Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

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

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

CLIENT'S NAME	ADSA ID	DATE OF BIRTH	AGE

CLIENT'S ADDRESS	PHONE NUMBER

CHOOSE ONE.	PHONE NUMBER (WITH AREA CODE)	REGION	REFERRAL DATE

DDA CASE MANAGER SUPERVISOR'S NAME	FORM 10-574 ATTACHED ☐ Yes ☐ No	WAIVER ☐ Yes ☐ No	IF YES, TYPE OF WAIVER:

Current Setting

Long-Term Residential Provider: **Choose One.**	PROVIDER'S NAME	CONTACT'S NAME
	EMAIL ADDRESS	PHONE NUMBER (WITH AREA CODE)
Eligible for discharge from acute care setting: **Evaluation and Treatment Facility (ENT)**	FACILITY'S NAME	CONTACT'S NAME
	EMAIL ADDRESS	PHONE NUMBER (WITH AREA CODE)

SAIF Eligibility

A person is eligible for admission to a Stabilization, Assessment, and Intervention Facility (SAIF) if the person:

	YES	NO
1. Is Age 18 years or older	☐	☐
2. Is eligible for DDA services under Chapter 388-823 WAC	☐	☐
3. Is eligible for enrollment on a home and community-based services waiver under Chapter 388-845 WAC	☐	☐
4. Is eligible for stabilization services under WAC 388-845-1100	☐	☐
5. Is eligible for discharge from an acute care setting or is at risk of admission to an acute care setting for non-medical reasons	☐	☐
6. Has an identified residential service provider	☐	☐
7. Has frequent stabilization, assessment, and intervention needs as indicated by:		
a. A history of hospital admissions for behavioral health stabilization in the last year; or	☐	☐
b. The regional clinical team's recommendation that behavioral health destabilization is likely to occur	☐	☐
8. The SAIF program will determine if the client poses a risk to the health and safety to the other SAIF clients.	☐	☐

SAIF Referral Process, Part 1.

The CRM will:

	YES	NO
• Discuss stabilization services with the client, client's legal representative, and the regional clinical team	☐	☐
• Confirm client meets SAIF eligibility requirements	☐	☐
• Verify the client consents to stabilization services provided by the SAIF program	☐	☐
• Verify the Residential Service Provider agrees to admit client into services after discharge from SAIF	☐	☐
• Verify the Residential Service Provider agrees to collaborate with SAIF through observation and team meetings	☐	☐

- **If client does not meet eligibility requirements CRM will submit a PAN.**

DISTRIBUTION: Client File; CRM / SW; SAIF Program Manager

Short-term goals (identify up to three goals using specific, measurable, achievable language):	**Desired outcomes that can be achieved in 90 days:**
Example: John will identify coping skills when interacting with his roommate.	*Example: John will reduce frequency and severity of physically aggressive behavior toward roommate.*

Describe the client's discharge plan following the SAIF Program (e.g., New Residential Provider, returning to existing Residential Service Provider, looking for new housing, hiring staff and staff need training in de-escalation techniques)

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

What current behavioral supports strategies are being used (e.g., staffing levels, restrictions, and schedules)?

Barriers to successful service delivery (e.g., how are the target behaviors impacting the client's daily life?):

Transition plan for client to discharge from the SAIF program to residential service provider:

SAIF Referral Process, Part 2. Regional Approval

The CRM must send the following current documents, if applicable, for review to the supervisor.

	ATTACHED	N/A
SAIF Referral form: _____	☐	
DSHS 14-012, Consent: _____	☐	
DSHS 10-574, Transition Care Planning and Tracking, Part A: _____	☐	
Current CARE Assessment details: _____	☐	
Guardianship Paperwork: _____	☐	
Medication Records: _____	☐	
	ATTACHED	N/A
Positive Behavior Support Plan (PBSP), date: _____	☐	☐
CARE assessment: _____	☐	☐
Functional Assessment, date: _____	☐	☐
Risk Assessment, effective date: _____	☐	☐
Community Protection Quarterly Plan and Risk Assessment, effective date: _____	☐	☐
Incident Reports (six months or one page data summary related to identified targeted behaviors)	☐	☐
Individualized Education Plan (IEP or 504): _____	☐	☐
Employment: _____	☐	☐
Hospital Records: _____	☐	☐
Other relevant documents: _____	☐	☐

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Hospitalizations (most recent)

Date: _____; reason: _____

Date: _____; reason: _____

Date: _____; reason: _____

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:

List current medications:

Communication style (visual aids, devices, ASL, or gestures):

Relevant work information (hours, days, restriction, supports needed):

List any other pertinent information including allergies, 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:

Referral Process, Part 3.

If the client meets admission requirements:

1. The FSA or designee must review and forward the prior approval to the Regional Administrator or designee.
2. The FSA or designee must review and forward the prior approval to the Adult SOCR Program Manager with a recommendation.
3. The Adult SOCR Program Manager will review and forward to the SAIF Program Inbox: dda_saif_referral@dshs.wa.gov.

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