Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)
NURSING FACILITY (NF)
RESIDENTIAL HABILITATION CENTERS (RHC)

Request for ICF/IID or NF Services at an RHC Admission Application

Upon CRM completion of this application, the CRM Supervisor must submit the packet to RHCAdmission@dshs.wa.gov.

CLIENT'S NAME	ADSA ID NUMBER	☐ Male ☐ Female	DATE OF BIRTH	AGE

NAME(S) CLIENT PREFERS TO BE CALLED

Does this client have a court appointed guardian? ☐ No ☐ Yes; if yes, complete the information below:

GUARDIAN'S NAME	GUARDIAN'S PHONE	GUARDIAN'S EMAIL

INTERPRETER SERVICES
☐ No ☐ Yes; if yes, specify language:

DDA CRM	REGION	TELEPHONE (WITH AREA CODE)

Current setting; start date:	**Identify the associated setting primary contact information:**
☐ Family home	PROVIDER / PRIMARY CAREGIVER / FACILITY NAME
☐ Own home (including Supported Living);	ADDRESS
☐ Adult Family Home	CONTACT NAME AND TITLE
☐ Hospital (admitted or emergency room)	CONTACT PHONE (WITH AREA CODE)
☐ Psychiatric Facility or Jail	CONTACT EMAIL
☐ Other:	

RHC requested service(s) and location(s) (Check all that apply)

Reference DDA Policy 17.02

☐ ICF/IID: ☐ Fircrest School ☐ Lakeland Village ☐ Rainier School

☐ Documented SER in CARE: Client and legal representative have received the RHC ICF brochure and have been informed that ICF/IID services are temporary and once discharge criteria has been met transition will begin.

☐ Documented SER in CARE: Client and legal representative have been provided information on applicable crisis stabilization services (i.e: waiver stabilization, diversion beds, IHS, SAIF).

☐ NF: ☐ Fircrest School ☐ Lakeland Village ☐ Crisis Stabilization at Yakima Valley School

Indicate applicable documents provided with this application with the date the document was last updated:

☐ Current DDA Assessment:
☐ Consent (DSHS 14-012):
☐ Cross Systems Crisis Plan:
☐ Hospital / medical records:
☐ Incident reports
☐ Psychiatric evaluation(s):
☐ Positive Behavior Support Plan:
☐ SOTP Risk Assessment:
☐ Other description:

Social Summary

Relevant history: Please identify the unmet need and/or skills required for supports in the community to be achieved and include pertinent hospitalizations, mental health information, such as prescriber, DDA and community services received to date, recent changes in residence settings and significant events that lead to this request and indicate, if known, the discharge plan:

Challenging Behaviors OR ☐ No Challenging Behaviors

Mark each applicable behavior(s) exhibited, identifying if it is in their current and/or the most recent past setting.

Place an * next to the prominent behavior(s) that impact the client from receiving supports in the community.

	CURRENT	PAST		CURRENT	PAST		CURRENT	PAST
Anorexia	☐	☐	Loud vocalizations	☐	☐	Suicidal action(s)	☐	☐
Biting	☐	☐	Physical aggression	☐	☐	Takes other's property	☐	☐
Bulimia	☐	☐	PICA	☐	☐	Verbal aggression	☐	☐
Elopement	☐	☐	Property destruction	☐	☐	Wandering	☐	☐
Encopresis / enuresis	☐	☐	Self-injurious	☐	☐	Other (specify)	☐	☐
Head banging	☐	☐	Sexually inappropriate	☐	☐			

Support Needs

For clients currently or within the past six months receiving community residential habilitation services, CRM please work with the applicable Resource Manager to complete 1 – 5 from the residential rate assessment:

1) Effective date:
2) Single Person Household (SPH) 4, 5, 6: ☐ No ☐ Yes, if yes, comments:
3) Exception to Policy (ETP) for SPH or Tier 9: ☐ No ☐ Yes, if yes, comments:
4) Two – one support column needs: ☐ No ☐ Yes, if yes, list domain with correlating hours per week:
5) Additional comments related to specialized supervision and supports:

For clients currently or within the past six months receiving Out-of-Home (OHS) Services, please attach the staffed residential rate assessment (DSHS 10-326) with this application. ☐ Yes, attached.

For clients receiving services in any other setting:

Identify awake, night and community supervision needs:

Restrictions in place at current setting (door / window alarms, food restrictions, mechanical restraints etc.):

Describe any medical and accessibility support needs and/or adaptive equipment required (ramp, roll-in shower, shower chair, Hoyer lift, etc.):

Select the type of assistance needed to take medications, apply medicated ointments or administer drops

☐ None (if applicable):
☐ Supervision only ☐ Verbal prompts ☐ Hand in cup ☐ Crushed in food
☐ Physical assistance ☐ Medications administered via enteral feeding
☐ Other:

Other Information

List any other pertinent information including preferred activities, like / dislikes, strengths, abilities: