Washington State Department of Social & Health Services
DDA Developmental Disabilities Administration

Limitation Extension Evaluation

NAME	BIRTHDATE	EVALUATION DATE
EVALUATOR'S NAME	CREDENTIAL NUMBER	TIME SPENT IN HOME
ADDRESS WHERE EVALUATION OCCURRED		
INDIVIDUALS PRESENT AT EVALUATION		

Activities of Daily Living (ADL) / Instrumental Activities of Daily Living (IADL)

Based on your observations:

- Check "Yes" if the following ADLs / IADLs are within developmental milestones.
- Check "No" if they are not within developmental milestones.

	YES	NO
1. Ambulation	☐	☐
2. Bed Mobility	☐	☐
3. Transfers	☐	☐
4. Toileting	☐	☐
5. Eating	☐	☐
6. Bathing	☐	☐
7. Dressing	☐	☐
8. Personal Hygiene	☐	☐
9. Medication Management	☐	☐
10. Meal Preparation	☐	☐
11. Housework	☐	☐

For each ADL / IADL you have checked "No" above, please provide the following information.

NAME OF ADL / IADL NOT WITHIN DEVELOPMENTAL MILESTONES	FREQUENCY OF TASK PERFORMANCE
	time per ☐ day ☐ week ☐ month

Description of how task was accomplished. Describe the level of self-performance and the kind of support provided:

Could the task be accomplished more quickly or with less assistance? ☐ Yes ☐ No

If yes, describe what would be needed to facilitate improved task accomplishment (e.g., assistive technology, durable medical equipment, training for support providers and/or clients that will allow task to be accomplished more quickly and/or with less assistance).

Estimated time to perform task based on recommendations:

Demonstrate proper technique, if appropriate. Is this something that can be taught during the visit? Additional comments:

ISSUES AND CONCERNS IMPACTING THE DELIVERY OF CARE TO THE INDIVIDUAL

Treatments / Programs

TREATMENTS	CHECK IF RECEIVES	FREQUENCY (EXAMPLE: TWO TIMES PER DAY FOR 15 MINUTES EACH)	INDIVIDUAL PROVIDING TREATMENT (PARENT, SCHOOL, THERAPIST)
Sensory Integration Therapy	☐		
Occupational Therapy	☐		
Passive Range of Motion	☐		
Active Range of Motion	☐		
Splint / Brace Assistance	☐		
Weighted Vest / Blanket	☐		
Turning and Repositioning	☐		
Other:	☐		
Other:	☐		

TREATMENT DESCRIPTION / COMMENTS / RECOMMENDATIONS

You may make additional comments by attaching them to this document.

EVALUATOR'S SIGNATURE DATE

Return the completed Limitation Extension Evaluation form, DSHS 10-503, to the LE Committee **and** the authorizing prescriber.

Email to: LEcommittee@dshs.wa.gov **or**
Fax to: Attention: LE Committee to (360)407-0955 **or**
Mail to: LE Committee
P.O. Box 45310
Olympia, WA 98504-5310