DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Stabilization, Assessment, and Intervention Services (SAIF) Eligibility and Referral

The Case Resource Manager completes this form for client consideration to the SAIF program.

CLIENT'S NAME	ADSA ID NUMBER	DATE OF BIRTH	AGE
CLIENT'S ADDRESS		PHONE NUMBER	
DDA CASE RESOURCE MANAGER'S NAME	PHONE NUMBER	REGION	REFERRAL DATE

WAIVER ☐ Yes ☐ No IF YES, TYPE OF WAIVER:

Current Setting:

Long-Term Residential Provider:

- ☐ Family or Individual Provider in Family Home
- ☐ Family or Individual Provider in Own Home
- ☐ Supported Living
- ☐ Group Home / Group Training Home
- ☐ Companion Home
- ☐ Adult Family Home

Eligible for discharge from acute care setting:

- ☐ Community Hospital:
- ☐ Residential Habilitation Center:
- ☐ Evaluation and Treatment Facility (ENT)
- ☐ State Psychiatric Hospital:

SAIF Eligibility

The client is:

	YES	NO
• Eligible for DDA services under Chapter 388-823 WAC	☐	☐
• Age 18 years or older	☐	☐
• Eligible for discharge from an acute care setting	☐	☐
• Has long-term behavioral health services in place	☐	☐
• Has established a long-term residential provider	☐	☐
• The program can meet the client's needs	☐	☐
• Has frequent stabilization, assessment, and intervention needs as indicated by at least one or more of the following:		
◦ Three or more hospital admissions for behavioral health stabilization in the last year	☐	☐
◦ A hospital admission for behavioral health stabilization lasting more than four months	☐	☐
◦ The regional clinical team's assessment that behavioral health destabilization is likely to occur	☐	☐

SAIF Referral Process, Part 1.

CRM believes a client might benefit from the SAIF program and have:

	YES	NO
• Discussed the services with the client, client's legal representative, and the regional clinical team	☐	☐
• Confirmed client meets SAIF admission criteria and agrees to SAIF services	☐	☐

Describe below the client's short-term goals, desired outcomes, and community resources that have been explored:

Short-term goals (identify three goals):

1.

2.

3.

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Desired outcomes (90 day achievable goal):

1.

2.

3.

Alternatives explored (e.g., community mental health or diversion bed services) by the client:

1.

2.

3.

The client, legal representative, and long-term residential services provider:

	YES	NO
• Agrees to actively participate in the client's stabilization and habilitative services	☐	☐
• Agrees to learning techniques and supports from the SAIF program and client's treatment team to provide to the client once the client discharges from the SAIF program and returns to the client's home	☐	☐
• Agrees to resuming support as the long-term residential provider upon discharge	☐	☐

SAIF Referral Process, Part 2.

If the client meets admission requirements, the CRM must complete Part 2 of the SAIF Referral form and submit a prior approval request in CARE to the FSA or designee. The FSA or designee must review and forward the prior approval to the Regional Administrator or designee. The Regional Administrator must review and forward the prior approval to the HQ SAIF Coordinator with a recommendation. The HQ SAIF Coordinator must notify the CRM on the status of the request via the CARE platform.

SAIF Referral Process, Part 3.

If the request is approved (in CARE), the CRM must submit the following to the SAIF Services Inbox:

	REQUIRED	ATTACHED	N/A
SAIF Referral form: _____	☐		
DSHS 14-012, Consent: _____	☐		
Current CARE Assessment details: _____	☐		
Positive Behavior Support Plan (PBSP), date: _____		☐	☐
Functional Assessment, date: _____		☐	☐
Risk Assessment, effective date: _____		☐	☐
Treatment Plan, effective date: _____		☐	☐
Incident Reports (six months or one page data summary related to identified targeted behaviors (59 SIB IR's, 01/01/2021 – 06/30/2021)		☐	☐
DDA CARE Assessment, effective date: _____		☐	☐
Hospital records, evaluations, clinical notes		☐	☐
Individualized Education Plan (IEP or 504: _____		☐	☐
Employment: _____		☐	☐
Other relevant documents: _____		☐	☐

Hospitalizations (most recent):

Date: _____; reason: _____

Date: _____; reason: _____

Date: _____; reason: _____

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Nurse Delegation:

Is skilled nursing or nurse delegation needed? ☐ Yes ☐ No

If yes, for what tasks:

Is there a nurse delegation currently in place? ☐ Yes ☐ No

If yes, Nurse Delegator's name and contact information:

Are there any current, unresolved medical issues? ☐ Yes ☐ No

If yes, explain:

Target Behaviors: Relevant work or school information (hours, days, restrictions, supports needed)

Barriers to successful service delivery, challenging behaviors exhibited, impact at home, work, and school, and desired outcomes:

Other Information

List any other pertinent information including preferred activities, likes / dislikes, strengths, abilities, nickname(s):

Restrictions in place at current residence (door / window alarms, food restrictions, other):

Accessibility needs (ramp, roll-in shower, shower chair, Hoyer lift, adaptive or mechanical supports, etc.:

Other:

Date SAIF Referral, Consent, assessment details, and other relevant documents (attachments listed above) submitted to SAIF Services Inbox:

HQ SAIF Coordinator will notify CRM and Regional leadership of the decision: ☐ Support ☐ Non-support	DATE
DDA CRM will document decision in CARE SER and update Prior Approval outcome: ☐ Approved ☐ Denied	DATE

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