

# Assistive Technology Intake Form

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Live in town?: Yes\_\_\_\_ No\_\_\_\_ (Go to Ag intake)  
State: KS Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Day Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Gender: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Other Insurance: No Yes Number: \_\_\_\_\_  
\_\_\_\_Family/\_\_\_\_Guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Referral Person:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Day Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

## The following information needs to be completed for the individual using equipment:

### English Proficiency:

\_\_\_\_ Yes  
\_\_\_\_ No

### Educational Level:

\_\_\_\_ Grade level  
\_\_\_\_ Regular  
\_\_\_\_ Special Education  
\_\_\_\_ High school grad or GED  
\_\_\_\_ Some College  
\_\_\_\_ College Graduate

### Marital Status:

\_\_\_\_ Unmarried / Single  
\_\_\_\_ Married  
\_\_\_\_ Divorced  
\_\_\_\_ Widowed  
\_\_\_\_ Separated  
\_\_\_\_ Unknown

### Veteran:

\_\_\_\_ Yes  
\_\_\_\_ No

### Veteran Disability:

\_\_\_\_ Yes  
\_\_\_\_ No

### Living Arrangements:

\_\_\_\_ Family  
\_\_\_\_ Institution  
\_\_\_\_ Lives Alone

### Current Funding/Benefits:

\_\_\_\_ Education Part B  
\_\_\_\_ HCBS-Autism  
\_\_\_\_ HCBS-FE  
\_\_\_\_ HCBS-HI  
\_\_\_\_ HCBS-MRDD  
\_\_\_\_ HCBS-PD  
\_\_\_\_ HCBS-MI Adult  
\_\_\_\_ HCBS-TA  
\_\_\_\_ Healthwave  
\_\_\_\_ Home Health  
\_\_\_\_ IDA  
\_\_\_\_ Infant / Toddler Part C  
\_\_\_\_ KAMP  
\_\_\_\_ KAN-SAIL  
\_\_\_\_ Kan Be Healthy  
\_\_\_\_ Medicaid  
\_\_\_\_ Medicare

### Current Funding/Benefits:

Cont:  
\_\_\_\_ Money Follows Person  
\_\_\_\_ Other  
\_\_\_\_ Private Insurance  
\_\_\_\_ SHS  
\_\_\_\_ Self / Family  
\_\_\_\_ State DD Funds  
\_\_\_\_ TAP  
\_\_\_\_ Title I, VR  
\_\_\_\_ Veteran's Affairs  
\_\_\_\_ WORK  
\_\_\_\_ Workers Compensation  
\_\_\_\_ Working Healthy

### Ethnicity:

\_\_\_\_ Caucasian  
\_\_\_\_ Hispanic  
\_\_\_\_ African American  
\_\_\_\_ Native American  
\_\_\_\_ Asian  
\_\_\_\_ Multi-Racial  
\_\_\_\_ Other  
\_\_\_\_ Unknown

### Employment Status:

\_\_\_\_ Not working  
\_\_\_\_ Part-time  
\_\_\_\_ Full-time  
\_\_\_\_ Retired  
  
**Income Source:**  
\_\_\_\_ SSI  
\_\_\_\_ SSDI  
\_\_\_\_ Social Security  
\_\_\_\_ Employed  
\_\_\_\_ Low Income Housing  
\_\_\_\_ Medicare  
\_\_\_\_ Medicaid  
\_\_\_\_ Other

### Attendant Information:

\_\_\_\_ No Attendant  
\_\_\_\_ Agency Employed  
\_\_\_\_ Consumer Employed

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

**Functional Limitations**

- Behavioral
- Breathing
- Hearing
- Learning
- Reaching / Lifting
- Seeing
- Speaking
- Stamina
- Walking

**Casual Disabilities**

- ADHD
- Accident/Injury
- Amputations
- Arthritis and Rheumatism
- Asthma/Allergies
- Autism/PDD
- Cause Unknown
- CP & Other Congenital
- Chronic Mental Health
- Chronic Physical Condition
- Developmentally Delayed
- Epilepsy
- Hearing Impairment
- Learning Disability

**Causal Disabilities:**

**Cont:**

- Mental Retardation
- Neurological
- Orthopedic Unspecified
- Other
- Spinal Cord Injury
- Stroke
- TBI
- Visual Impairment

**Independent Living Services Requested:**

I participated in the development of this plan either in person or over the phone. I know that if I want to change it I may do so at any time.

I understand that I have the right to an ILP. A plan is unnecessary in my situation, therefore I choose not to participate in a plan.

**COMMENTS:**

Consumer Signature & Date: X \_\_\_\_\_

This agreement is made on \_\_\_\_\_ 2009, between the Assistive Technology Access Site case manager and \_\_\_\_\_, the consumer. The consumer is Medicaid eligible and currently maintains a medical card. The consumer furthermore agrees to follow goals and objectives reimbursable through Medicaid and established through the joint effort of the consumer and their Assistive Technology case manager. The consumer gives SKIL and the Assistive Technology staff the authority to bill Medicaid for cost incurred while attempting to meet their outlined goals and objectives as applicable to Assistive Technology Case Management Services.

Consumer Signature / Date: X \_\_\_\_\_

Assistive Technology Staff Signature / Date: \_\_\_\_\_