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|  | **Adult Family Home (AFH) Resident  Significant Change Assessment Request** | | | |
| The 30-day clock will not begin until all of the required information below is **completed** and submitted electronically to DSHS with the Negotiated Care Plan. | | | | |
| RESIDENT’S NAME | | DDA / ADSA ID NUMBER | | HCS ACES ID NUMBER |
| AFH PROVIDER’S NAME | | | | PHONE NUMBER (WITH AREA CODE) |
| Date of most recent:  Medical appointment:  Mental Health appointment (if applicable):  Medication Review (if applicable): | | | | |
| MEDICAL PROVIDER’S NAME | | | | PHONE NUMBER (WITH AREA CODE) |
| Select the resident’s support acuity domain that has changed (select all that apply):  Medical / Behavioral diagnosis  Eating  Psych / Social (behavior)  Hygiene  Mobility  Sleep  Toileting  Other (please specify): | | | | |
| Provide a **detailed** description of when and how the resident’s needs changed for **each** area selected above: | | | | |
| NAME OF PERSON SUBMITTING REQUEST | | | NAME OF RESIDENT’S DSHS CASE MANAGER OR SOCIAL WORKER | |
| **For DSHS Use Only**  Date DSHS received **complete** written request from AFH provider:  Date(s) the AFH provider was contacted to schedule assessment:  Date assessment completed:  ; Completed by:  Assessment resulted in a change in the resident’s daily rate?  Yes  No  If “Yes,” what is the new daily rate effective date? | | | | |
| Copies: DSHS Client File; AFH Provider | | | | |