



DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
ADULT FAMILY HOME (AFH)
AFH Quality Improvement Initial Visit

FACILITY'S NAME		PROVIDER'S NAME		LIVES IN HOME <input type="checkbox"/> Yes <input type="checkbox"/> No	
RESIDENT MANAGER'S NAME		LIVES IN HOME <input type="checkbox"/> Yes <input type="checkbox"/> No	TELEPHONE NUMBER	PRIMARY CAREGIVER'S NAME (IF DIFFERENT)	
STREET ADDRESS			CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM AFH)			CITY	STATE	ZIP CODE
TELEPHONE NUMBER		FAX NUMBER		CELL PHONE NUMBER	E-MAIL ADDRESS
LICENSE NUMBER	SSPS PROVIDER NUMBER	DSHS AFH LICENSED CAPACITY		DSHS AFH CONTRACT EXPIRATION DATE	
LICENSOR					TELEPHONE NUMBER
SPECIALTY DESIGNATION <input type="checkbox"/> DD <input type="checkbox"/> Mental Health <input type="checkbox"/> Dementia					NURSE DELEGATED <input type="checkbox"/> Yes <input type="checkbox"/> No
CONDITIONS ON LICENSE IF ANY					
LICENSED CAPACITY		BEDROOMS <input type="checkbox"/> Shared <input type="checkbox"/> Single		VACANCIES <input type="checkbox"/> Shared <input type="checkbox"/> Single	WHEELCHAIR ACCESSIBLE <input type="checkbox"/> Yes <input type="checkbox"/> No
EVACUATION LEVEL <input type="checkbox"/> 1 (Independent with one verbal cue) <input type="checkbox"/> 2 (Assistance Required)			WILL ACCEPT EMERGENCY PLACEMENTS <input type="checkbox"/> Yes <input type="checkbox"/> No		NURSE ON STAFF <input type="checkbox"/> Yes <input type="checkbox"/> No
COMMENTS					
HOUSEHOLD LAYOUT/DYNAMICS <input type="checkbox"/> Single Level <input type="checkbox"/> Two Story <input type="checkbox"/> Split Level <input type="checkbox"/> With Basement		RESIDENT BEDROOMS <input type="checkbox"/> Main Floor <input type="checkbox"/> Upstairs <input type="checkbox"/> Basement		OTHERS RESIDING IN HOME <input type="checkbox"/> Children <input type="checkbox"/> Spouse <input type="checkbox"/> Pets (Dogs, Cats, Birds, Fish, etc.)	
REFERRAL PREFERENCES/LIMITATIONS <input type="checkbox"/> DDD <input type="checkbox"/> Co-Occurring Disorder (Intellectual Disability/Mental Health) <input type="checkbox"/> Challenging Behaviors <input type="checkbox"/> Aging <input type="checkbox"/> Eating Disorder					
PREFERRED AGE RANGE		PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either		SMOKING <input type="checkbox"/> Smokers Permitted <input type="checkbox"/> Designated Smoking Area Outside	
COMMENTS					
NEIGHBORHOOD Yes No					
<input type="checkbox"/>	<input type="checkbox"/>	Typical Residential neighborhood.			
<input type="checkbox"/>	<input type="checkbox"/>	Accessible public transportation.			
<input type="checkbox"/>	<input type="checkbox"/>	Para transit/other service available.			
<input type="checkbox"/>	<input type="checkbox"/>	Does Provider assist with transportation?			
<input type="checkbox"/>	<input type="checkbox"/>	Close proximity to community service and amenities.			

CONTRACTED RESPITE PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No	INTERESTED IN RESPITE <input type="checkbox"/> Yes <input type="checkbox"/> No	SCHOOL DISTRICT
COMMENTS		
PROVIDER AND CAREGIVER EXPERIENCE/EDUCATION (RN, LPN, CAN, NAR, WORK EXPERIENCE):		
POSITIVE BEHAVIOR SUPPORT EXPERIENCE/TRAINING:		
PROVIDER'S COMMITMENT TO COMMUNITY INTEGRATION/OUT OF HOME ACTIVITY:		
COMMENTS		
POSITIVE COMMENTS		
AREAS OF CONCERN		