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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF) DDA / DCYF Request to Cost Share | | | | | | | | | |  |
| DATE |
| CHILD’S NAME | | | | | | | | | | | DATE OF BIRTH |
| DDA ID NUMBER | | DDA SOCIAL WORKER’S NAME | | | | | | | | | |
| FAMILINK ID NUMBER | | DCYF SOCIAL WORKER’S NAME | | | | | | | | | |
| DDA REGIONAL CONTACT PERSON | | | | | | | DCYF REGIONAL CONTACT PERSON | | | | |
| BASIS FOR DDA ELIGIBILITY  Diagnosis:  ICAP?  Yes  No ICAP Review Date: | | | | | | | | | | | |
| Does this child have a mental health diagnosis?  Yes  No  If yes, please describe how the child’s environment is being impacted by their mental health diagnosis. | | | | | | | | | | | |
| CURRENT MEDICATIONS | | | DOSAGE | | | | | Why are these medications prescribed? | | | |
| CURRENT LIVING SITUATION | | | | | | | | | | | |
| SUMMARY OF PRESENTING ISSUES | | | | | | | | | | | |
| Has a request for Out-of-Home Services (OHS) been submitted for this child / youth?  Yes  No | | | | | | | | | | | |
| SERVICES  Skilled Nursing through MICP  Basic Plus Waiver  Core Waiver  No paid services from DDA  Individual and Family Services  CIIBS Waiver  Medicaid Personal Care hours per month | | | | | | | | | | | |
| SSI  **$** | | | | SSA  **$** | | | | | SSP  **$** | | |
| Is there an open CPS or CWS case with DCYF?  Yes  No Explain: | | | | | | | | | | | |
| Why are you requesting DSHS / DDA and DCYF financially share in the cost of this case? | | | | | | | | | | | |
| Summarize steps taken at the regional level for resolution: | | | | | | | | | | | |
| Has there been a staffing with headquarters program managers?  Yes  No If “No,” please explain. | | | | | | | | | | | |
| Are both DDA and DCYF Regional Administrators/designees in agreement to pursue cost share?  Yes  No  If “No,” please explain. | | | | | | | | | | | |
| DATES OF STAFFING | | | | | | Who participated in the staffing? | | | | | |
| Did DDA and CA come to any agreements on how to support this child/family?  Yes  No Explain: | | | | | | | | | | | |
| Is the child receiving Early Support for Infants and Toddlers (ESIT) services?  Yes  No | | | | | | | | | | | |
| Is the child currently enrolled in school?  Yes  No If “No,” why not? | | | | | | | | | | | |
| CURRENT SCHOOL NAME | | | | | CURRENT SCHOOL DISTRICT | | | | | Does this child have an IEP?  Yes  No | |
| Is there a current Behavior Support Plan in place?  Yes  No If “No,” why not? | | | | | | | | | | | |
| Briefly describe a typical school day for this child: | | | | | | | | | | | |