) Is this dwelling a suitable candidate for weatherization?

Yes
No
Already completed
Above income guidelines

13) Recommended changes to environment:

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

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

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

What types of Assistive Technology and services do you currently use to support your independence? _____

Briefly describe any Assistive Technology services you may need this year, how this will increase your independence, employment, health and safety or prevent institutionalization, and an estimated overall cost. This service must be requested and approved by the WORK Program Manager before payment to provider will be authorized.

Technology	Justification statement	Estimated Cost	Estimated PAS savings

Consumer Rights

- Consumers have the right to information that will help them to make an informed choice regarding whether they want to enroll in *Working Healthy* and *WORK*.
- Consumers enrolled in *WORK* have the right to have personal services, inside and outside of the home, at a level that supports employment.
- Consumers have the right to timely enrollment in *WORK*
- Consumers have the right to a person-centered planning process, when developing Plans for Independence, Individualized Budgets, and Emergency Back-Up Plans.
- Consumers have the right to the supports needed to develop their Plans for Independence and Individualized Budgets, including any or all of the following; a representative, family, friends, or Independent Living Counselor.
- Consumers have the right to self-direct their services, or to choose an agency to direct their services on their behalf.
- Consumers have the right to provide their own fiscal management once they have successfully completed a mandatory Fiscal Management Training program.
- Consumers have the right to all of the services they are entitled to through the Kansas Medical Assistance Program (KMAP).
- Consumers have the right to have personal or program issues reviewed by KHPA and, if necessary, a plan of action by KHPA to correct any problems.
- Consumers have the right to report abuse, neglect, and exploitation to SRS.
- Consumers have the right to file a grievance regarding *WORK* or appeal actions taken by KHPA, the Contractor, or a provider.

Consumer Responsibilities

- Consumers have the responsibility to obtain the necessary information that will help them to make an informed choice whether they want to participate in *WORK*.
- Consumers have the responsibility to ensure that their Plan for Independence includes the supports necessary to ensure that they can live and work safely in their home and community.
- Consumers have the responsibility to ensure that the services and costs listed on their Individualized Budget reflect what is included in their Plan for Independence.
- Consumers have the responsibility to complete an Emergency Back-Up Plan that ensures adequate coverage in the event that their employees do not come, and indicates that they have made provisions for their safety in the event of a natural or any other form of disaster.
- Consumers have the responsibility to pay a premium monthly in a timely manner, and to keep abreast of their payments at all times.
- Consumers have the responsibility to complete their six-month eligibility desk review, providing their Eligibility Worker with all necessary paperwork in a timely manner
- Consumers choosing to manage their attendants will be responsible for the following:
 - becoming familiar with, and being able to complete, all required paperwork;
 - deciding whether to obtain a background check for attendant(s);
 - determining reimbursement rates and benefits;
 - pay, or hire a Fiscal Management Service to pay attendant wages, applicable taxes, unemployment insurance, workers' compensation, benefits, and any other withholdings required by State or Federal government;
 - reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to SRS Adult Protective Services (see K.S.A. 39-1430); and
 - bringing to the attention of KHPA staff or an Independent Living Counselor any concerns they have regarding the quality of their attendants and/or services.
- Consumers have the responsibility to budget their allocation in a way that meets their individual needs, to spend the funds only on those services and/or goods that are consistent with independence and employment and within the parameters established by KHPA.
- Consumers choosing to assume fiscal management will be responsible to maintain separate checking and savings accounts for *WORK* funds, and will provide a monthly report to KHPA which includes the following:
 - funds received;
 - payments made to each attendant;
 - taxes, unemployment insurance, worker's compensation, and other benefits withheld;
 - funds spent on alternative purchases;
 - total funds disbursed;
 - amount of monthly allocation not disbursed;
 - checking account balance; and
 - savings account or IDA balance for approved purchase(s).
- Consumers have the responsibility to request the permission of KHPA to use unexpended funds from their allocation to establish a savings account or Individualized Development Account.
- Consumers have the responsibility not to spend their allocation on anything prohibited by KHPA or KMAP.
- Consumers have the responsibility to report and account for any unexpended funds from their allocation.
- Consumers have the responsibility to return any unexpended funds to KHPA if they dis-enroll from *WORK*.
- Consumers have the responsibility to inform their Eligibility worker when they are no longer employed, and to contact their Benefits Specialist to set up an Employment Plan if they want to remain in *WORK* during the six months "grace" period.
- Consumers have the responsibility to inform KHPA or their Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

Civil Rights

No person shall, on the grounds of race, color, national origin, age, disability, religion, or sex, be excluded from participation in, be denied the benefits of or be subject to discrimination under any program or activity of the Department of Social and Rehabilitation Services or Kansas Health Policy Authority.