Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

ADATSA INCAPACITY DECISION/DISPOSITION

A. CLIENT DATA

1. NAME	2. CASE NUMBER

3. Type of action:
   - ☐ Initial decision
   - ☐ Redetermination
   - ☐ Other action

4. FC code for ADATSA *(check one most applicable)*:

ADATSA TREATMENT:

When client meets incapacity criteria for ADATSA treatment, check:

- 0 ☐ If no incapacity other than chemical dependency (CD) - ADATSA treatment only
- 1 ☐ If psychological or physical impairment and CD: eligible for ADATSA treatment and GAU and/or ADATSA shelter

ADATSA SHELTER ONLY:

When client meets incapacity criteria for ADATSA shelter, but does NOT meet incapacity criteria for GAU, check:

- 2 ☐ If cognitive impairment resulted from CD
- 3 ☐ If physical impairment resulted from CD

ADATSA SHELTER AND GAU:

When client meets incapacity criteria for both ADATSA shelter AND GAU check:

- 4 ☐ If psychological incapacity and cognitive impairment resulted from CD
- 5 ☐ If physical incapacity and impairment resulted from CD

B. ADATSA TREATMENT

1. ☐ Approved for ADATSA treatment. Entry date: _____ *(See attached information)*
2. ☐ Pending ADATSA treatment (waiting list).
   a. Date of assessment/medical eligibility: _____
   b. Month expected to enter treatment: _____ *(See attached information and Section D. below)*
3. ☐ Denied ADATSA treatment.
   - ☐ Client does not meet incapacity requirements for ADATSA treatment (WAC 388-240-2400, 2450).
   - ☐ Client is not currently amenable to treatment (WAC 388-240-3100).
   - ☐ Other *(please specify)*:

C. ADATSA SHELTER

1. ☐ Approved for ADATSA SHELTER. *Review due date:* _____
   - ☐ Contracted
     Facility/payee: _____
   - ☐ Intensive Protective Payee (IPP)
     Name/address: _____
   - ☐ Pending treatment (See Section B above)
     Other impairments: _____
2. ☐ Denied ADATSA shelter:
   - ☐ Client does not meet combined incapacity criteria for shelter services (WAC 388-240-2500, 2550).
   - ☐ Other *(please specify)*: _____

D. MEDICAL ASSISTANCE ONLY

1. ☐ Client is eligible for ADATSA medical coverage. Assessment date: _____ Review date: _____
   - a. ☐ Client is pending ADATSA treatment (Section B. 2., above).
   - b. ☐ Client is currently enrolled in a state approved methadone maintenance program.
   - c. ☐ Client declined ADATSA shelter services, though eligible.

E. SSI REFERRAL

1. ☐ Client referred to SSI facilitator for decision on SSI referral.
2. ☐ Mandatory referral; subject to sanction for failure to follow through.
3. Date referred: _____
4. Date SSI interim assistance agreement signed: _____

INCAPACITY SPECIALIST'S SIGNATURE	TELEPHONE NUMBER	DATE