Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Residential Quarterly Report for Children's Residential Services

For Licensed Staffed Residential, Group Care Facility, and SOLA

CLIENT'S NAME	CONTRACTED / STATE OPERATED PROVIDER
PERSON SUBMITTING REPORT	RESIDENCE / HOUSE NAME
REPORTING PERIOD	DATE SUMITTED

Shared Parenting and Relationships		
Parent / Guardian 1	NAME	Number of days visited this quarter: _____ Number of other contacts this quarter: _____
Parent / Guardian 2	NAME	Number of days visited this quarter: _____ Number of other contacts this quarter: _____
Other Family or Friends	NAME	Number of days visited this quarter: _____ Number of other contacts this quarter: _____

SUMMARIZE THE PARENT INVOLVEMENT IN THIS QUARTER.

HOW HAS THIS CLIENT PARTICIPATED IN THEIR PERSONAL CULTURE, TRADITIONS, AND EVENTS THIS QUARTER?

Independent Living Skills / Skills Acquisition / Teaching Strategies	
Target Skill 1	GOAL
Target Skill 2	GOAL
Target Skill 3	GOAL
Target Skill 4	GOAL
Target Skill 5	GOAL
Target Skill 6	GOAL
Target Skill 7	GOAL
Target Skill 8	GOAL

SUMMARIZE THE CLIENT'S PROGRESS WITH INDEPENDENT LIVING SKILLS. REFER TO SKILL DEVELOPMENT TRACKING DATA AND INCLUDE CHARTS OR GRAPHS AS APPLICABLE.

Behavior Support

DATE OF CURRENT PLAN	PLAN AUTHOR AND AGENCY	Has the plan been updated in the last quarter: ☐ Yes ☐ No

Target Behavior 1	GOAL
Target Behavior 2	GOAL
Target Behavior 3	GOAL
Target Behavior 4	GOAL
Target Behavior 5	GOAL
Target Behavior 6	GOAL
Target Behavior 7	GOAL
Target Behavior 8	GOAL

SUMMARIZE PROGRESS WITH THE TARGET BEHAVIORS AND ANY NOTABLE OBSERVATIONS. REFER TO BEHAVIOR TRACKING DATA AND INCORPORATE CHARTS OR GRAPHS, IF APPLICABLE. SUMMARIZE CHANGES THAT OCCURRED TO THE BEHAVIORAL PLAN, IF ANY.

New Behaviors	GOAL

DESCRIBE ANY NEW CHALLENGING BEHAVIORS THAT HAVE NOT BEEN ADDRESSED BY THE BEHAVIORAL PLAN, HOW DIRECT CARE STAFF ARE RESPONDING TO THESE BEHAVIORS AND WHETHER ADDITIONAL SUPPORT OR PLANNING IS NEEDED.

Significant Incidents

SUMMARIZE CLIENT INCIDENTS THAT OCCURRED IN THIS QUARTER AND ANY RELATED TRENDS OR OBSERVATIONS. LIST THE NUMBER OF TIMES EACH TYPE OF INCIDENT OCCURRED. FOR EXAMPLE, HOW MANY INCIDENTS WERE RELATED TO SIB, ASSAULTS, HOSPITALIZATIONS, MED ERRORS, ETC.

Health / Medical / Treatments or Therapies

Current weight:

SUMMARIZE THE CLIENT'S HEALTH THIS QUARTER. INCLUDE ANY NEW DIAGNOSES OR SIGNIFICANT CHANGES IN THE CLIENT'S FUNCTIONING OR CONDITION. DESCRIBE ANY SIGNIFICANT ILLNESSES, THEIR EFFECTS, AND ANY INTERVENTIONS.

WHAT ONGOING SERVICES OR TREATMENTS DOES THIS CLIENT RECEIVE (ABA, WISe, ETC.)? WHAT ADDITIONAL SERVICES ARE NEEDED, IF ANY?

SUMMARIZE THE CLIENT'S TYPICAL SLEEP PATTERN IN THIS QUARTER. INCLUDE NIGHTTIME SLEEP AND DAYTIME NAPS. IF APPLICABLE, ALSO EXPLAIN NIGHTTIME BEHAVIORS OR OTHER FACTORS THAT INTERFERE WITH SLEEPING.

Compared to the previous quarter, the sleep pattern is generally: ☐ The same ☐ Changed

REPORT ANY SPECIAL DIETARY OR NUTRITIONAL NEEDS AND HOW THEY ARE BEING MET.

Compared to the previous quarter, the diet is generally: ☐ The same ☐ Changed

Appointments

List each medical, dental, mental health, therapy session that occurred this quarter. Include appointments that occurred in the residence, clinic, community, or other locations. Add copies of this chart or attach a separate log if needed to report all appointments in this quarter.

DATE	PROVIDER	REASON	COMMENTS (OUTCOME, RECOMMENDATIONS, FOLLOW UP, ETC.)

Medications	List all current prescribed medications, supplements, or PRNs given. Add copies of this chart or attach a separate log if needed to report all medications.				
CURRENT MEDICATIONS	PURPOSE	DOSAGE AND FREQUENCY	CHECK IF NEW, CHANGED, OR DISCONTINUED THIS QUARTER		
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Education / Transitional Services

SCHOOL DISTRICT OR TRANSITION SERVICE AGENCY	SCHOOL OR PROGRAM		GRADE
TEACHER OR PRIMARY CONTACT	DATE OF CURRENT IEP	HAS THE PROVIDER RECEIVED THE CURRENT IEP? ☐ Yes ☐ No	DATE OF NEXT IEP MEETING (IF KNOWN)

Does the client attend a full school day? ☐ Yes ☐ No

SUMMARIZE UPDATES FROM SCHOOL / TRANSITIONAL SERVICES. INCLUDE ANY CHANGES TO THE CLIENT'S IEP (IF APPLICABLE).

EXPLAIN ANY ABSENCES, INCLUDING ILLNESS, REFUSAL, SUSPENSION, OR OTHER.

Activities
SUMMARIZE HOW THE CLIENT USUALLY SPENDS THEIR TIME IN THE RESIDENCE. COMMUNITY ACTIVITIES WILL BE REPORTED ON ATTACHMENT 1.
DESCRIBE ANY BARRIERS THAT MAY BE PREVENTING THIS CLIENT FROM ENGAGING IN MORE PREFERRED ACTIVITIES IN THE COMMUNITY OR IN THE RESIDENCE.
WHAT ELSE WILL BE DONE TO HELP THIS CLIENT LIVE THE LIFE THEY WANT?

SUBMITTED BY SIGNATURE	DATE	NAME AND ROLE
APPROVED BY SIGNATURE (IF APPLICABLE)	DATE	NAME AND ROLE
DATE SENT TO DDA		DATE SENT TO FAMILY

Attachment 1								
Community Activities / Community Inclusion								
This is a report of ALL of the client's activities in the community except for school attendance, professional appointments, and family visits. School, professional, and family activities may be reported if other community inclusion elements occurred AND a direct support professional was present to facilitate the activity. The use and balance of Community Inclusion Funds is also reported. Add copies of this page as needed.								
CLIENT'S NAME					CONTRACTED / STATE OPERATED PROVIDER			
RESIDENCE / HOUSE NAME					LEDGER START DATE		LEDGER START BALANCE $	
DATE	ACTIVITY TYPE / DESCRIPTION (OR REPORT FUNDS ADDED OR HOW FUNDS WERE USED)	PARTICIPATED, ATTEMPTED, OR DECLINED			STAFF NAME AND SIGNATURE FOR FUNDS USED	$ AMOUNT	BALANCE	
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					LEDGER END DATE	LEDGER END BALANCE $	

SIGNATURE OF PERSON SUBMITTING THIS FORM DATE	NAME AND ROLE