|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | Developmental Disabilities Administration (DDA)  **Lake Burien Transitional Care Facility  Dedicated Review Committee (DRC) Determination** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Youth’s Name | | | | | | ADSA ID Number | | | | DDA CRM | | | | | | | | | | Region | |
| Name(s) Youth Prefers to be called / Pronouns | | | | | | | | | | | | | DDA Enrolled?  Yes  No | | | | | Date of Request | | | |
| **Committee Members Present** | | | | | | | | | | | | | | | | | | | | | |
| Present  1 - DDA Name:  2 - DDA Name:  3 - DDA Name:  4 - DCYF Name:  5 – OOS / BHA Name:  Please note, the above number(s) are assigned for responses to Eligibility Determination statements in below section. | | | | | | | | | | | | | | | | | | | | | |
| **Eligibility Determination** | | | | | | | | | | | | | | | | | | | | | |
| **Information on Youth Family and Social Supports** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | 1 | | | 2 | | | 3 | | 4 | | | | 5 |
| 1. The youth would benefit from the specialized treatment provided at Lake Burien Transitional Care Facility. | | | | | | | | | Yes  No | | | Yes  No | | | Yes  No | | Yes  No | | | | Yes  No |
| Comments: | | | | | | | | | | | | | | | | | | | | | |
| 1. Less restrictive services supporting youth care needs are inadequate or unavailable in their community. | | | | | | | | | Yes  No | | | Yes  No | | | Yes  No | | Yes  No | | | | Yes  No |
| Comments: | | | | | | | | | | | | | | | | | | | | | |
| 1. Proper treatment of the youth’s condition requires specialized treatment on an inpatient basis under the direction of a physician. | | | | | | | | | Yes  No | | | Yes  No | | | Yes  No | | Yes  No | | | | Yes  No |
| Comments: | | | | | | | | | | | | | | | | | | | | | |
| 1. The specialized treatment provided is expected to improve the youth’s condition in order to benefit from outpatient community-based services. | | | | | | | | | Yes  No | | | Yes  No | | | Yes  No | | Yes  No | | | | Yes  No |
| Comments: | | | | | | | | | | | | | | | | | | | | | |
| **Need – Response Analysis** | | | | | | | | | | | | | | | | | | | | | |
| The youth’s needs and system response as determined by the documentation in the Lake Burien referral.  Key: 1. Basic Support; 2. Moderate Support; and 3. Intensive Support. | | | | | | | | | | | | | | | | | | | | | |
| Mental Health | | Physical Health | | | Behavioral Support | | | Educational Support | | | | | | Community Resources | | | | | Family Needs | | |
| Need | Response | Need | | Response | Need | | Response | Need | | | Response | | | Need | | Response | | | Need | Response | |
| 1  2  3 | 1  2  3 | 1  2  3 | | 1  2  3 | 1  2  3 | | 1  2  3 | 1  2  3 | | | 1  2  3 | | | 1  2  3 | | 1  2  3 | | | 1  2  3 | 1  2  3 | |
| Comments: | | | | | | | | | | | | | | | | | | | | | |
| **Additional Referral Comments** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Recommendation** | | | | | | | | | | | | | | | | | | | | | |
| The Dedicated Review Committee recommends admission to Lake Burien Transitional Care Facility:  Yes  No | | | | | | | | | | | | | | | | | | | | | |