Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Adult Family Home Referral Request

Please complete electronically and email to PQIS.

DATE OF REQUEST	
URGENCY OF REQUEST ☐ High ☐ Medium ☐ Low	

CLIENT'S NAME	GENDER ☐ Male ☐ Female	AGE	ADSA ID NO.

REQUESTING CASE MANAGER'S NAME	PHONE NUMBER (WITH AREA CODE)

CARE CLASSIFICATION LEVEL	☐ Non-Waiver ☐ Waiver	EVACUATION LEVEL

GEOGRAPHIC PREFERENCE

1. 2. 3.

DATE PLACEMENT NEEDED	DATE OF LAST CARE ASSESSMENT

LEGAL REPRESENTATIVE'S NAME	PHONE NUMBER (WITH AREA CODE)

THE REFERRING CASE MANAGER MUST:

☐ Talk with the client and family about funding and client responsibility.

☐ Attach Individuals with Challenging Support Issues, DSHS 10-234. **(Complete if there is any self-injurious behavior; inappropriate behavior; physical or verbal aggression; community safety issues; property destruction; or fire setting behavior.)**

☐ Attach current signed Consent, DSHS 14-012 (specifying consent for AFH referrals).

CLIENT DESCRIPTION (LIKE, DISLIKES, PERSONAL INTERESTS, HOBBIES, AND HOW THE CLIENT PREFERS TO SPEND THEIR DAY)

DESCRIBE CURRENT RESIDENTIAL SETTING AND THE REASON FOR REFERRAL

CLIENT PARTICIPATES IN (INCLUDE DETAILS FOR ALL THAT APPLY)

☐ Work / School:

☐ Day program:

☐ Community activities:

☐ Other (specify):

CONSIDERATIONS AND SUPPORTS (INCLUDE DETAILS FOR ALL THAT APPLY)

☐ Specialized communication style:

☐ Overnight support needs:

☐ Wandering / exit seeking:

☐ Recent hospitalizations:

☐ Significant medical support needs:

☐ Diagnosis:

☐ Mental health issues:

☐ Substance abuse issues:

☐ Regional Clinical Team involvement:

☐ Law enforcement involvement:

☐ Technical assistance / supports/ interventions that have been offered to maintain current placement:

☐ Transportation needs: ☐ School ☐ Work ☐ Community activities ☐ Medical appointments

Additional transportation needs information:

☐ Other (specify):

REFERRAL CONSIDERATIONS (SELECT ALL THAT APPLY)

- ☐ Wheelchair / ADA accessible home
- ☐ Home with few / no stairs
- ☐ Single room ONLY
- ☐ Provider with nursing background
- ☐ Male or ☐ Female **residents** ONLY:
- ☐ Male or ☐ Female **AFH staff** ONLY:
- ☐ Roll-in shower
- ☐ Must be close to bus line
- ☐ Nurse Delegation required
- ☐ Smoker / other substance use:
- ☐ Medical needs / specialized equipment:
- ☐ Requires awake night staff because:
- ☐ Client has pet(s); specify types of pet(s):
- ☐ **Please specify if client needs a home without pets due to allergies and/or preference**:

COMMENTS