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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Stabilization, Assessment, and Intervention** **Services Facility (SAIF) Eligibility and Referral** |
| **The Case Resource Manager completes this form for client consideration to the SAIF program.** |
| CLIENT’S NAME | ADSA ID | DATE OF BIRTH | AGE |
| CLIENT’S ADDRESS | PHONE NUMBER |
|  | PHONE NUMBER (WITH AREA CODE) | REGION | REFERRAL DATE |
| DDA CASE MANAGER SUPERVISOR’S NAME | FORM 10-574 ATTACHED[ ]  Yes [ ]  No | WAIVER IF YES, TYPE OF WAIVER:[ ]  Yes [ ]  No  |
| **Current Setting** |
| Long-Term Residential Provider: | PROVIDER’S NAME | CONTACT’S NAME |
| EMAIL ADDRESS | PHONE NUMBER (WITH AREA CODE) |
| Eligible for discharge from acute care setting: | FACILITY’S NAME | CONTACT’S NAME |
| EMAIL ADDRESS | PHONE NUMBER (WITH AREA CODE) |
| **SAIF Eligibility** |
| **A person is eligible for admission to a Stabilization, Assessment, and Intervention Facility (SAIF) if the person:**YES NO1. Is Age 18 years or older [ ]  [ ]
2. Is eligible for DDA services under Chapter 388-823 WAC [ ]  [ ]
3. Is eligible for enrollment on a home and community-based services waiver underChapter 388-845 WAC [ ]  [ ]
4. Is eligible for stabilization services under WAC 388-845-1100 [ ]  [ ]
5. Is eligible for discharge from an acute care setting or is at risk of admission to an acutecare setting for non-medical reasons [ ]  [ ]
6. Has an identified residential service provider [ ]  [ ]
7. Has frequent stabilization, assessment, and intervention needs as indicated by:
	1. A history of hospital admissions for behavioral health stabilization in the last year; or [ ]  [ ]
	2. The regional clinical team’s recommendation that behavioral health destabilization is likely to occur [ ]  [ ]
8. The SAIF program will determine if the client poses a risk to the health and safetyto the other SAIF clients. [ ]  [ ]
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| **SAIF Referral Process, Part 1.** |
| **The CRM will:** YES NO* Discuss stabilization services with the client, client’s legal representative, and the regionalclinical team [ ]  [ ]
* Confirm client meets SAIF eligibility requirements [ ]  [ ]
* Verify the client consents to stabilization services provided by the SAIF program [ ]  [ ]
* Verify the Residential Service Provider agrees to admit client into services after discharge from SAIF [ ]  [ ]
* Verify the Residential Service Provider agrees to collaborate with SAIF through observation and team meetings [ ]  [ ]
* **If client does not meet eligibility requirements CRM will submit a PAN.**
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| **Short-term goals (identify up to three goals using specific, measurable, achievable language):** | **Desired outcomes that can be achieved in 90 days:** |
| *Example: John will identify coping skills when interacting with his roommate.* | *Example: John will reduce frequency and severity of physically aggressive behavior toward roommate.* |
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| Describe the client’s discharge plan following the SAIF Program (e.g., New Residential Provider, returning to existing Residential Service Provider, looking for new housing, hiring staff and staff need training in de-escalation techniques) |
| What community services have been explored (e.g., community mental health or diversion bed services) by the client: |
| What current behavioral supports strategies are being used (e.g., staffing levels, restrictions, and schedules)? |
| Barriers to successful service delivery (e.g., how are the target behaviors impacting the client’s daily life?): |
| Transition plan for client to discharge from the SAIF program to residential service provider: |
| The CRM must send a service PAN:1. When stabilization services – crisis diversion bed are approved, denied, withdraw, or terminated.
2. If the client does not meet eligibility for stabilization services – crisis diversion bed; or
3. When the client is discharged from SAI.
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| **Hospitalizations (most recent)** |
| Date:  ; reason:  Date:  ; reason:  Date:  ; reason:   |
| **Nurse Delegation** |
| Is skilled nursing or nurse delegation needed? [ ]  Yes [ ]  NoIf yes, for what tasks:  |
| Is there a nurse delegation currently in place? [ ]  Yes [ ]  No If yes, Nurse Delegator’s name and contact information:  |
| **Are there any current, unresolved medical issues?**  [ ]  Yes [ ]  NoIf yes, explain:  |
| List current medications:  |
| Communication style (visual aids, devices, ASL, or gestures):  |
| Relevant work information (hours, days, restriction, supports needed): |
| List any other pertinent information including allergies, preferred activities, likes / dislikes, strengths, abilities, nickname(s): |
| Restrictions in place at current residence (door / window alarms, food restrictions, other): |
| Accessibility needs (ramp, roll-in shower, shower chair, Hoyer lift, adaptive or mechanical supports, etc.): |
| Other: |
| **Referral Process, Part 3.** |
| If the client meets admission requirements:1. CRM supervisor or designee must review and forward referral packet to the SAIF Program Inbox: dda\_saif\_referral@dshs.wa.gov
2. The Adult SOCR Program Manager will review and forward referral to the SAIF Program.
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