|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Adult Family Home Referral Request**  Please complete electronically and email to PQIS. | | | | DATE OF REQUEST | |
| URGENCY OF REQUEST  High  Medium  Low | |
| CLIENT’S NAME | | | GENDER  Male  Female | | AGE | ADSA ID NO. |
| REQUESTING CASE MANAGER’S NAME | | | | | PHONE NUMBER (WITH AREA CODE) | |
| CARE CLASSIFICATION LEVEL | | | Non-Waiver  Waiver | | | EVACUATION LEVEL |
| GEOGRAPHIC PREFERENCE | | | | | | |
|  | |  | |  | | |
| DATE PLACEMENT NEEDED | | | DATE OF LAST CARE ASSESSMENT | | | |
| LEGAL REPRESENTATIVE’S NAME | | | | | PHONE NUMBER (WITH AREA CODE) | |
| THE REFERRING CASE MANAGER MUST:  Talk with the client and family about funding and client responsibility.  Attach Individuals with Challenging Support Issues, DSHS 10-234. **(Complete if there is any self-injurious behavior; inappropriate behavior; physical or verbal aggression; community safety issues; property destruction; or fire setting behavior.)**  Attach current signed Consent, DSHS 14-012 (specifying consent for AFH referrals). | | | | | | |
| CLIENT DESCRIPTION (LIKE, DISLIKES, PERSONAL INTERESTS, HOBBIES, AND HOW THE CLIENT PREFERS TO SPEND THEIR DAY) | | | | | | |
| DESCRIBE CURRENT RESIDENTIAL SETTING AND THE REASON FOR REFERRAL | | | | | | |
| CLIENT PARTICIPATES IN (INCLUDE DETAILS FOR ALL THAT APPLY)  Work / School:  Day program:  Community activities:  Other (specify): | | | | | | |
| CONSIDERATIONS AND SUPPORTS (INCLUDE DETAILS FOR ALL THAT APPLY)  Specialized communication style:  Overnight support needs:  Wandering / exit seeking:  Recent hospitalizations:  Significant medical support needs:  Diagnosis:  Mental health issues:  Substance abuse issues:  Regional Clinical Team involvement:  Law enforcement involvement:  Technical assistance / supports/ interventions that have been offered to maintain current placement:  Transportation needs:  School  Work  Community activities  Medical appointments  Additional transportation needs information:  Other (specify): | | | | | | |
| REFERRAL CONSIDERATIONS (SELECT ALL THAT APPLY)  Wheelchair / ADA accessible home  Home with few / no stairs  Single room ONLY  Provider with nursing background  Male or  Female **residents** ONLY:  Male or  Female **AFH staff** ONLY:  Roll-in shower  Must be close to bus line  Nurse Delegation required  Smoker / other substance use:  Medical needs / specialized equipment:  Requires awake night staff because:  Client has pet(s); specify types of pet(s):  **Please specify if client needs a home without pets due to allergies and/or preference**: | | | | | | |
| COMMENTS | | | | | | |