Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
ADULT FAMILY HOME (AFH)
ADULT RESIDENTIAL CARE FACILIITY (ARC)

AFH / ARC Provider Referral Letter

PROVIDER NAME AND ADDRESS

Dear ,

I am referring _____ to you for your review:
CLIENT NAME

ENCLOSED	NOT AVAILABLE	TYPE OF INFORMATION
☐	☐	Release of Information, DSHS 14-012(X)
☐	☐	Person Centered Service Plan / Other Support Plans Type: Date:
☐	☐	Financial information
☐	☐	Health information **(per RCW 70.24.105, HBV / HIV status is confidential)**
☐	☐	Legal information
☐	☐	Educational / vocational / other agency records
☐	☐	Individual with Challenging Support Issues, DSHS 10-234 (if applicable)
☐	☐	Other (specify):

Please notify me of your decision within ten (10) working days of receipt of this packet so that we may proceed with discussion of a pre-placement visit.

Upon receipt of this letter and packet, please sign this cover letter and return an original signature copy to me.

Please let me know if you need additional information. My telephone number is .

Thank you for considering this person for services.

Sincerely,

_____

I have received the referral information for the individual named above. I have not yet accepted the individual for placement. If the person is not accepted, I will return all referral information to DDA.

PROVIDER'S SIGNATURE DATE

DISTRIBUTION: Provider, Client File