DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
ADULT FAMILY HOME (AFH)

AFH Quality Improvement Visit Assessment

DDA PQIS	
DATE OF VISIT	TIME OF VISIT ☐ A.M. ☐ P.M.

PROVIDER NAME			
STREET ADDRESS		MAILING ADDRESS (IF DIFFERENT FROM AFH)	
CITY	ZIP CODE	CITY	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS
LICENSE NUMBER	P1 NUMBER	DSHS AFH LICENSED CAPACITY	DSHS AFH CONTRACT EXPIRATION DATE

*** Asterisk those residents present during visit.**

NAME OF DDA RESIDENT	DDA NUMBER	AGE	CRM	DAILY RATE	EVACUATION LEVEL

REASON FOR VISIT

NAME AND TITLE OF STAFF OBSERVED OR INTERVIEWED DURING THE VISIT

OTHER NON-AFH RESIDENTS LIVING IN THE HOME

STRENGTHS REGARDING HOUSEHOLD INFORMATION

ISSUES/CONCERNS

IF NEW RESIDENT(S), REASON FOR MOVE

NEGOTIATED CARE PLANS:

☐ Current ☐ Not Current – Explain:

DDA ASSESSMENT:

☐ Current ☐ Not Current – Explain:

Competence

COMMENTS / CONCERNS

Health and Safety

COMMENTS / CONCERNS

Inclusion

COMMENTS / CONCERNS

Relationships

COMMENTS / CONCERNS

Power and Choice

COMMENTS / CONCERNS

Status and Contribution

COMMENTS / CONCERNS

CASE RESOURCE MANAGER CONTACT	☐ SER Completed