Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Provider Referral Letter for Residential Services

	Completed for all providers.
	Completed for Out of Home Services.
	Completed for Adult Family Homes (AFH).
	Completed by all providers except AFH.

Date

Dear Provider,

I am referring **Client's Name** to you for residential supports. This client is moving from **Setting** and requires supports by **Date: MM/DD/YYYY**; and prefers to live in (city) **Option 1**, **Option 2**, **Option 3**.

Included in Referral Packet: Please save all documents in the following order: Last name, first name, name of document, and month and year of referral (i.e., mm/yy or mm/yyyy).

ENCLOSED	TYPE OF INFORMATION	N/A
Information provided by client or legal representative	**This section completed for all providers.**	
☐	Client and/or legal representatives' message or information they wish to convey, including a video referral.	☐
Information provided for all referrals	**This section completed for all providers**	
☐	Consent form DSHS14-012: Current signed and dated (must reflect requested provider types).	☐
☐	Guardianship, supportive decision-making agreement, protective arrangements, power of attorney, adoption, and/or legal representative: Any information and documentation identifying others with legal authority to provide consent and make decisions.	☐
☐	DDA assessment details and Person-Centered Plan Summary: Most current client's assessment summary.	☐
☐	Positive behavior support plan: Client's current support plan, for example, Individual Instruction and Support Plan (IISP), Functional Assessment (FA) and Positive Behavior Support Plan (PBSP), if applicable.	☐
☐	Psychological and/or mental health information: Dates, sources, and copies of the most recent documents, if applicable, psychological and/or mental health evaluations, for example, Applied Behavior Analysis (ABA) plan, behavioral and psychiatric information, treatment plans, and/or WISe care plans	☐
☐	Educational and/or vocational records: Including Individualized Education Program (IEP), school evaluation and Behavior Intervention Plan (BIP).	☐
☐	Financial information: Such as verification of SSI/SSA status, eligibility for financial assistance (e.g., food benefits, Medicaid), earned and unearned income and resources, payee information, and whether client is receiving SSP funds.	☐
☐	Legal information	☐
☐	Medical history, immunization records, medications, POLST, and/or specialized protocols. Note: A client's Hepatitis B Virus (HBV) and HIV status are confidential and must not be shared (RCW 70.24.105).	☐
☐	Nurse delegation assessments, when applicable.	☐
For individuals with challenging support issues	**This section completed for all providers.**	
☐	Challenging Supports form DSHS 10-234, Individual with Challenging Support Issues.	☐
☐	Cross-System Crisis Plan (CSCP)/Safety Plan if available	☐
☐	Enhanced Respite Services: DSHS 10-584, Data Summary and Recommendations, if applicable	☐
For individuals with Community Protection Issues	**This section completed for all providers.**	
☐	Community Protection (CP) DSHS 10-258, Individual with Community Protection Issues.	☐
☐	Most recent psychological and psychosexual evaluation / risk assessment.	☐
For individuals requesting Out of Home Services	**This section completed for Out of Home Services.**	
☐	Social Summary: Family profile, strengths of child and family, past and current services and treatments that have been accessed through private insurance, Medicaid and DDA services, hospitalizations history, and any additional relevant school information (specialized school program, shortened school day, specialized para educator supports 1:1, etc.)	☐

For individuals requesting Adult Family Home Services **This section completed for AFH, ALF, and EARC.**

☐ Client Description (age, dislikes, personal interests, hobbies, and how the client prefers to spend their day); include information about the client's participation in work or school, day program, community activities, and other activities.

Daily Rate:

☐ Allergies to animals:
☐ Has pets: type:
☐ Specialized communications style:
☐ Smoker / other substance use:
☐ Wandering / Exit Seeking:
☐ Law Enforcement involvement:
☐ Transportation needs:
☐ Prefers male residents only
☐ Prefers female residents only
☐ Prefers male staff
☐ Prefers female staff
☐ Single room (AFH only)
☐ Wheelchair / ADA accessible home
☐ Home with few / no stairs
☐ Has specialized equipment:
☐ Overnight support needs:
☐ Roll-in Shower
☐ Nurse Delegation Needs
☐ Must be close to bus line
☐ Provider with nursing background
☐ Evacuation level:

To consider supporting this client, please do the following:

- Read through the referral packet and request any further documentation needed.
- Meet the client, family, legal representative, current provider, etc.
- **Contact the Case Resource Manager (see DDA assessment for contact information) to discuss client support needs.**
- Please evaluate the referral to determine whether your agency has the resources to meet the client's needs and provide a response within 10 business days.

Thank you for considering this individual for services.

For Providers of Supported Living, Group Home, Group Training Home and Out of Home Services ONLY – Complete the section below. **Stop! AFH do NOT complete.**

Provider Response (Return to Resource Manager)

☐ I agree to support this client if the client agrees.

If interested in exploring further:

☐ I have contacted this client for follow up and they have agreed to more time to research the referral. Date of when response is due: _____ who approved the extension _____.
☐ I would like to discuss additional options with the resource team.
☐ I would like more information about (_____)

If declined:

I decline this referral for the following reason (select one or more):

☐ Agency doesn't wish to add an additional home at this time
☐ Unable to recruit and retain enough staff to start new home within timeline desired for start of services
☐ Unable to fill current vacant positions, vacancy rate is
☐ Do not have management or program staff or DSP expertise to meet client's unique needs
☐ Housemate match is not compatible.
☐ Lack the infrastructure to add clients (program managers, trainers, human resources support)
☐ Client or guardian expectations cannot be met.
☐ Other (please explain):

Per my contract I have ☐ returned or ☐ destroyed the referral packet.

If a decision is not possible within ten days, the service provider will consult with the RM to mutually agree on an extended timeframe.

PROVIDER'S NAME DATE