



DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
ADULT FAMILY HOME (AFH)
**AFH QUALITY IMPROVEMENT VISIT
ASSESSMENT**

DD PQI RESOURCE MANAGER	
DATE OF VISIT	TIME OF VISIT
	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

FACILITY'S NAME		PROVIDER'S NAME	
STREET ADDRESS		MAILING ADDRESS (IF DIFFERENT FROM AFH)	
CITY	ZIP CODE	CITY	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

*** ASTERISK THOSE RESIDENTS PRESENT DURING VISIT**

NAME OF DDD RESIDENT	DATE OF BIRTH	CRM	WAIVER STATUS	DAILY RATE	EVACUATION LEVEL	DD NUMBER

REASON FOR VISIT

NAME OF STAFF OBSERVED OR INTERVIEWED DURING THE VISIT

OTHER NON-RESIDENTS LIVING IN THE HOME

POSITIVE COMMENTS REGARDING HOUSEHOLD INFORMATION

ISSUES/CONCERNS

IF NEW RESIDENT(S), REASON FOR MOVE

NEGOTIATED CARE PLANS:

Current Not Current – Explain:

DDD ASSESSMENT:

Current Not Current – Explain:

COMPETENCE

COMMENTS/CONCERNS

HEALTH AND SAFETY

COMMENTS/CONCERNS

INTEGRATION

COMMENTS/CONCERNS

RELATIONSHIPS

COMMENTS/CONCERNS

POWER AND CHOICE

COMMENTS/CONCERNS

STATUS

COMMENTS/CONCERNS

CASE RESOURCE MANAGER CONTACT

SER Completed