Washington State Department of Social & Health Services
Transforming lives

Adult Family Home (AFH) Resident Significant Change Assessment Request

The 30-day clock will not begin until all of the required information below is **completed** and submitted electronically to DSHS with the Negotiated Care Plan.

RESIDENT'S NAME	DDA / ADSA ID NUMBER	HCS ACES ID NUMBER
AFH PROVIDER'S NAME		PHONE NUMBER (WITH AREA CODE)

Date of most recent:

Medical appointment: _____

Mental Health appointment (if applicable): _____

Medication Review (if applicable): _____

MEDICAL PROVIDER'S NAME	PHONE NUMBER (WITH AREA CODE)

Select the resident's support acuity domain that has changed (select all that apply):

- ☐ Medical / Behavioral diagnosis
- ☐ Psych / Social (behavior)
- ☐ Mobility
- ☐ Toileting
- ☐ Eating
- ☐ Hygiene
- ☐ Sleep
- ☐ Other (please specify):

Provide a **detailed** description of when and how the resident's needs changed for **each** area selected above:

NAME OF PERSON SUBMITTING REQUEST	NAME OF RESIDENT'S DSHS CASE MANAGER OR SOCIAL WORKER

For DSHS Use Only

Date DSHS received **complete** written request from AFH provider: _____

Date(s) the AFH provider was contacted to schedule assessment: _____

Date assessment completed: _____; Completed by: _____

Assessment resulted in a change in the resident's daily rate? ☐ Yes ☐ No

If "Yes," what is the new daily rate effective date? _____

Copies: DSHS Client File; AFH Provider