**Data Collection**

**Cover Page**

Rev. 09/18

**CDDO Use Only**

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Data Entered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unique Identifier:

\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_

 *Last 4 SSN Assessment Type Date*

**Consumer Name:**

**Social Security #:**

**TCM Agency:**

**TCM:**

***(Please be sure to include the Children’s Supplemental for assessments completed for persons between ages 5 and 11)***

[ ] **I – Initial Assessment** includes the following:

[ ] **Initial** – this individual has never been entered into KAMIS before.

[ ] **Re-Admit** – this individual was previously entered into KAMIS, but closed all services and would like to receive services again.

[ ] **A – Annual Assessment** includes the following:

[ ] **Annual Assessment**

[ ] **Child reaching the age of 5** – to be entered after the 5th birth date.

[ ] **S – Special Permission** includes the following:

[ ] **Annual Assessment is late** – this assessment was not completed within 365 days.

[ ] **Assessment Appeal** – individual /guardian has appealed the assessment and permission has been granted by KDADS to re-enter.

[ ] **Special Re-eval** – assessment completed due to allocation of IDD/HCBS funds. Please check the tyepe of funds received: **CRISIS** [ ]  **WAITING LIST** [ ]  **WAIVER TRANS** [ ]

[ ] **Special Re-eval** – assessment completed to add individual to the ID HCBS waiting list.

[ ] **Changes/Update**

[ ] **Information Section Change** – (If changing of adding new guardian, please submit copy of court documents granting guardianship.)

[ ] **Service Section Change**

 *(Please be sure options counseling has occurred for all provider changes.)*

[ ] **Termination/Transfer**

[ ] One or more services have been closed.

[ ] Closing TCM Services, transfer to CDDO for waiting list purposes.

[ ] Close all services and mark individual as Inactive in KAMIS. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Transferred to another CDDO area within the state. (Reason)

**Quality oversight completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (initial)

**Instructions:** mark all that apply. Please staple this cover sheet in the upper left corner to any forms submitted. **Form changes may be submitted in writing or electronically.** All changes should be legibly indicated in **Red** ink. Please call: 316-660-1931 with any questions you may have. Submit documents to: basis@sedgwick.gov or fax to 316-660-4911.