Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Provider Referral Letter for Residential Services

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**.

WAIVER STATUS Choose one: ☐ CORE ☐ Non-waiver ☐ CPP ☐ Other waiver awaiting approval for CORE or CPP	
INCLUDED IN REFERRAL PACKET	
ENCLOSED	TYPE OF INFORMATION
☐	Signed and dated consent form. *last.first-consent MO-YR*
☐	Legal representative information and documentation. *last.first-guardainship papers MO-YR*
☐	The client's current DDA Person Centered Service Plan including Assessment details and Summary. *last.first-current assessment details MO-YR*
☐	The client's current Functional Assessment and Positive Behavior Support Plan (PBSP) if they have one. *last.first-FAPBSP MO-YR*
☐	Dates, sources, and copies of the most recent psychological and mental health evaluations, including any behavioral and psychiatric information and treatment plans. *last.first-psych mental health MO-YR*
☐	Educational and vocational records, including IEP information if available. *last.first-IEP00-19 or last.first-vocational MO-YR*
☐	Financial information (may be found in ACES), such as verification of SSI/SSA status, eligibility for financial assistance (e.g., food stamps, Medicaid), earned and unearned income and resources, payee information, and whether client is receiving SSP funds. *last.first-financial eligibility MO-YR*
☐	Legal information. *last.first-legal MO-YR*
☐	Medical history, immunization records, and medications. Note: A client's Hepatitis B Virus (HBV) and HIV status are confidential and must not be shared (RCW 70.24.105). *last.first-medical history MO-YR*
☐	Nurse delegation assessments, when applicable. *last.first-nurse delegation assessment MO-YR*
☐	Any message or information a client wishes to convey, including a video referral. *last.first-video referral MO-YR*
For individuals with Challenging support Issues:	
☐	DSHS 10-234, Individual with Challenging Support Issues. *last.first-indiviual w challenging support issues MO-YR*
☐	Cross-System Crisis Plan (CSCP) if available. *last.first-CSCP MO-YR*
For individuals with Community Protection Issues:	
☐	DSHS 10-258, Individual with Community Protection Issues. *last.first-individual w CP issues MO-YR*
☐	Most recent psychological and psychosexual evaluation/risk assessment. *last.first-risk assesment MO-YR*
Information provided by client or legal representative:	
☐	The following information is provided by the client, the client's legal representative, or both. Please be aware that DSHS has not reviewed or verified the accuracy of this information. List files here:

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 contact information below) to discuss client support needs.
- Within 10 business days of receipt of the referral packet, evaluate the referral to determine whether your agency has the resources to meet the client's needs and respond below.

Thank you for considering this individual for services.

Sincerely,

CASE MANAGER'S PRINTED NAME _____ TELEPHONE NUMBER _____

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