|  |  |
| --- | --- |
| Transforming Lives |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Adult Family Home (AFH) Referral Checklist** |
| CLIENT NAME | DDA CASE NUMBER | CRM / SW / SSS NAME |
| ADULT FAMILY HOME (AFH) PROVIDER NAME | AFH TELEPHONE NUMBER (INCLUDE AREA CODE) | CELL PHONE/PAGER NUMBER |
| PROVIDER’S STREET ADDRESS |
| **Provider Issues** |
| 1. Confirm the following per the DDA PQIS or via the Aging and Disability Services AFH database: Date:  Current AFH license: **[ ]**  Yes **[ ]**  No MH Specialty designation: **[ ]**  Yes **[ ]**  NoCurrent DSHS AFH contract: **[ ]**  Yes **[ ]**  No Dementia Specialty designation: **[ ]**  Yes **[ ]**  NoDD Specialty designation: **[ ]**  Yes **[ ]**  No Conditions on license: **[ ]**  Yes **[ ]**  No If yes, specify:  |
| Licensed capacity:   |
| 2. Per the PQI staff or AFH provider: Number of current residents:   |
| **Referral Process** |
| 1. Release of Information form Date:  2. Discuss referral need with AFH PQI staff Date:  3. Discussion of individual’s needs/referral with provider Date:  4. Delivery of referral packet to provider (Form DSHS 10-232A) Date:  5. Pre-move visit Date:  6. Is nurse delegation assessment required: **[ ]**  Yes **[ ]**  No If “Yes,” give the date of the completed Nurse Delegation assessment Date:   (**this must occur no later than the date of move**) Is AFH trained and willing to do nurse delegation: **[ ]**  Yes **[ ]**  No |
| **Service Authorization** |
| 1. Date of current DDA assessment:  Daily Rate:   ETR: [ ]  Yes [ ]  No Amount: Behavior Point Score:  (if eligible for Meaningful Day, contact MD Specialist)2. [ ]  Basic Plus [ ]  Non-Waiver PCSP includes AFH service: [ ]  Yes [ ]  No3. Date of move:  4. Start date of AFH payment authorization:   |
| **Comments** |
| LEGAL REPRESENTATIVE | LEGAL STATUS | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| CLIENT REPRESENTATIVE FOR NSA | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| COMMENTS |
| CRM SIGNATURE | DATE |