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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Developmental Disabilities Administration (DDA)  **Lake Burien Transitional Care Facility  Specialized Treatment Referral and Application** | | | | | | | | | |
| Upon CRM completion of this referral, the CRM must submit the referral and application packet to [LakeBurienTCF@dshs.wa.gov](mailto:LakeBurienTCF@dshs.wa.gov). | | | | | | | | | | |
|  | | | | | | | | | | |
| Youth’s Name | | | | ADSA ID Number | | Male  Female  Non-Binary | | | Date of Birth | Age |
| Name(s) Youth Prefers to be called / Pronouns | | | | Preferred Language of Youth | | | | | Date of Request | |
| Parent / Legal Guardian’s Name | | Preferred Language of Youth’s Parent / Guardian | | | | DDA CRM | | | | Region |
| **Current setting; start date:** | | | | | | | | | | |
| Family home  Hospital (admitted or emergency room)  Out-of-Home Setting such as OHS or DCYF placement  Residential Habilitation for Dependent Youth  Out-of-State Facility or Educational Setting  Juvenile Detention or Juvenile Rehabilitation Facility  Psychiatric Facility or CLIP  Other: | | | | | | | | | | |
| Primary contact name, phone number and/or email in current residential setting if outside of the guardian’s home. | | | | | | | | | | |
| **Step 1. Eligibility Criteria (to be determined by DDA CRM)** | | | | | | | | | | |
| 1. DDA-eligible under Chapter 388-823 WAC or assessed to have a diagnosed neurodevelopmental disorder, another neurological, or other genetic condition:  Yes  No 2. Is age 13 – 17 years old:  Yes  No 3. Has accessed all appropriate and available less restrictive services and the youth’s assessed health care needs exceed what is available in the community.   Yes (**as evidenced by Step 1.A. and 1.B. below**)  No | | | | | | | | | | |
| **Step 1.A. Need for Services (to be completed by DDA CRM)** | | | | | | | | | | |
| List treatment services and supports in each domain that have been tried and provide detail as to how these failed to meet the need. **Confirm recommended medically necessary services and provide status of current MCO referrals.** Examples may include services provided by private insurance, physical and behavioral health benefits under Medicaid, and DDA services:  Mental Health services: | | | | | | | | | | |
| Behavioral Support services: | | | | | | | | | | |
| Physical Health services: | | | | | | | | | | |
| Educational supports: | | | | | | | | | | |
| DDA services: | | | | | | | | | | |
| Any additional Community services: | | | | | | | | | | |
| Substance Use Disorder services (if applicable): | | | | | | | | | | |
| **Step 1.B. Complex Support Needs affecting success in the community setting (to be completed by DDA CRM)** | | | | | | | | | | |
| Mark each applicable behavior(s) exhibited, identifying if it is in their current and/or the most recent past setting.  Place an \* next to the prominent behavior(s) that impact the client from receiving supports in the community. | | | | | | | | | | |
| Current Past  Anorexia  Arson / Fire Setting    Biting  Bulimia  Elopement  Encopresis / enuresis  Head banging | | | Current Past  Loud vocalizations  Physical aggression  PICA  Property destruction  Self-injurious  Sexually inappropriate  Substance Use Disorder | | | | | Current Past  Suicidal action(s)  Takes other’s property  Verbal aggression  Wandering  Other (specify) | | |
| Please list all current I/DD diagnosis: | | | | | | | | | | |
| Please list all current Behavioral health diagnosis: | | | | | | | | | | |
| **Step 1.C. Cultural and Social Considerations (to be completed by DDA CRM)** | | | | | | | | | | |
| 1. What is the cultural background and traditions of the youth (holidays, traditions, customs, and cultural practices observed by the family)? | | | | | | | | | | |
| 1. What family relationships and support networks are important to the youth? | | | | | | | | | | |
| 1. What are the youth’s racial and ethnic identity? Is there any tribal affiliation? | | | | | | | | | | |
| 1. Please share information about the youth’s family / social history. | | | | | | | | | | |
| **Provide all applicable documents with this application with the date the document was last updated:**  Current DDA Assessment:  Consent (DSHS 14-012) **(required)**:  Hospital / medical records for the last 30 days **(required)**:  Last six months of Medication Management Notes:  Current Psychiatric evaluation dated within six months **(required)**:  All Psychiatric hospitalization discharge summaries for the past year:  Any and all Psychiatric evaluations completed in the last two years **(required)**:  Any completed IQ testing:  Neuropsychological Evaluations:  Autism Evaluations:  Outpatient Mental Health Treatment Plans:  Functional Behavior Assessment:  Behavior Intervention Plan:  BCBA / ABA treatment plans and evaluations within the past year:  Psychosexual Evaluation:  Speech / Language Evaluations, OT or PT evaluations:  Education documents:  Current IEP **(required)**:  Behavior Intervention Plan:  Education Evaluation **(required)**:  SUD Assessment:  Court reports from the last two years (must include description of any recent offenses)  Other description: | | | | | | | | | | |
| **Step 1.D. Service Review with MCO or ASO (to be completed by DDA CRM)** | | | | | | | | | | |
| CRM must consult with the youth’s MCO or ASO to confirm recommended medically necessary services and provide status of current MCO referrals in Section 1.A.  Identify the MCO serving the youth and the assigned care coordinator: | | | | | | | | | | |
| MCO’s Name | | | | | Care Coordinator’s Name | | | | | |
| **Step 2. Eligibility Criteria to be completed by Regional Clinical Team** | | | | | | | | | | |
| * Has a serious psychiatric diagnosis:  Yes  No * Experiences a severity, intensity, and frequency of behavior that:  Yes  No * Significant impairment of a youth’s functioning and * Prevents the youth from being safely supported in a less restrictive setting. | | | | | | | | | | |
| **Recommendation and Signature** | | | | | | | | | | |
| The Regional Clinical Team recommends application to Lake Burien Transitional Care Facility:  Yes  No | | | | | | | | | | |
| Signature of RCT Representative Date | | | | | | | Printed RCT Representative’s Name | | | |