|  |  |
| --- | --- |
|  |  **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 [ ]  NoIf “Yes,” what is the new daily rate effective date?   |
| Copies: DSHS Client File; AFH Provider |