Developmental Disabilities Administration (DDA)
Residential Health Center (RHC)

Respite, Stabilization, and RHC Support Referral

Client Information

Client Name	ADSA ID	Date of Birth	Age	Referral Date

Parent / Legal Representative's Name	Emergency Phone (with area code)	DCYF Dependent? ☐ Yes ☐ No

Client's Address	Client Phone (with area code)

Preferred Language	Interpreter Required ☐ Yes ☐ No	Translated Documents ☐ Yes ☐ No

Form completed by:	Title	Phone (with area code)	Region Select

Client's Current Program

- ☐ Waiver Select
- ☐ RCL
- ☐ CFC only
- ☐ NPS
- ☐ State Only

Recent Hospitalizations (previous 12 months):

Date	Reason

Settings

Current Setting

- ☐ Community Hospital:
- ☐ In Home: Select
- ☐ Adult Family Home (AFH):
- ☐ Community Residential:
- ☐ Correctional Facility:
- ☐ Unhoused
- ☐ Foster Home
- ☐ Mental Health Residential Treatment Facility:
- ☐ State Hospital:
- ☐ Other:

Contact's Name at current setting | Phone (with area code) | Email

Requested Setting / Service(s) (Check all that apply)

- ☐ Enhanced Respite Services (ERS)
- ☐ Intensive Habilitative Services (IHS)
- ☐ Stabilization, Assessment, and Intervention Facility (SAIF)
- ☐ Crisis Bed-based Diversion
- ☐ Overnight Planned Respite Services (OPRS)
- ☐ Planned Respite by a Nursing Facility at an RHC
- ☐ Intermediate Care Facility (ICF) at an RHC
- ☐ Nursing Facility (NF) at an RHC
- ☐ Crisis Stabilization at Yakima Valley School
- ☐ Emergency Transitional Support at Rainier RHC

Preferred / Requested Location, if applicable:

Social Summary

Include reason for request, family profile, and DDA services or other benefits accessed in the last 12 months.

Include key information about the individual such as preferred activities, likes / dislikes, strengths, abilities: preferred recreational activities and community participation

Any relevant school or employment information

Any cultural or religious support requirements? If yes, please describe.

Date(s) requested for OPRS or RHC planned respite:

From _____ to _____

From _____ to _____

From _____ to _____

Note: Verify requested dates are available prior to requesting OPRS (see calendar(s)).

Behavior Support Needs

Please check any behaviors below the provider should be aware of OR

Check here if none ☐.

- ☐ Biting
- ☐ Eating Disorder
- ☐ Elopement
- ☐ Inappropriate toileting:
- ☐ Fire setting
- ☐ Head banging
- ☐ Inappropriate sexual behaviors
- ☐ Loud vocalizations
- ☐ Physical aggression
- ☐ PICA
- ☐ Property destruction:
- ☐ Self-injurious behaviors:
- ☐ Substance use:
- ☐ Sensory / noise / touch:
- ☐ Suicidal attempts / threats:
- ☐ Throwing objects
- ☐ Verbal Aggression
- ☐ Wandering / not exit-seeking
- ☐ None
- ☐ Other:

Restrictions in place at current residence (door / window alarms, food restrictions, other). If so, please describe.

What are things to avoid (loud music, touch, food, etc.)?

Most concerning behavior displayed at home, in the community, and their employment site or at school:

Is a behavior support plan being utilized at home or school? ☐ Yes ☐ No If yes, please provide a copy of the plan.

Medical Needs

- ☐ Allergies (type):
  Reaction:
- ☐ Anemia / Blood Disorder
- ☐ Blood Thinners
- ☐ Catheters / Ostomies
- ☐ Cancer (type):
- ☐ Diabetes:
  - ☐ Insulin Dependent
  - ☐ Non-insulin Dependent
- ☐ Dietary restrictions:
- ☐ Dietary texture/ dysphagia:
- ☐ Frequent falls
- ☐ Gastrointestinal issues:
- ☐ Internal Implants:
- ☐ Multi-drug resistant organism (current or history)
- ☐ Pressure or Wound Injury(s) (specify):
- ☐ Respiratory disease:
  - ☐ Asthma
  - ☐ Frequent lung infection
  - ☐ Pneumonia
  - ☐ Recurrent aspiration
  - ☐ Ventilator
  - ☐ BiPap / C-Pap / Nebulizer
- ☐ Seizures (if checked, please include type, frequency, severity):
- ☐ Surgical Procedure; reason:
- ☐ Tracheostomy
  - ☐ Chronic cough
  - ☐ Other
- ☐ Tuberculosis / PPD history
- ☐ Tube or other enteral feeding
- ☐ Other:

Last Medical Appointment:	Last Psychoactive Medical Review:
Provider Name:	Provider Name:
Date:	Date:
Reason:	Reason:

Medication Assistance Needed

Describe what type of assistance is needed to take medications and/or apply mediated ointments or drops (including vitamins): ☐ Supervision ☐ Verbal prompts ☐ Hand in cup ☐ Crushed in food ☐ Physical assistance

☐ Medications administered via g-tube or other enteral pathway

☐ Individual does not have any oral / topical medications

☐ Other:

Is nurse delegation needed? ☐ Yes ☐ No

Are there any current, unresolved medical issues? ☐ Yes ☐ No Describe:

What safety issues are of concern to you?

Please note that respite providers may nee to request written instructions from the treating professional on the use of protective equipment such as helmets, arm splints, etc.

Describe accessibility support needs and adaptive equipment required (ramp, wheelchair / ramp, roll-in shower, shower chair, Hoyer lift, or dietary related equipment):

Supervision and Routine

Supervision Requirements

Describe the level of supervision for health and safety (line of sight, one to one, awake staff, etc.):

Community Supervision Needs (1 to 1 in community due to challenges, can be supervised with other adults or children):

Describe typical daily routine

Morning routine:

Evening routine and bedtime:

Typical school / workday routine, if applicable:

Non-school / workday routine:

Describe nighttime support needs:

Habilitative Goals and Desired Outcomes (complete for IHS and SAIF requests)

Work with individual and family, legal representative, or primary support person to determine their goals. Review with identified regional specialists for the applicable program to determine that the goals are habilitative in nature, can be achieved in 90 days, and do not require medical treatment.

Examples: Goals	**Examples: Desired outcomes**
1. John will identify coping skills when interacting with his roommate.	John will reduce frequency and severity of physically aggressive behavior towards his roommate.
2. Sarah will learn how to develop skills necessary to setting and awaking to an alarm clock.	Sarah will set an alarm each night and awake in the morning with verbal cues.
1.	

2.	
3.	

Discharge Plan

What is the planned discharge setting?

- ☐ Client will return to their previous setting with family / previous supports.
- ☐ Client will seek new setting to move to upon completion of service;
- ☐ Client has identified a new setting they will move to upon completion of service.
- ☐ Client requesting nursing facility at an RHC, discharge not applicable.

Describe plan for discharge, including what needs to be in place to support a successful move and how the receiving support (family or provider) will participate in a successful transition out of the stabilization or respite setting.

Post-Discharge Survey (required only for ERS, SAIF, and IHS

Please indicate preferred method to receive the post discharge survey:

☐ Via Email ☐ Via Paper ☐ Email or mailing address:

Referral Checklist (include all that apply)

- ☐ Current DDA Assessment Details and Services Summary
- ☐ Consent (DSHS 14-012)
- ☐ Cross Systems Crisis Plan
- ☐ Guardianship / Supported Decision-Making documentation
- ☐ Applicable medical records, including current MAR Individualized Intensive Support Plan or Negotiated Care Plan
- ☐ CRM Confirmed requested program(s) eligibility
- ☐ Verify discharge plan and participant support (family agreement form, mutual acceptance confirmation, etc.)
- ☐ Incident reports in the last 12 months
- ☐ Functional Assessment / Positive Behavior Support Plan
- ☐ SOTP Risk Assessment (if applicable)
- ☐ Individualized Education Plan (IEP)
- ☐ SER documenting clients requested service and information shared about the scope and support provided within requested service(s)
- ☐ Other (please specify):

Application Review and Signatures

Signature of Person Completing this form	Date	Printed name of person completing this form
Signature of Legal Representative	Date	Printed name of Legal Representative, if different