Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMNISTRATION (DDA)

Initial Staff and Family Consultation Plan

CLIENT NAME		CASE MANAGER NAME
PROVIDER NAME	PROVIDER AGENCY NAME	DATE PLAN WAS WRITTEN OR REVISED

Staff or Family (S/F) member's goal. Include a brief description of the staff or family members situation that requires Staff and Family Consultation:

Needed support to assist S/F in working toward their goal: check all that apply.

- ☐ Observation of S/F member actions
- ☐ Modeling appropriate techniques to S/F
- ☐ Phone consultation
- ☐ Referral to family support group or advocacy organization

Describe:

Is there a current therapeutic or related plan in place for the client that the staff or family member needs supporting to follow? ☐ Yes ☐ No

If yes, identify the component of the therapeutic or related plan that you will be consulting with the S/F member on.

If no, please identify what consultation is being provided to the Staff and/or Family and what referrals (if any) will be made:

SMART goal(s) and objective(s)

Describe the S/F SMART goal(s) and objective(s) addressed as they appear in Policy 4.19. No more than three goals per plan.

SMART goals and objective are:

- **Specific**
- **Measurable**
- **Achievable**
- **Relevant**
- **Time-bound**

Goal 1	
Goal 2	
Goal 3	

Consultation strategies to achieve the goal(s)

Goal 1	
Goal 2	
Goal 3	

Goal completion criteria stated in objective, measurable terms	
Goal 1	
Goal 2	
Goal 3	

Signatures			
CLIENT SIGNATURE	DATE	LEGAL REPRESENTATIVE'S SIGNATURE	DATE
PROVIDER SIGNATURE	DATE		

Instructions for Initial Staff and Family Consultation Plan

Client Name: Add in the name of the client.

Provider Name: Add in provider's name who is working with the staff or family. If an agency, please include the name of the agency, and then the specific clinician / individual providing the service.

Case Manager Name: Include the name of the client's case manager.

Date plan as written or revised: Include the date this plan was completed.

Staff or Family (S/F) member overarching goal and brief description of current situation indicating the need for Staff and Family Consultation: Include in this section, what the presenting problem is that has resulted in the staff or family member requesting SFC services. What is their main goal? An overarching goal is their general, large goal that they would like to reach by utilizing this service.

Needed Support to assist S/F in working toward their goal (check all that apply): Identify how the staff or family member will be directed by the provider during staff and family consultation.

Is there a current therapeutic or related plan in place for the client that the staff or family member needs supporting to follow?: Does the client have a therapeutic plan in place (this can be with a physician, PT, OT, ST, BCBA, IEP, etc.). If the client does have a therapeutic plan, identify what part of the plan the staff or family member needs consultation on. If no, please explain what the staff or family member will be receiving consultation on.

Describe the S/F SMART goal(s) and objective(s) addressed as they appear in Policy 4.19. No more than three goals per plan: Identify what the goal(s) are that the staff or family member would like to work on. Use the chart to the right of the document (S.M.A.R.T.) to make sure the goal is stated with this criteria in mind.

Consultation Strategies to achieve the goal(s): Identify here what the provider will be doing through consultation to help the staff or family member reach their goal(s).

Goal Completion criteria, stated in objective measurable terms: Identify how goal completion will be measured or attained.

Client Signature: The client must sign here.

Legal Representative Signature: When applicable, the client's legal representative needs to sign here, agreeing to this initial plan.

Provider Signature: The SFC provider will sign here.