Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Adult Family Home (AFH) Referral Checklist

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

Provider Issues

1. Confirm the following per the DDA PQIS or via the Aging and Disability Services AFH database:

   Date: _____

   Current AFH license: ☐ Yes ☐ No
   Current DSHS AFH contract: ☐ Yes ☐ No
   DD Specialty designation: ☐ Yes ☐ No
   MH Specialty designation: ☐ Yes ☐ No
   Dementia Specialty designation: ☐ Yes ☐ No
   Conditions on license: ☐ Yes ☐ No If yes, specify:

   Licensed capacity: _____

2. Per the PQI staff or AFH provider: Number of current residents: _____

Referral Process

1. Release of Information form ..... Date: _____
2. Discuss referral need with AFH PQI staff ..... Date: _____
3. Discussion of individual's needs/referral with provider ..... Date: _____
4. Delivery of referral packet to provider (Form DSHS 10-232A) ..... Date: _____
5. Pre-move visit ..... Date: _____
6. Is nurse delegation assessment required: ☐ Yes ☐ No

   If "Yes," give the date of the completed Nurse Delegation assessment ..... Date: _____
   (**this must occur no later than the date of move**)

   Is AFH trained and willing to do nurse delegation: ☐ Yes ☐ No

Service Authorization

1. Date of current DDA assessment: _____ Daily Rate: _____

   ETR: ☐ Yes ☐ No Amount: _____

   Behavior Point Score: _____ (if eligible for Meaningful Day, contact MD Specialist)

2. ☐ Basic Plus ☐ Non-Waiver

   PCSP includes AFH service: ☐ Yes ☐ No

3. Date of move: _____
4. 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