STATE OF KANSAS BIDDERS PREFERENCE PROGRAM
EMPLOYEE EVALUATION FORM

INSTRUCTIONS: EMPLOYER COMPLETES SECTIONS I, II AND IF APPLICABLE, SECTION III. IF SECTION III DOES NOT APPLY, A HEALTH PROFESSIONAL COMPLETES SECTION IV. IN EITHER CASE, EMPLOYER SHOULD COMPLETE AND SIGN EMPLOYER CERTIFICATION.

I. EMPLOYER BACKGROUND

Business / Organization Name _____ Total Number of Employees _____

Contact Name _____ Phone _____

Business Address _____

Employer is a charitable organization in the State of Kansas and exempt from income tax under Internal Revenue Code 501 (c)(3).

Circle One: Yes No

II. EMPLOYEE BACKGROUND

Name _____ Hire Date _____

Job Title _____ Job Location _____

Last Four Digits SSN _____

III. HOME AND COMMUNITY-BASED WAIVER SERVICES

The employee is receiving services, has received services or is eligible to receive services under the following Medicaid waiver:

Circle one: FE PD I/DD TBI Other _____

Medicaid Number _____

EMPLOYER CERTIFICATION

I, _____, certify the above as true to the best of my knowledge.

_____ _____

Employer Contact Signature Date

_____

Printed Name

IV. HEALTH PROFESSIONAL CERTIFICATION

A. PHYSICAL/MENTAL IMPAIRMENT

The employee has a physical or mental impairment that constitutes a substantial barrier to employment.

Physical impairment: Yes No Mental impairment: Yes No

Description of Disability / Barrier to Employment: _____

B. SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI)

The employee has a severe and persistent mental illness. Yes No

Description of SPMI / Barrier to Employment: _____

I, _____, a Kansas Health Professional do hereby certify that the above-referenced employee has a physical or mental impairment which constitutes a barrier to employment; and/or a severe and persistent mental illness.

_____ _____

Signature Date

_____ _____

Printed Name Phone