DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Voluntary Placement Services (VPS)
Foster Care Medical Team (FCMT) Communication

Child's Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	GENDER	ETHNICITY	ACES CLIENT ID	SOCIAL SECURITY NUMBER
	☐ Male ☐ Female			

CLIENT RESIDES IN THE FOLLOWING SETTING (PLEASE CHECK ONE)	HCBS CORE WAIVER	ROADS TO COMMUNITY LIVING ELIGIBLE
☐ Child Foster Home ☐ Staffed Residential ☐ Group Care Facility	☐ Yes ☐ No	☐ Yes ☐ No
	DATE APPROVED FOR HCBSWAIVER	DATE ENTERED INTO VOLUNTARY PLACEMENT

Foster Parent's Information

LAST NAME	FIRST NAME	TELEPHONE NUMBER (WITH AREA CODE)
		( )

FOSTER HOME ADDRESS	CITY	STATE	ZIP CODE
		WA	

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE
		WA	

Staffed Residential / Group Care Facility's Information

RESIDENTIAL AGENCY	TELEPHONE NUMBER (WITH AREA CODE)
	( )

RESIDENTIAL ADDRESS	CITY	STATE	ZIP CODE
		WA	

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE
		WA	

PRIMARY CONTACT NAME	TELEPHONE NUMBER (WITH AREA CODE)
	( )

DDA VPS Social Worker's Information

SOCIAL WORKER'S NAME	TELEPHONE NUMBER (WITH AREA CODE)
	( )

REQUIRED (CHECK ALL THAT APPLY)

- ☐ New Request
- ☐ Updated client address
- ☐ Updated DDA Social Worker
- ☐ Annual Assessment
- ☐ End of RCL year moving onto HCBS Waiver
- ☐ No change in Service
- ☐ No longer DDA client (put reason in comment box)
- ☐ Other (put information or request in comment box)
- ☐ Put DDASW on AREP Screen for Medicaid / Waiver Program

COMMENTS

FCMT Social Worker's Information

FCMT WORKER'S NAME	TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER
	( )	( )