Developmental Disabilities Community Services (DDCS)

Lake Burien Transitional Care Facility
Specialized Treatment Referral and Application

Upon completion of this referral, the Regional Clinical Team designee must submit the referral and application packet to LakeBurienTCF@dshs.wa.gov.

Youth's Name	ADSA ID Number	☐ Male ☐ Female ☐ Non-Binary	Date of Birth	Age
Name(s) Youth Prefers to be called / Pronouns	Preferred Language of Youth		Date of Request	
Parent / Legal Guardian's Name	Preferred Language of Youth's Parent / Guardian	Parent / Legal Guardian's Email Address		
DDCS CRM	DDCS CRM Contact Information (i.e., phone, email, etc.)		Region	

Current setting; start date:

- ☐ Family home
- ☐ Out-of-Home Setting such as OHS or DCYF placement
- ☐ Out-of-State Facility or Educational Setting
- ☐ Psychiatric Facility or CLIP
- ☐ Other:
- ☐ Hospital (admitted or emergency room)
- ☐ Residential Habilitation for Dependent Youth
- ☐ Juvenile Detention or Juvenile Rehabilitation Facility

Primary contact name, phone number and/or email in current residential setting if outside of the guardian's home.

Step 1. Eligibility Criteria (to be determined by DDCS CRM)

1. DDCS-eligible under Chapter 388-823 WAC or assessed to have a diagnosed neurodevelopmental disorder, another neurological, or other genetic condition: ☐ Yes ☐ No
2. Is age 13 – 17 years old: ☐ Yes ☐ No
3. Has accessed all appropriate and available less restrictive services and the youth's assessed health care needs exceed what is available in the community.
   ☐ Yes (**as evidenced by Step 1.A. and 1.B. below**) ☐ No

Step 1.A. Need for Services (to be completed by DDCS CRM)

List treatment services and supports in each domain that have been tried and provide detail as to how these failed to meet the need. **Confirm recommended medically necessary services and provide status of current MCO referrals.** Examples may include services provided by private insurance, physical and behavioral health benefits under Medicaid, and DDCS services:

☐ Mental Health services:

☐ Behavioral Support services:

☐ Physical Health services:

☐ Educational supports:

☐ DDCS services:

☐ Any additional Community services:

☐ Substance Use Disorder services (if applicable):

Step 1.B. Complex Support Needs affecting success in the community setting (to be completed by DDCS CRM)

Mark each applicable behavior(s) exhibited, identifying if it is in their current and/or the most recent past setting.
Place an * next to the prominent behavior(s) that impact the client from receiving supports in the community.

	Current	Past		Current	Past		Current	Past
Anorexia	☐	☐	Loud vocalizations	☐	☐	Suicidal action(s)	☐	☐
Arson / Fire Setting	☐	☐	Physical aggression	☐	☐	Takes other's property	☐	☐
Biting	☐	☐	PICA	☐	☐	Verbal aggression	☐	☐
Bulimia	☐	☐	Property destruction	☐	☐	Wandering	☐	☐
Elopement	☐	☐	Self-injurious	☐	☐	Other (specify)	☐	☐
Encopresis / enuresis	☐	☐	Sexually inappropriate	☐	☐			
Head banging	☐	☐	Substance Use Disorder	☐	☐			

☐ Please list all current I/DD diagnosis:

☐ Please list all current Behavioral health diagnosis:

☐ Identify the youth's three to five most critical clinical issues that need to be addressed in treatment:

☐ Identify any barriers family may have to participate in treatment, visits, and passes:

Step 1.C. Cultural and Social Considerations (to be completed by DDCS CRM)

1) What is the cultural background and traditions of the youth (holidays, traditions, customs, and cultural practices observed by the family)?

2) What family relationships and support networks are important to the youth?

3) What are the youth's racial and ethnic identity? Is there any tribal affiliation?

4) Please share information about the youth's family / social history.

5) What is the projected discharge plan for the youth (this can be a general goal, and must be provided)?

Provide all applicable documents with this application with the date the document was last updated:

- ☐ Current DDCS Assessment:
- ☐ Consent (DSHS 14-012) **(required)**:
- ☐ Hospital / medical records for the last 30 days **(required)**:
- ☐ Last six months of Medication Management Notes:
- ☐ Current Psychiatric evaluation dated within six months **(required)**:
- ☐ All Psychiatric hospitalization discharge summaries for the past year:
- ☐ Any and all Psychiatric evaluations completed in the last two years **(required)**:
- ☐ Any completed IQ testing:
- ☐ Neuropsychological Evaluations:
- ☐ Autism Evaluations:
- ☐ Outpatient Mental Health Treatment Plans:
- ☐ Functional Behavior Assessment:
- ☐ Behavior Intervention Plan:
- ☐ BCBA / ABA treatment plans and evaluations within the past year:
- ☐ Psychosexual Evaluation:
- ☐ Speech / Language Evaluations, OT or PT evaluations:
- ☐ Education documents:
  - ☐ Current IEP **(required)**:
  - ☐ Behavior Intervention Plan:
  - ☐ Education Evaluation **(required)**:
- ☐ SUD Assessment:
- ☐ Court reports from the last two years (must include description of any recent offenses)
- ☐ Other description:

Step 1.D. Service Review with MCO or ASO (to be completed by DDCS CRM)

CRM must consult with the youth's MCO or ASO to confirm recommended medically necessary services and provide status of current MCO referrals in Section 1.A.

Identify the MCO serving the youth and the assigned care coordinator:

MCO's Name	Care Coordinator's Name

Step 2. Eligibility Criteria to be completed by Regional Clinical Team

- Has a serious psychiatric diagnosis: ☐ Yes ☐ No
- Experiences a severity, intensity, and frequency of behavior that: ☐ Yes ☐ No
  - Significant impairment of a youth's functioning and
  - Prevents the youth from being safely supported in a less restrictive setting.

Recommendation and Signature

The Regional Clinical Team recommends application to Lake Burien Transitional Care Facility: ☐ Yes ☐ No

Signature of RCT Representative	Date	Printed RCT Representative's Name