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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  ADULT FAMILY HOME (AFH)  **AFH Quality Improvement Initial Visit** | | | | | | | | | | | | | DDA PQIS    DATE OF VISIT TIME OF VISIT  A.M.  P.M. | | | | | | | |
| PROVIDER NAME | | | | | | | | | | | | | | | | | | | | LIVES IN HOME  Yes  No | |
| RESIDENT MANAGER’S NAME | | | | | | LIVES IN HOME  Yes  No | | | | TELEPHONE NUMBER | | | | PRIMARY CAREGIVER’S NAME (IF DIFFERENT) | | | | | | | |
| STREET ADDRESS | | | | | | | | | | | | CITY | | | | | | STATE | | | ZIP CODE |
| MAILING ADDRESS (IF DIFFERENT FROM AFH) | | | | | | | | | | | | CITY | | | | | | STATE | | | ZIP CODE |
| TELEPHONE NUMBER | | FAX NUMBER | | | | | | | | | | CELL PHONE NUMBER | | | | | E-MAIL ADDRESS | | | | |
| LICENSE NUMBER | P1 PROVIDER NUMBER | | | | | | | DSHS AFH LICENSED CAPACITY | | | | | | | DSHS AFH CONTRACT EXPIRATION DATE | | | | | | |
| SPECIALTY DESIGNATION  DD  Mental Health  Dementia | | | | | | | | | | | | | | | | | | | NURSE DELEGATED  Yes  No | | |
| CONDITIONS ON LICENSE IF ANY | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF CURRENT VACANCIES | | | | BEDROOMS  Shared  Single | | | | | | | | VACANCIES  Shared  Single | | | | | WHEELCHAIR ACCESSIBLE  Yes  No | | | | |
| EVACUATION LEVEL  1 (Independent with one verbal cue)  2 (Assistance Required | | | | | | | | | WILL ACCEPT EMERGENCY PLACEMENTS  Yes  No | | | | | | | NURSE ON STAFF  Yes  No | | | | | |
| COMMENTS | | | | | | | | | | | | | | | | | | | | | |
| HOUSEHOLD LAYOUT  Single Level  Two Story  Split Level  With Basement | | | | | | | RESIDENT BEDROOMS  Main Floor  Upstairs  Basement | | | | | | | | OTHERS RESIDING IN HOME  Children  Spouse  Pets () | | | | | | |
| PREFERRED AGE RANGE | | | PREFERRED GENDER  Male  Female  Either | | | | | | | | | | SMOKING  Smokers Permitted (Has outside designated area)  Nonsmoking only | | | | | | | | |
| COMMENTS / PREFERENCES / LIMITATIONS | | | | | | | | | | | | | | | | | | | | | |
| NEIGHBORHOOD  Yes No  Typical Residential neighborhood.  Accessible public transportation.  Para transit/other service available.  Provider assist with transportation?  Close proximity to community service and amenities. | | | | | | | | | | | | | | | | | | | | | |
| CONTRACTED RESPITE PROVIDER  Yes  No | | | | | INTERESTED IN RESPITE  Yes  No | | | | | | SCHOOL DISTRICT | | | | | | | | | | |
| COMMENTS | | | | | | | | | | | | | | | | | | | | | |
| PROVIDER AND CAREGIVER EXPERIENCE/EDUCATION (RN, LPN, NAC, NAR, HCA-C, WORK EXPERIENCE) | | | | | | | | | | | | | | | | | | | | | |
| POSITIVE BEHAVIOR SUPPORT EXPERIENCE / TRAINING | | | | | | | | | | | | | | | | | | | | | |
| COMMUNITY INTEGRATION / OUT OF HOME ACTIVITY (HOW ACTIVITIES ARE CURRENTLY SUPPORTED BY) | | | | | | | | | | | | | | | | | | | | | |
| COMMENTS | | | | | | | | | | | | | | | | | | | | | |
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| ADITIONAL STRENGTHS | | | | | | | | | | | | | | | | | | | | | |
| ADDITIONAL AREAS OF CONCERN | | | | | | | | | | | | | | | | | | | | | |