



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  
**Adult Family Home (AFH) Placement Checklist**

CLIENT'S NAME	DDA CASE NUMBER	CASE RESOURCE MANAGER'S NAME
ADULT FAMILY HOME (AFH) PROVIDER'S NAME	AFH TELEPHONE NUMBER (INCLUDE AREA CODE)	CELL PHONE/PAGER NUMBER
PROVIDER'S STREET ADDRESS		

**Provider Issues**

1. Confirm the following per the Aging and Disability Services AFH database or the DDA PQI CRM:
- Date: \_\_\_\_\_
- |                            |                              |                             |                                 |                              |                             |
|----------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|
| Current AFH license:       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | MH Specialty designation:       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Current DSHS AFH contract: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dementia Specialty designation: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DD Specialty designation:  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Conditions on license:          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If yes, specify: \_\_\_\_\_
- Licensed capacity: \_\_\_\_\_
2. Per the PQI staff or AFH provider: Number of current residents: \_\_\_\_\_

**Referral Process**

- Release of Information form ..... Date: \_\_\_\_\_
- Discuss placement need with AFH PQI staff ..... Date: \_\_\_\_\_
- Discussion of individual's needs/referral with provider ..... Date: \_\_\_\_\_
- Delivery of referral packet to provider (Form DSHS 10-232) ..... Date: \_\_\_\_\_
- Pre-placement visit ..... Date: \_\_\_\_\_
- Is nurse delegation assessment required:  Yes  No  
If "Yes," give the date of the completed Registered Nurse assessment ..... Date: \_\_\_\_\_  
**(this must occur no later than the date of placement)**  
Is AFH trained and willing to do nurse delegation:  Yes  No

**Service Authorization**

- Date of current DDA assessment: \_\_\_\_\_ Daily Rate: \_\_\_\_\_  
ETR:  Yes  No Amount: \_\_\_\_\_
- Basic Plus  Non-Waiver  
ISP includes AFH service:  Yes  No
- Date of placement: \_\_\_\_\_
- Start date of AFH payment authorization: \_\_\_\_\_

**COMMENTS**

LEGAL REPRESENTATIVE	LEGAL STATUS	TELEPHONE NUMBER (INCLUDE AREA CODE)
CLIENT REPRESENTATIVE FOR NSA		TELEPHONE NUMBER (INCLUDE AREA CODE)

COMMENTS

CRM SIGNATURE	DATE
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