



DEVELOPMENTAL DISABILITIES ADMINISTRATION
AGING AND LONG-TERM SUPPORT ADMINISTRATION

Individual With Challenging Support Issues

CLIENT'S NAME
DATE OF BIRTH

MENTAL HEALTH DIAGNOSIS <input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHOLOGICAL/BEHAVIORAL ASSESSMENT <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	DDA IDENTIFICATION NUMBER	CLIENT ACES ID NUMBER	REGION
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Section 1. Check one or all that apply (documentation must be present in file)

Check all relevant boxes below.

	HISTORY OF OCCURRENCE INDICATE FREQUENCY AS DAILY, WEEKLY, OR MONTHLY		
	1 – 2 YEARS	3 – 5 YEARS	5+ YEARS
<input type="checkbox"/> Assaultive (significant aggression or physical abuse toward others) Describe: _____ Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Destructive (significant property destruction which puts self or others at risk) Describe: _____ Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Self-Injurious (suicidal behavior; significant self-injury, danger to self) Describe: _____ Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> History of misdemeanor-type behavior. May or may not have been charged (shoplifting, theft, trespassing, buying liquor for minors, forgery, malicious mischief, motor vehicle citations, disturbing the peace, etc) Describe: _____ Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inappropriate sexual behaviors (that are not for sexual gratification: e.g., exposing, undressing in public) Describe: _____ Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2. (Only complete if agency requires) Addendum

INFORMATION VERIFICATION BY: <input type="checkbox"/> Police report <input type="checkbox"/> Court records <input type="checkbox"/> Self-report <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Psycho-sexual assessment <input type="checkbox"/> Other (specify): _____	COOPERATION WITH SUPERVISION <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____	CURRENT DAY PROGRAM <input type="checkbox"/> Employment <input type="checkbox"/> School <input type="checkbox"/> Community access <input type="checkbox"/> None <input type="checkbox"/> Other
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CURRENT RESIDENCE (SEE STAFF INSTRUCTIONS)

AFH AL ARC CFH CH CPRS DOC EARC ESF ESH GH/GTH ICF/ID
 JRA SL WSH Own home Parent/relative home Other (specify): _____

SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, ETC.)

GUARDIANSHIP <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME _____	TYPE <input type="checkbox"/> Full <input type="checkbox"/> Limited
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LEGAL STATUS

Current charge pending; if checked, specify: _____
 Competent to stand trial
 Incompetent to stand trial
 Not Guilty by Reason of Insanity (NGRI)
 Current Less Restrictive Alternative (LRA) (attach copy of court order)
 Currently in jail; projected release date: _____
 Probation/parole (attach conditions of probation)
 Conditional release (attach conditions of release)

This form was completed based on available information.

CASE/RESOURCE MANAGER'S SIGNATURE _____	DATE _____
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DISTRIBUTION: Case Management File Client File Agency File

Instructions for Individual with Challenging Support Issues

This form must be part of the client's referral packet provided to residential providers.

Copies will be kept in the:

- Client record; and
- Client file maintained by the residential program.

Case manager/social worker responsibilities:

- Provide the forms/copies to the residential provider; and
- Keep the client information on the form current.

Residential provider responsibilities:

- Maintain the client files;
- Ensure the safety of all clients; and
- Inform DSHS of any change of condition with regard to the person's challenging support issues.

DEFINITIONS:

Mental Health Diagnosis: Indicate only "Yes" or No." Additional information about mental health is in the client's record.

DDA Identification Number: This number is the case identifier of the authorizing agency.

RESIDENCE TYPES:

AFH	Adult Family Home
AL	Alternate Living
ARC	Adult Residential Care facility licensed as an Assisted Living facility
CFH	Children's Foster Home
CH	Companion Home (contracted with DDA)
CPRS	Community Protection Residential Services (Supported Living)
DOC	Department of Corrections
EARC	Enhanced ARC facility
ESF	Enhanced Services Facility
ESH	Eastern State Hospital
GH	Group Home (contracted with DDA) with an Assisted Living license
GTH	Group Training Home
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disabilities
JRA	Juvenile rehabilitation facility
SL	Supported Living Services
WSH	Western State Hospital

SIGNATURES:

Case / Resource Manager's signature: Signature of the staff completing the form.