DSHS
WASHINGTON STATE Department of Social and Health Services

Adult Family Home (AFH) • Assisted Living Facility (ALF) • Enhanced Services Facility (ESF)

Notice of Bed Hold

WAC 388-105-0045

To be completed by facility. Please print.

Client Name: Last, First, Middle Initial	
DSHS ACES Client ID (required for submission)	ProviderOne Number

Section I. Information of Facility Requesting Bed Hold

Name of Facility		Phone Number (with area code)
Street Address	City	State Zip Code
Name of Person Making the Request		Date

Section II. Type of Action

Bed Hold for Clients receiving MPC, CFC, or CFC+COPES Services

1. ☐ Bed Hold Request
   a. Admission date to the acute care hospital / SNF:
   b. Name of acute care hospital / SNF client transitioned to:
   c. Reason for transition to the acute care hospital / SNF:

2. ☐ Bed Hold Outcome
   a. Enter the date the client returned to the residential facility:
   b. If client will not be returning to the residential facility, enter the date that determination was made:

Bed Hold for Clients Receiving RSW Services

3. ☐ Bed Hold Request
   a. Admission date to the acute care hospital, SNF, Institute for Mental Disease (IMD) or inpatient behavioral health agency to which client admitted:
   b. Name of acute care hospital, SNF, IMD or inpatient behavioral health agency client transitioned to:
   c. Reason for transition to the acute care hospital, SNF, IMD or inpatient behavioral health agency:

4. ☐ Bed Hold Outcome
   a. Enter the date the client returned to the residential facility:
   b. If client will not be returning to the residential facility enter the date that determination was made:

This form is to be filled out and mailed to DMS, PO Box 45826, Olympia WA 98599-5826, or faxed to 855-635-8305.

Instructions for Completing DSHS 05-249

Section I. Information of Facility Requesting Bed Hold

Name of the Facility: Enter the name of the residential facility.

Phone Number: Enter the phone number of the residential facility.

Address: Enter the full address of the residential facility.

Name of the Person Making the Request: Provide the name of the person who is initiating the request.

Date: Enter the date form was filled out.

Section II: Type of Action

Bed Hold Start for Clients receiving MPC, CFC or CFC+COPES Services

1. **Check box if notifying of bed hold outcome.**
   a. Enter the date client was admitted to an acute care hospital or Skilled Nursing Facility (SNF).
   b. Enter the name of the acute care hospital or SNF to which client admitted.
   c. Enter reason the client admitted to acute care hospital or SNF.
2. **Check box if client returned to the residential facility from the acute care hospital or SNF.**
   a. Enter the date the client returned to the residential facility.
   b. If client will not be returning to the residential facility, enter the date that determination was made.

Bed Hold for Clients on Residential Support Waiver Services

3. **Check box if notifying of bed hold outcome.**
   a. Enter the date client was admitted to an acute care hospital or Skilled Nursing Facility (SNF), Institute for Mental Disease (IMD) or inpatient behavioral health agency.
   b. Enter the name of the acute care hospital, SNF, IMD or inpatient behavioral health agency to which client admitted.
   c. Enter reason the client was admitted to acute care hospital, SNF, IMD or inpatient behavioral health agency.
4. **Check box if client returned to the residential facility from acute care hospital, SNF, IMD or inpatient behavioral health agency.**
   a. Enter the date the client returned to the residential facility.
   b. If client will not be returning to the residential facility, enter the date that determination was made.

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