

## Provider Referral Letter for Residential Services

	Completed for all providers.
	Completed for SL, GH, GTH only.
	Completed for Out of Home Services.
	Completed for Adult Family Homes (AFH).
	Completed by all providers <b>except AFH.</b>

Date

Dear Provider,

I am referring **Client's Name** to you for residential supports. This client is moving from **Setting** and requires supports by **Date: MM/DD/YYYY**; and prefers to live in (city) **Option 1, Option 2, Option 3.**

<b>Included in Referral Packet:</b> Please save all documents in the following order: Last name, first name, name of document, and month and year of referral (i.e., mm/yy or mm/yyyy).		
ENCLOSED	TYPE OF INFORMATION	N/A
<b>Information provided by client or legal representative</b>		<b>This section completed for all providers.</b>
<input type="checkbox"/>	Client and/or legal representatives' message or information they wish to convey, including a video referral.	<input type="checkbox"/>
Did the client request their referral information to be sent to specific providers? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the name of the requested provider(s): (required for SL / GH / GTH)		
<b>Information provided for all referrals</b>		<b>This section completed for all providers</b>
<input type="checkbox"/>	Consent form <a href="#">DSHS 14-012</a> : Current signed and dated (must reflect requested provider types).	<input type="checkbox"/>
<input type="checkbox"/>	Companion Home option has been discussed. Client is interested: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<input type="checkbox"/>	Guardianship, supportive decision-making agreement, protective arrangements, power of attorney, adoption, and/or legal representative: Any information and documentation identifying others with legal authority to provide consent and make decisions.	<input type="checkbox"/>
<input type="checkbox"/>	DDA assessment details and Person-Centered Plan Summary: Most current client's assessment summary.	<input type="checkbox"/>
<input type="checkbox"/>	Positive behavior support plan: Client's current support plan, for example, Individual Instruction and Support Plan (IISP), Functional Assessment (FA) and Positive Behavior Support Plan (PBSP), if applicable.	<input type="checkbox"/>
<input type="checkbox"/>	Psychological and/or mental health information: Dates, sources, and copies of the most recent documents, if applicable, for example, Applied Behavior Analysis (ABA) plan, behavioral and psychiatric information, treatment plans, and/or WISE care plans <b>if noted in attached consent.</b>	<input type="checkbox"/>
<input type="checkbox"/>	Educational and/or vocational records: Including Individualized Education Program (IEP), school evaluation and Behavior Intervention Plan (BIP).	<input type="checkbox"/>
<input type="checkbox"/>	Financial information: Such as verification of SSI/SSA status, eligibility for financial assistance (e.g., food benefits, Medicaid), earned and unearned income and resources, payee information, and whether client is receiving SSP funds.	<input type="checkbox"/>
<input type="checkbox"/>	Legal information	<input type="checkbox"/>
<input type="checkbox"/>	Medical history, immunization records, medications, POLST, and/or specialized protocols.	<input type="checkbox"/>
<input type="checkbox"/>	Nurse delegation assessments, when applicable.	<input type="checkbox"/>
<b>For individuals with challenging support issues</b>		<b>This section completed for all providers.</b>
<input type="checkbox"/>	Challenging Supports form <a href="#">DSHS 10-234, Individual with Challenging Support Issues.</a>	<input type="checkbox"/>
<input type="checkbox"/>	Cross-System Crisis Plan (CSCP) / Safety Plan if available	<input type="checkbox"/>
<input type="checkbox"/>	Most recent psychological and psychosexual evaluation / risk assessment (if approved for CPP)	<input type="checkbox"/>
<b>For Supported Living, Group Home, Group Training Home</b>		<b>This section completed for SL / GH / GTH.</b>
<input type="checkbox"/>	Attachment to Consent form DSHS 14-012D	Required
<input type="checkbox"/>	Client Referral Summary DSHS 15-358	Required

<b>For Out of Home Services</b>	<b>This section completed for Out of Home Services.</b>
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<input type="checkbox"/>	Social Summary: Family profile, strengths of child and family, past and current services and treatments that have been accessed through private insurance, Medicaid and DDA services, hospitalizations history, and any additional relevant school information (specialized school program, shortened school day, specialized para educator supports 1:1, etc.)	<input type="checkbox"/>
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<b>For individuals requesting Adult Family Home Services</b>	<b>This section completed for AFH, ALF, and EARC.</b>
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Client Description (age, dislikes, personal interests, hobbies, and how the client prefers to spend their day); include information about the client's participation in work or school, day program, community activities, and other activities.

**Daily Rate:**

<input type="checkbox"/> Allergies to animals: <input type="checkbox"/> Has pets: type: <input type="checkbox"/> Specialized communications style: <input type="checkbox"/> Smoker / other substance use: <input type="checkbox"/> Wandering / Exit Seeking: <input type="checkbox"/> Law Enforcement involvement: <input type="checkbox"/> Transportation needs: <input type="checkbox"/> Prefers male residents only <input type="checkbox"/> Prefers female residents only <input type="checkbox"/> Prefers male staff	<input type="checkbox"/> Prefers female staff <input type="checkbox"/> Single room (AFH only) <input type="checkbox"/> Wheelchair / ADA accessible home <input type="checkbox"/> Home with few / no stairs <input type="checkbox"/> Has specialized equipment: <input type="checkbox"/> Overnight support needs: <input type="checkbox"/> Roll-in Shower <input type="checkbox"/> Nurse Delegation Needs <input type="checkbox"/> Must be close to bus line <input type="checkbox"/> Provider with nursing background <input type="checkbox"/> Evacuation level:
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**To consider supporting this client, please do the following:**

- Read through the referral packet and request any further documentation needed.
- Meet the client, family, legal representative, current provider, etc.
- **Contact the Case Resource Manager (see DDA assessment for contact information) to discuss client support needs.**
- Please evaluate the referral to determine whether your agency has the resources to meet the client's needs and provide a response within 10 business days.

Thank you for considering this individual for services.

<b>For Providers of Supported Living, Group Home, Group Training Home and Out of Home Services <u>ONLY</u> – Complete the section below.</b>	<b>Stop! CH and AFH do NOT complete.</b>
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**Provider Response (Return to Resource Manager)**

I agree to support this client if the client agrees.

**If interested in exploring further:**

I have contacted this client for follow up and they have agreed to more time to research the referral. Date of when response is due: \_\_\_\_\_ who approved the extension \_\_\_\_\_.

I would like to discuss additional options with the resource team.

I would like more information about ( \_\_\_\_\_ )

**If declined:**

I decline this referral for the following reason (select one or more):

Agency doesn't wish to add an additional home at this time

Unable to recruit and retain enough staff to start new home within timeline desired for start of services

Unable to fill current vacant positions, vacancy rate is

Do not have management or program staff or DSP expertise to meet client's unique needs

Housemate match is not compatible.

Lack the infrastructure to add clients (program managers, trainers, human resources support)

Client or guardian expectations cannot be met.

Other (please explain):

Per my contract I have  returned or  destroyed the referral packet.

**If a decision is not possible within ten days, the service provider will consult with the RM to mutually agree on an extended timeframe.**

PROVIDER'S NAME	DATE
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