TCM Affiliate Meeting
05.04.17

Present: Lisa Frazier, SDCMS; Tim Gorton, SLI; Cheryl Davenport, CDDO; Tracey Herman, TARC; Robert Smith, CDDO; Nancy Rhone, CDDO; Paula O'Brian, CDDO; Ann Barr, TARC; Merilee Larson, Lifeworx; Debra McKee, TARC; Stephany Semple, TARC; Jamie Cooper, CDDO; Coleen Hernandez, CDDO; Jess Reling, CDDO; Paula O'Brian, CDDO; Jeremy Chard, CDDO; Sabrina Crevoiserat; ESCF; Donna Holstein, SLI; Robert Smith, CDDO; Samantha Boldra, SAMI; Nancy Rhone, CDDO; Sabrina Winston, CDDO; Billie Padilla, CDDO; Cassidy Kearney, IBT

CDDO Updates:

- Introductions of new CDDO staff Jamie Cooper, Assessor and Jeremy Chard, IT
- Provider update: An individual in services is recuperating from his injury at KU Medical Center. The CDDO has been monitoring services and continues to monitor by visiting both day and residential services. It was stated that the staff has been incredible. It was suggested that if any TCM has someone in services with the provider to please follow-up with that person.
- It was stressed the importance of keeping BCI current with any changes such as current address, emergency contacts, guardian information and a picture if possible.
- BCI was transferred to the Cloud on May 5. If a screen pops up asking you to install Dyna Soft, ignore it. Upload as usual ignore the tabs at the top for now. Cheryl and Jeremy are aware of issues that occurred during the transfer such as Case Notes.
- Your password will not expire for one year; if you need to change it contact Cheryl at cdavenport@sncddo.org or Jeremy at jchard@sncddo.org.
- New Status Action Form (SAF 06-008.002) should be used. The only time a SAF should be emailed is if it is an initial. For internal changes: send an email showing the changes. Always click on "save and send" and upload for each individual person. Be sure to include information of why the person is closing such as; moving out of State, moving to a new provider, etc. See attached.
- Forms are now on the Home Page in BCI under Resources. Please discard old forms and access updated forms.
- Transition Checklist Refresher Course Training – All TCMs are required to attend. A notification will be emailed for the following dates June 15, June 20, July 18, July 27, Aug. 17 and Aug. 29 the training will be from 10 a – 12 p.

Guest Speaker:

Ken Lassman, TILRC Seating and Mobility Clinic, previously at KNI.

- Technology has changed significantly over the years to meet the needs of individuals to assist in mobility.
- The clinic works with several different vendors. If you are working with Numotion you can call them to make an appointment. If you are working with another vendor call Ken.

- What is needed for an appointment?
  - A doctor's order
  - The three-page pre-evaluation completed (attached).
  - The individual to come in with their wheelchair. Anyone that is part of the decision making is welcome to come to the appointment.
- It was asked if they offer loaners or rentals.
  A. They are working with Munns Medical Supplies to have equipment on-hand.
- Insurance covers the cost every five years unless there is a significant change. An exception could be made after an extensive 12-page evaluation has been completed and explanation of why a new chair is needed.
- In-service staff training is available, tips on how to make minor repairs, there is a fee for the training.

  If you have any questions, contact Ken at klassman@tilrc.org (785) 233-1561.

Lisa Hastings, Valeo. Valeo is a non-profit organization, they have 26 mental health centers in Kansas.

- Point of Entry - 400 Oakley South Entrance
- Walk-In Clinic – Monday-Friday 8 am-3 pm
- Crisis Center – Open 24 hours 785-234-3300 (Shawnee County)
- The Residence – is for crisis stabilization for individuals that need supports but not at the hospital level. They have 26 beds, 16 are licensed and 10 unlicensed (used for observation).
- Crisis Diversion – wrap around services to assist the individual stay out of jail.
- Outpatient Services
- Other Programs include but not limited to:
  - Expressive Therapy (adults)
  - Supported Employment
  - C.A.R.E., Peer Support
  - Navigate Program – for 15-24-year-olds
- Valeo will work with I/DD providers if an individual is a Valeo client. They will provide cross-over training, if requested.
- They have two co-responders' teams that work with the police department when needed to assist with individuals.

Upcoming:

- May 17 – CCM/QOC 12-1 TARC Training Room
- June 22 – CDDO Quarterly Training 8:30 am-12 pm TARC Board Room

The next meeting is 3 pm on Thursday, July 5.

Topeka Independent Living Resource Center (TILRC) has staff who specialize in helping individuals maintaining their independence, productivity and engagement with the community. Please check any of the following areas you would be interested in talking about with TILRC staff:

_____I am interested in finding out what my options are for transitioning back to my home/an apartment as an alternative to an institutional setting (i.e. residential nursing facility)

_____I am interested in getting assistance in obtaining benefits through Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) benefits, a Plan for Achieving Self Support (PASS) or other health care access issues such as how to choose the right Medicare Part D Prescription Drug Plan

_____I am interested in obtaining Home and Community Based Services (HCBS) Counseling and Payroll Services and/or Financial Management Services that will help me find and manage personal care attendants

_____I am interested in discussing vocational/work options by accessing the Kansas Vocational Rehabilitation Services Program and/or the Working Healthy Program

_____I am interested in finding out more about financing for getting Durable Medical Equipment (DME) for things like shower chairs, toilet risers, walkers and specialized telecommunications equipment

_____I am interested in finding out more about the George Wolf Youth Internship Program, a paid job opportunity program for persons aged 14-19

_____I am interested in talking to someone about obtaining affordable housing and/or making my home/apartment more accessible through home modifications

_____I would like to find out more about my transportation options, including learning how to use the LIFT Paratransit service, the public bus system, and/or getting Medicaid to pay for transportation to medical appointments

_____I would like to find out more about social and recreational activities in our community and events organized by the TILRC Social and Recreational Committee

_____I am interested in finding out more about individual and systems advocacy efforts and resources that are available through TILRC

I would like to meet with someone to discuss these topics

_____ at the conclusion of the Seating and Mobility evaluation before I leave TILRC OR

_____at a separate time from the Seating Clinic visit. If this, please provide a phone number/email address where you can be reached by TILRC staff:

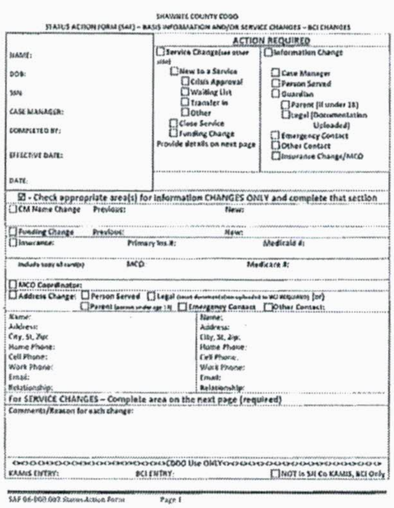
Your name:

Phone number/email address where you can be reached (and best time to reach you):

SHAWNEE COUNTY CDDO

STATUS ACTION FORM (SAF)

STATUS ACTION FORM



SHAWNEE COUNTY CDDO

STATUS ACTION FORM (SAF) – BASIS INFORMATION AND/OR SERVICE CHANGES – BCI CHANGES

NAME:
DOB:
SSN:
CASE MANAGER:
COMPLETED BY:
EFFECTIVE DATE:
DATE:

ACTION REQUIRED

- ☐ Service Change (see other side)
  - ☐ New to a Service
    - ☐ Crisis Approval
    - ☐ Waiting List
    - ☐ Transfer in
    - ☐ Other
  - ☐ Close Service
  - ☐ Funding Change
- Provide details on next page
- ☐ Information Change
  - ☐ Case Manager
  - ☐ Person Served
  - ☐ Guardian
    - ☐ Parent (if under 18)
    - ☐ Legal (Documentation Uploaded)
  - ☐ Emergency Contact
  - ☐ Other Contact
  - ☐ Insurance Change/MCO

☑ - Check appropriate area(s) for information CHANGES ONLY and complete that section

☐ CM Name Change Previous: New:

☐ Funding Change Previous: New:

☐ Insurance: Primary Ins #: Medicaid #:

MCO: Medicare #:

☐ MCO Coordinator:

☐ Address Change: ☐ Person Served ☐ Legal (or) ☐ Parent ☐ Emergency Contact ☐ Other Contact:

Name:	Name:
Address:	Address:
City, St, Zip:	City, St, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Relationship:	Relationship:

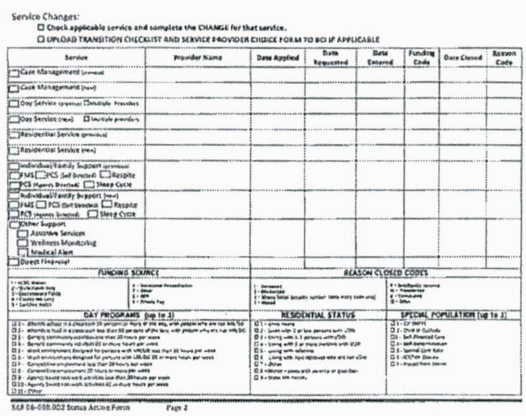
For SERVICE CHANGES – Complete area on the next page (required)

Comments/Reason for each change:

CDDO Use ONLY

KAMIS ENTRY: BCI ENTRY: ☐ NOT in SN Co KAMIS, BCI Only

SAF 06-000.002 Status Action Form Page 1



Service Changes:

☐ Check applicable service and complete the CHANGE for that service.

☐ UPLOAD TRANSITION CHECKLIST AND SERVICE PROVIDER CHOICE FORM TO BCI IF APPLICABLE

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Case Management (previous)							
☐ Case Management (new)							
☐ Day Service (previous) ☐ Multiple Providers							
☐ Day Service (new) ☐ Multiple providers							
☐ Residential Service (previous)							
☐ Residential Service (new)							
☐ Individual/Family Support ☐ FMS ☐ PCS (Self Directed) ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							
☐ Individual/Family Support (new) ☐ FMS ☐ PCS ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							
☐ Other Support ☐ Assistive Services ☐ Wellness Monitoring ☐ Medical Alert							
☐ Direct Financial							

FUNDING SOURCE | REASON CLOSED CODES

DAY PROGRAMS (up to 3) | RESIDENTIAL STATUS | SPECIAL POPULATION (up to 3)

SAF 06-000.002 Status Action Form Page 2

PART 1 – BASIC INFORMATION

1. NAME – Enter the person's first and last name
2. DOB – Enter the person's date of birth
3. SSN – Enter the person's last 4 digits of their Social Security number
4. CASE MANAGER - Enter the Case Manager's first and last name
5. COMPLETED BY – Enter the first and last name of person completing the Status Action Form
6. EFFECTIVE DATE – Enter the effective date of the change(s)
7. DATE – Enter the date the Status Action Form is completed.

NAME:

DOB:

SSN:

CASE MANAGER:

COMPLETED BY:

EFFECTIVE DATE:

DATE:

PART 2 - ACTION REQUIRED

1. SERVICE CHANGE – Check all boxes that apply and provide details of the change(s) on the next page

1. INFORMATION CHANGE – Check all boxes that apply and provide details of the change(s) on the lower portion of this page.

ACTION REQUIRED

☐ Service Change(see other side) ☐ New to a Service ☐ Crisis Approval ☐ Waiting List ☐ Transfer In ☐ Other ☐ Close Service ☐ Funding Change Provide details on next page	☐ Information Change ☐ Case Manager ☐ Person Served ☐ Guardian ☐ Parent (if under 18) ☐ Legal (Documentation Uploaded) ☐ Emergency Contact ☐ Other Contact ☐ Insurance Change/MCO

PART 3 – INFORMATION CHANGE(S)

1. Complete the fields based on the Information Changes checked in Part 2
2. CM NAME CHANGE – Enter first & last name of previous and new Case Manager
3. FUNDING CHANGE – Enter the previous and new Funding Source. See the next page for a list of funding sources
4. INSURANCE – If person has Private insurance enter the Insurance company name and Primary Insurance number. If the person has Medicaid enter the Medicaid number and enter the Managed Care Organization (MCO). If the person has Medicare enter the Medicare number.
5. MCO COORDINATOR – Enter the MCO Coordinator's first and last name.

☑ - Check appropriate area(s) for Information CHANGES ONLY and complete that section			
☐ CM Name Change	Previous:	New:	
☐ Funding Change	Previous:	New:	
☐ Insurance:	Primary Ins.#:	Medicaid #:	
Include copy of card(s)	MCO:	Medicare #:	
☐ MCO Coordinator:			

PART 3 – INFORMATION CHANGE(S) CONTINUED

1. ADDRESS CHANGE – Check the appropriate boxes for address changes of the Person Served, Legal Guardian, Parent, Emergency Contact and/or Other Contact.
2. Enter the Name, new address, city, state, zip, phone numbers, Email address and Relationship.

☐ Address Change: ☐ Person Served ☐ Legal (court documentation uploaded to BCI REQUIRED) (or)
☐ Parent (person under age 18) ☐ Emergency Contact ☐ Other Contact:

Name:	Name:
Address:	Address:
City, St, Zip:	City, St, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Relationship:	Relationship:

For SERVICE CHANGES – Complete area on the next page (required)

PART 3 – INFORMATION CHANGE(S) CONTINUED

1. COMMENTS/REASON FOR EACH CHANGE – Enter Comments and/or Reason for each change.
2. CDDO USE ONLY – CDDO staff will complete this area.

Comments/Reason for each change:
<><><><><><><><><><><><><><><><><><><><><><>**CDDO Use ONLY**<><><><><><><><><><><><><><><><><><><><><><>
KAMIS ENTRY: **BCI ENTRY:** ☐ **NOT in SN Co KAMIS, BCI Only**

PART 4 – SERVICE CHANGES

If the Transition Checklist and Service Provider Choice Form are required they must be uploaded when the Status Action Form is uploaded.

Service Changes:

- ☐ **Check applicable service and complete the CHANGE for that service.**
- ☐ UPLOAD TRANSITION CHECKLIST AND SERVICE PROVIDER CHOICE FORM TO BCI IF APPLICABLE

PART 4 – SERVICE CHANGES CONTINUED

Case Management Provider change

1. Enter PREVIOUS Case Management provider name
2. Enter Date Closed
3. Enter Reason Closed Code (See reason closed codes at the bottom of the page)
4. Enter NEW Case Management provider name
5. Enter Date Applied
6. Enter Date Requested
7. Enter Date Entered
8. Enter Funding Source Code (See Funding Source Codes at the bottom of the page)

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Case Management (previous)							
☐ Case Management (new)							

FUNDING SOURCE	
1 - HCBS Waiver 2 - State Funds Only 3 - Discretionary Funds 4 - County Mill Levy 5 - Certified Match	6 - Vocational Rehabilitation 7 - Other 8 - MFP 9 - Private Pay

REASON CLOSED CODES	
1 - Deceased 2 - Discharged 4 - Wrong Social Security number (data entry code only) 7 - Moved	9 - Self/Family removal 10 - Transferred 11 - Terminated 12 - Other

PART 4 – SERVICE CHANGES CONTINUED

Day Service Provider change

1. Enter PREVIOUS Day Service provider name. If there are Multiple Providers enter all the provider's names.
2. Enter Date Closed
3. Enter Reason Closed Code (See reason closed codes at the bottom of the page)
4. Enter NEW Day Service provider name. If there are Multiple Providers enter all the provider's names.
5. Enter Date Applied
6. Enter Date Requested
7. Enter Date Entered
8. Enter Funding Source Code (See Funding Source Codes at the bottom of the page)

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Day Service (previous) ☐ Multiple Providers							
☐ Day Service (new) ☐ Multiple providers							

FUNDING SOURCE	
1 - HCBS Waiver 2 - State Funds Only 3 - Discretionary Funds 4 - County Mill Levy 5 - Certified Match	6 - Vocational Rehabilitation 7 - Other 8 - MFP 9 - Private Pay

REASON CLOSED CODES	
1 - Deceased 2 - Discharged 4 - Wrong Social Security number (data entry code only) 7 - Moved	9 - Self/Family removal 10 - Transferred 11 - Terminated 12 - Other

PART 4 – SERVICE CHANGES CONTINUED

Residential Service Provider change

1. Enter PREVIOUS Residential Service provider name.
2. Enter Date Closed
3. Enter Reason Closed Code (See reason closed codes at the bottom of the page)
4. Enter NEW Residential Service provider name.
5. Enter Date Applied
6. Enter Date Requested
7. Enter Date Entered
8. Enter Funding Source Code (See Funding Source Codes at the bottom of the page)

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Residential Service (previous)							
☐ Residential Service (new)							

FUNDING SOURCE	
1 - HCBS Waiver 2 - State Funds Only 3 - Discretionary Funds 4 - County Mill Levy 5 - Certified Match	6 - Vocational Rehabilitation 7 - Other 8 - MFP 9 - Private Pay

REASON CLOSED CODES	
1 - Deceased 2 - Discharged 4 - Wrong Social Security number (data entry code only) 7 - Moved	9 - Self/Family removal 10 - Transferred 11 - Terminated 12 - Other

PART 4 – SERVICE CHANGES CONTINUED

Individual/Family Support Provider; FMS; PCS; Respite; Sleep Cycle change

1. Check the appropriate box (FMS, PCS(self directed), Respite, PCS (agency directed), Sleep Cycle)
2. Enter PREVIOUS Service provider name
3. Enter Date Closed
4. Enter Reason Closed Code (See reason closed codes at the bottom of the page)
5. Check the appropriate box (FMS, PCS(self directed), Respite, PCS (agency directed), Sleep Cycle)
6. Enter NEW Service provider name
7. Enter Date Applied
8. Enter Date Requested
9. Enter Date Entered
10. Enter Funding Source Code (See Funding Source Codes at the bottom of the page)

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Individual/Family Support (previous) ☐ FMS ☐ PCS (Self Directed) ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							
☐ Individual/Family Support (new) ☐ FMS ☐ PCS (Self Directed) ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							

FUNDING SOURCE	
1 - HCBS Waiver 2 - State Funds Only 3 - Discretionary Funds 4 - County Mill Levy 5 - Certified Match	6 - Vocational Rehabilitation 7 - Other 8 - MFP 9 - Private Pay

REASON CLOSED CODES	
1 - Deceased 2 - Discharged 4 - Wrong Social Security number (data entry code only) 7 - Moved	9 - Self/Family removal 10 - Transferred 11 - Terminated 12 - Other

PART 4 – SERVICE CHANGES CONTINUED

Other Support, Assistive Services, Wellness Monitoring, Medical Alert and Direct Financial change

1. Check the appropriate box (Assistive Services, Wellness Monitoring, Medical Alert, Direct Financial)
2. Enter Service provider name
3. Enter Date Applied
4. Enter Date Requested
5. Enter Date Entered
6. Enter Funding Source Code (See Funding Source Codes at the bottom of the page)
7. If closing service Enter Closed Date
8. Enter Reason Closed Code (See reason closed codes at the bottom of the page)

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Other Support ☐ Assistive Services ☐ Wellness Monitoring ☐ Medical Alert							
☐ Direct Financial							

FUNDING SOURCE	
1 - HCBS Waiver 2 - State Funds Only 3 - Discretionary Funds 4 - County Mill Levy 5 - Certified Match	6 - Vocational Rehabilitation 7 - Other 8 - MFP 9 - Private Pay

REASON CLOSED CODES	
1 - Deceased 2 - Discharged 4 - Wrong Social Security number (data entry code only) 7 - Moved	9 - Self/Family removal 10 - Transferred 11 - Terminated 12 - Other

PART 4 – SERVICE CHANGES CONTINUED

Day Programs – Residential Status – Special Population

1. Any time the Day programs, Residential Status or Special Populations change check the appropriate boxes for each of them.

DAY PROGRAMS (up to 3)
☐ 1 - Attends school in a classroom 50 percent or more of the day, with people who are not MR/DD
☐ 2 - Attends school in a classroom less than 50 percent of the day, with people who are not MR/DD
☐ 3 - Generic community activities less than 20 hours per week
☐ 4 - Generic community activities 20 or more hours per week
☐ 5 - Work environment designed for persons with MR/DD less than 20 hours per week
☐ 6 - Work environment designed for persons with MR/DD 20 or more hours per week
☐ 7 - Competitive employment less than 20 hours per week
☐ 8 - Competitive employment 20 hours or more per week
☐ 9 - Agency based non-work activities less than 20 hours per week
☐ 10 - Agency based non-work activities 20 or more hours per week
☐ 11 - Other

RESIDENTIAL STATUS
☐ 1 - Lives Alone
☐ 2 - Lives with 2 or less persons with I/DD
☐ 3 - Living with 3-7 persons with I/DD
☐ 4 - Living with 8 or more persons with I/DD
☐ 5 - Living with relatives
☐ 6 - Living with non-relatives who are not I/DD
☐ 7 – Other
☐ 8 – Minor – Lives with parents or guardian
☐ 9 – State MR Facility

SPECIAL POPULATION (up to 3)
☐ 1 - CIP (MFP)
☐ 2 - Child in Custody
☐ 3 - Self-Directed Care
☐ 4 - Self-Determination
☐ 5 - Special Care Rate
☐ 6 - ICF/MR Closure
☐ 7 - Placed from SMHH

STATUS ACTION FORM

New TCM Referral and Initials – before you have access to the person in BCI

Complete and email or fax the Status Action Form and signed Service Provider Choice form to the IT Coordinator.

TCM Provider changes

The previous case manager will complete and upload the Status Action Form, Service Provider Choice form and Transition Checklist into BCI.

Internal TCM changes

If a provider is moving a caseload from one case manager to another case manager within their agency email a list of the caseload to be changed by secure email to the IT Coordinator. The Status Action Form does **not** need to be completed for each person.

STATUS ACTION FORM

A Blank Status Action Form is located in the BCI Forms section

Download the Status Action Form

Complete the Status Action Form and Save it to your computer

Log into BCI, go to documents, upload the Status Action Form and select "Save and Send"

When the "Save and Send" is selected BCI will send an email notification to the CDDO and all agencies providing a service to the individual

The CDDO staff will make the change(s)

If there are other documents (Service Provider Choice Form, Transition Checklist, etc) to upload **DO NOT** combine. **Each document should be uploaded separately using the appropriate document type.**

PRE-EVALUATION for TILRC Seating & Mobility Clinic ● FAX: 785-233-1561

Please complete this form & fax/mail it to TILRC before your appointment. This information is required by Medicare, Medicaid, & insurance for funding repairs & purchases. It will also help us be prepared with equipment for trials, if possible.

▪Name:_____ ▪Male/Female (circle one) ▪Date:_____
▪Address: ▪Parents/guardian/spouse name:
Address:
Address:

▪Best Phone to reach: _____ ▪2nd phone:_____

▪Birth Date:_____ ▪Age:_____ ▪Weight: _____ ▪Height:_____

▪Prescribing Physician:_____ ▪Phone:_____

▪Primary Insurance & Policy/Group Number: _____

▪Secondary Insurance & Policy/Group Number: _____

▪He/She will be accompanied to the assessment by:

MEDICAL BACKGROUND

▪Relevant Diagnoses:

▪Any changes in medical condition/functioning relevant to assessment? (circle) Yes/No If yes, describe:

▪Surgery history: ▪Any surgeries planned in the near future? Yes/No ▪If yes, describe:

Medications:

▪Cardiac/Heart issues:

▪Respiratory Status (history of pneumonia, COPD, use CPAP, Oxygen, etc):

▪Seizures:

▪Sensitivity to Latex? Yes/No (circle one, describe)

▪Splints/AFOs, other orthotics:

CURRENT WHEELCHAIR/STROLLER

▪Wheelchair _____ Stroller _____ None_____ ▪Type: Brand, model:
▪Serial number:

▪Check at least one: Manual _____ Power _____ Tilt _____ Recline _____

▪Seat cushion type/name_____

▪Back cushion type/name_____
▪Additional seating system components:

▪Vendor/Supplier: ▪Age of system:
▪Additional information:

▪Why was the client referred? Please describe any problems with the current chair/seating system:

▪Activities I use the wheelchair for (check all that apply, add comments if needed):
_____ going from room to room in home
_____ get dressed while in wheelchair
_____ sit in during meals
_____ sit in while brushing teeth, combing hair, etc.
_____ sit in while watching TV, reading, at desk, etc.
▪Incontinent: Bladder: Yes/No Bowel: Yes/No Accidents: Yes/No

HOME ACCESSIBILITY

▪Residence: Rent/Own ▪Type of residence (house, apartment, etc):
▪Lives alone/with others ▪If with others, how many: ▪Number of hours alone/week:
▪Is home w/c acccessible? Yes/No Comments:
▪Is there a ramp? Yes/No ▪If not, do you need a ramp? Yes/No
▪Will wheelchair be used on carpet? Yes/No
▪List any adapted equipment: (shower chair, grab bars, etc.):

TRANSPORTATION

▪Vehicle(s) used to transport wheelchair (make, model, year): ▪Public transportation Yes/No

▪Vehicle has wheelchair lift? Yes/No ▪Tie downs? Yes/No ▪Ramp? Yes/No

▪Does wheelchair need to breakdown or fold? Yes/No ▪Who will be lifting chair:
▪Does wheelchair user drive? Yes/No ▪Hand controls? Yes/No ▪In wheelchair when driving? Yes/No/NA

Please describe any special equipment used/needed in other locations such as school, at work, etc:

▪History of skin breakdown (when, location):

▪Current Areas of Redness? Yes/No (circle one) ▪Location:
▪Able to perform effective self-weight shifts? Yes/No ▪Able to perform self-repositioning? Yes/No
▪Amount of time wheelchair will be used: _____hrs/day
▪Vision & hearing status:
▪(circle) Right/Left Handed
▪Other Precautions:

FUNCTIONAL MOBILITY
▪Transfers (check one):_____independent _____needs assistance _____dependent
▪Please describe:

_____

_____

▪Self propels manual chair? Yes/No/NA ▪If yes, uses: Arm: R/L/both Feet: R/L/both Both arms & feet

▪Does person have adequate safety awareness to independently use wheelchair? Yes/No

▪Does person have adequate strength for going up/down ramps? Yes/No ▪On uneven terrain? Yes/No

OUTSIDE ACCESSIBILITY
▪Terrains on which wheelchair will be used (circle): Gravel Grass Sidewalk/pavement
▪Client's hopes/goals/expectations for any new equipment and/or seating changes (check all that apply)
( ) improve posture:
( ) pressure relief:
( ) accommodate deformity:
( ) relieve pain/increase sitting tolerance:
( ) reduce influence of tone:
( ) improve functional level:
( ) allow for growth/weight gain:
( ) improve appearance:
( ) meet caregiver goals:
( ) meet transportation/vocational/school goals:
( ) repair, improve, replace current equipment:
( ) other:
▪Explain:

▪Other information important to consider:

Person(s) completing this form: DATE:_____

3-17

TILRC Seating and Mobility Center

501 Jackson, 4th Floor

Topeka, KS 66603

785-233-4572(voice) 785-233-1561 (fax)

Hello,

You have been scheduled to come to the TILRC Seating and Mobility Center at _____ on

_____.

When coming to the TILRC Seating and Mobility Center, getting ready it is as simple as 1-2-3:

1: Get a physician's order for us that asks to "Evaluate for wheelchair and seating/positioning system." Please have them include the "ICD-10 code" (they will understand what that means: they are the diagnosis codes that are sometimes helpful in getting you a wheelchair).

2: Fill out the enclosed/attached "Pre-evaluation." This 3 page form gives us a little background on your medical condition and history that can help us make sure we have the right kinds of wheelchairs and seating options for you to try out at the clinic**. If possible we'd like to have your pre-evaluation filled out and back to us a couple of weeks before the evaluation.**

3. Bring your existing wheelchair and seating system components to the appointment (if you have one)**.** There are a couple reasons why that's important: A) We need to document what is wrong with any current wheelchair you are using and why it won't work. B) It takes a while to get a new wheelchair approved and even more time to actually have it prepped and be delivered. Sometimes the current chair can be tweaked to fit better/be usable until a new chair arrives/repairs can be made, and if you bring it, we can sometimes work in some adjustments.

So there you go: expect the evaluation to last a couple hours; we want to make sure we make the right recommendations and that just takes time. If you get sick/have to cancel, please let us know at least 24 hours in advance so we can try to move someone else into your time slot.

If you have any questions about any of this, feel free to call Andrea at 785-235-5200 or Ken at 785-233-4572.

Thanks, and see you soon!

Ken Lassman, OTR/L for the TILRC Seating and Mobility Center
klassman@TILRC.org

SHAWNEE COUNTY CDDO

STATUS ACTION FORM (SAF) – BASIS INFORMATION AND/OR SERVICE CHANGES – BCI CHANGES

NAME: **DOB:** **SSN:** **CASE MANAGER:** **COMPLETED BY:** **EFFECTIVE DATE:** **DATE:**	**ACTION REQUIRED** ☐ **Service Change**(see other side) ☐ New to a Service ☐ Crisis Approval ☐ Waiting List ☐ Transfer In ☐ Other ☐ Close Service ☐ Funding Change **Provide details on next page** ☐ **Information Change** ☐ Case Manager ☐ Person Served ☐ Guardian ☐ Parent (if under 18) ☐ Legal (Documentation Uploaded) ☐ Emergency Contact ☐ Other Contact ☐ Insurance Change/MCO

☑ - Check appropriate area(s) for Information CHANGES ONLY and complete that section

☐ **CM Name Change** **Previous:** **New:**

☐ **Funding Change** **Previous:** **New:**

☐ **Insurance:** **Primary Ins.#:** **Medicaid #:**

Include copy of card(s) **MCO:** **Medicare #:**

☐ **MCO Coordinator:**

☐ **Address Change:** ☐ **Person Served** ☐ **Legal** (court documentation uploaded to BCI REQUIRED) **(or)**
☐ **Parent** (person under age 18) ☐ **Emergency Contact** ☐ **Other Contact:**

Name: Address: City, St, Zip: Home Phone: Cell Phone: Work Phone: Email: Relationship:	Name: Address: City, St, Zip: Home Phone: Cell Phone: Work Phone: Email: Relationship:

For SERVICE CHANGES – Complete area on the next page (required)

Comments/Reason for each change:

<><><><><><><><><><><><><><><><><><><><><><>CDDO Use ONLY<><><><><><><><><><><><><><><><><><><><><><>

KAMIS ENTRY: **BCI ENTRY:** ☐ **NOT in SN Co KAMIS, BCI Only**

Service Changes:

☐ **Check applicable service and complete the CHANGE for that service.**

☐ **UPLOAD TRANSITION CHECKLIST AND SERVICE PROVIDER CHOICE FORM TO BCI IF APPLICABLE**

Service	Provider Name	Date Applied	Date Requested	Date Entered	Funding Code	Date Closed	Reason Code
☐ Case Management (previous)							
☐ Case Management (new)							
☐ Day Service (previous) ☐ Multiple Providers							
☐ Day Service (new) ☐ Multiple providers							
☐ Residential Service (previous)							
☐ Residential Service (new)							
☐ Individual/Family Support (previous) ☐ FMS ☐ PCS (Self Directed) ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							
☐ Individual/Family Support (new) ☐ FMS ☐ PCS (Self Directed) ☐ Respite ☐ PCS (Agency Directed) ☐ Sleep Cycle							
☐ Other Support ☐ Assistive Services ☐ Wellness Monitoring ☐ Medical Alert							
☐ Direct Financial							

FUNDING SOURCE

1 - HCBS Waiver
2 - State Funds Only
3 - Discretionary Funds
4 - County Mill Levy
5 - Certified Match
6 - Vocational Rehabilitation
7 - Other
8 - MFP
9 - Private Pay

REASON CLOSED CODES

1 - Deceased
2 - Discharged
4 - Wrong Social Security number (data entry code only)
7 - Moved
9 - Self/Family removal
10 - Transferred
11 - Terminated
12 - Other

DAY PROGRAMS (up to 3)

☐ 1 - Attends school in a classroom 50 percent or more of the day, with people who are not MR/DD
☐ 2 - Attends school in a classroom less than 50 percent of the day, with people who are not MR/DD
☐ 3 - Generic community activities less than 20 hours per week
☐ 4 - Generic community activities 20 or more hours per week
☐ 5 - Work environment designed for persons with MR/DD less than 20 hours per week
☐ 6 - Work environment designed for persons with MR/DD 20 or more hours per week
☐ 7 - Competitive employment less than 20 hours per week
☐ 8 - Competitive employment 20 hours or more per week
☐ 9 - Agency based non-work activities less than 20 hours per week
☐ 10 - Agency based non-work activities 20 or more hours per week
☐ 11 - Other

RESIDENTIAL STATUS

☐ 1 - Lives Alone
☐ 2 - Lives with 2 or less persons with I/DD
☐ 3 - Living with 3-7 persons with I/DD
☐ 4 - Living with 8 or more persons with I/DD
☐ 5 - Living with relatives
☐ 6 - Living with non-relatives who are not I/DD
☐ 7 – Other
☐ 8 – Minor – Lives with parents or guardian
☐ 9 – State MR Facility

SPECIAL POPULATION (up to 3)

☐ 1 - CIP (MFP)
☐ 2 - Child in Custody
☐ 3 - Self-Directed Care
☐ 4 - Self-Determination
☐ 5 - Special Care Rate
☐ 6 - ICF/MR Closure
☐ 7 - Placed from SMHH