



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
ADULT FAMILY HOME (AFH)

AFH Quality Improvement Initial Visit

DDA PQIS	
DATE OF VISIT	TIME OF VISIT <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

PROVIDER NAME			LIVES IN HOME <input type="checkbox"/> Yes <input type="checkbox"/> No	
RESIDENT MANAGER'S NAME	LIVES IN HOME <input type="checkbox"/> Yes <input type="checkbox"/> No	TELEPHONE NUMBER	PRIMARY CAREGIVER'S NAME (IF DIFFERENT)	
STREET ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM AFH)		CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS	
LICENSE NUMBER	P1 PROVIDER NUMBER	DSHS AFH LICENSED CAPACITY	DSHS AFH CONTRACT EXPIRATION DATE	
SPECIALTY DESIGNATION <input type="checkbox"/> DD <input type="checkbox"/> Mental Health <input type="checkbox"/> Dementia			NURSE DELEGATED <input type="checkbox"/> Yes <input type="checkbox"/> No	
CONDITIONS ON LICENSE IF ANY				
NUMBER OF CURRENT VACANCIES	BEDROOMS <input type="checkbox"/> Shared <input type="checkbox"/> Single	VACANCIES <input type="checkbox"/> Shared <input type="checkbox"/> Single	WHEELCHAIR ACCESSIBLE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EVACUATION LEVEL <input type="checkbox"/> 1 (Independent with one verbal cue) <input type="checkbox"/> 2 (Assistance Required)		WILL ACCEPT EMERGENCY PLACEMENTS <input type="checkbox"/> Yes <input type="checkbox"/> No	NURSE ON STAFF <input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMENTS				
HOUSEHOLD LAYOUT <input type="checkbox"/> Single Level <input type="checkbox"/> Two Story <input type="checkbox"/> Split Level <input type="checkbox"/> With Basement		RESIDENT BEDROOMS <input type="checkbox"/> Main Floor <input type="checkbox"/> Upstairs <input type="checkbox"/> Basement	OTHERS RESIDING IN HOME <input type="checkbox"/> Children <input type="checkbox"/> Spouse <input type="checkbox"/> Pets ()	
PREFERRED AGE RANGE	PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either	SMOKING <input type="checkbox"/> Smokers Permitted (Has outside designated area) <input type="checkbox"/> Nonsmoking only		
COMMENTS / PREFERENCES / LIMITATIONS				
NEIGHBORHOOD Yes No <input type="checkbox"/> <input type="checkbox"/> Typical Residential neighborhood. <input type="checkbox"/> <input type="checkbox"/> Accessible public transportation. <input type="checkbox"/> <input type="checkbox"/> Para transit/other service available. <input type="checkbox"/> <input type="checkbox"/> Provider assist with transportation? <input type="checkbox"/> <input type="checkbox"/> Close proximity to community service and amenities.				
CONTRACTED RESPITE PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No		INTERESTED IN RESPITE <input type="checkbox"/> Yes <input type="checkbox"/> No	SCHOOL DISTRICT	

COMMENTS
PROVIDER AND CAREGIVER EXPERIENCE/EDUCATION (RN, LPN, NAC, NAR, HCA-C, WORK EXPERIENCE)
POSITIVE BEHAVIOR SUPPORT EXPERIENCE / TRAINING
COMMUNITY INTEGRATION / OUT OF HOME ACTIVITY (HOW ACTIVITIES ARE CURRENTLY SUPPORTED BY)
COMMENTS
ADDITIONAL STRENGTHS
ADDITIONAL AREAS OF CONCERN