Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Diversion Services Referral and Intake Information

CLIENT'S FULL NAME		DATE OF BIRTH	ADSA NUMBER
NAME OF PERSON MAKING REFERRAL	TELEPHONE NUMBER	☐ DCR ☐ OTHER: ☐ DDA	
DDA CASE MANAGER		DDA CM TELEPHONE NUMBER	
RESIDENTIAL AGENCY PROVIDER		PROVIDER TELEPHONE NUMBER	
FAMILY / LEGAL REPRESENTATIVE		REPRESENTATIVE TELEPHONE NUMBER	
☐ MEDICAID ☐ MEDICARE ☐ MEDICARE PART D PROVIDER:		☐ OTHER INSURANCE:	PROVIDERONE ID

Current Housing Situation

Communication Style (nonverbal/verbal, primary language, preferred modes):

Diagnosis:

Briefly describe why this person is being referred. List current symptoms / behaviors of concern (define and state frequency and severity of each symptom/behavior).

History of Violent / Dangerous Behaviors and No Contact Orders:

Is this individual a Community Protection Participant? ☐ Yes ☐ No

History of Fire-Setting:

History of Sexual Abuse/Assault:

History of Substance Abuse:

History of Vandalism/Destructive Behavior:

Legal History (DOC, jail, mental health commitments, chemical dependency commitments):

Is person on a Court Order or LRA? ☐ Yes ☐ No	NAME OF CORRECTIONS OFFICER OR LRA MONITORING AGENCY	TELEPHONE NUMBER

Previous Mental Health Involvement:

Describe all known allergies:

Describe all Known Physical and Medical Issues:

Describe all Known Medical or Mental Health Treatments Needed:

CURRENT PRIMARY CARE PHYSICIAN	TELEPHONE NUMBER
CURRENT MH PRESCRIBER	TELEPHONE NUMBER

Is the person ambulatory? ☐ Yes ☐ No

Does the person use a prosthetic device? ☐ Yes ☐ No
If yes, describe:

Is the person willing to take medications as prescribed? ☐ Yes ☐ No
Date of last medication review:
Is nurse delegation needed? ☐ Yes ☐ No If yes, nurse delegation records must be included in the referral.

Known Appointments Scheduled (who / where / when):

Treatment Plan / Goals for the Person Receiving Diversion Services:

Client Financial Resource Information (optional for mobile diversion):

Other important information:

Discharge Plans:

Hobbies / Interests:

Favorite Foods:

Favorite Places:

Dislikes:

Information Checklist (documents to be included as appropriate):

- ☐ Signed Physician's Orders (durable medical equipment, medication, and nurse delegation orders, etc.)
- ☐ Cross System Crisis Plan
- ☐ Functional Assessment
- ☐ Positive Behavior Support Plan
- ☐ Individual Instruction and Support Plan (IISP)
- ☐ DDA Assessment Details
- ☐ Psychiatric / Psychological Evaluations
- ☐ Community Protection Treatment Plan and Current Risk Assessment
- ☐ Guardianship Documentation
- ☐ Current Medication Record
- ☐ Other (specify):

SIGNATURE OF PERSON COMPLETING FORM	TITLE	DATE

TO BE FILLED OUT BY CRISIS DIVERSION BED PROVIDER

Referred for: ☐ Bed-based ☐ Mobile Who is transporting the person?	Person accepted? ☐ Yes ☐ No Who is transporting the person?	
PROVIDER SIGNATURE	TITLE	DATE