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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)**Adult Family Home Referral Request**Please complete electronically and email to PQIS. | DATE OF REQUEST |
| URGENCY OF REQUEST[ ]  High [ ]  Medium [ ]  Low |
| CLIENT’S NAME | GENDER[ ]  Male [ ]  Female | AGE | ADSA ID NO. |
| REQUESTING CASE MANAGER’S NAME | PHONE NUMBER (WITH AREA CODE) |
| CARE CLASSIFICATION LEVEL | [ ]  Non-Waiver [ ]  Waiver | EVACUATION LEVEL |
| GEOGRAPHIC PREFERENCE |
| 1.
 | 1.
 | 1.
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| DATE PLACEMENT NEEDED | DATE OF LAST CARE ASSESSMENT |
| LEGAL REPRESENTATIVE’S NAME | PHONE NUMBER (WITH AREA CODE) |
| THE REFERRING CASE MANAGER MUST:[ ]  Talk with the client and family about funding and client responsibility.[ ]  Attach Individuals with Challenging Support Issues, DSHS 10-234. **(Complete if there is any self-injurious behavior; inappropriate behavior; physical or verbal aggression; community safety issues; property destruction; or fire setting behavior.)**[ ]  Attach current signed Consent, DSHS 14-012 (specifying consent for AFH referrals). |
| CLIENT DESCRIPTION (LIKE, DISLIKES, PERSONAL INTERESTS, HOBBIES, AND HOW THE CLIENT PREFERS TO SPEND THEIR DAY) |
| DESCRIBE CURRENT RESIDENTIAL SETTING AND THE REASON FOR REFERRAL |
| CLIENT PARTICIPATES IN (INCLUDE DETAILS FOR ALL THAT APPLY)[ ]  Work / School: [ ]  Day program: [ ]  Community activities: [ ]  Other (specify):  |
| CONSIDERATIONS AND SUPPORTS (INCLUDE DETAILS FOR ALL THAT APPLY)[ ]  Specialized communication style: [ ]  Overnight support needs: [ ]  Wandering / exit seeking: [ ]  Recent hospitalizations: [ ]  Significant medical support needs: [ ]  Diagnosis: [ ]  Mental health issues: [ ]  Substance abuse issues: [ ]  Regional Clinical Team involvement: [ ]  Law enforcement involvement:  [ ]  Technical assistance / supports/ interventions that have been offered to maintain current placement: [ ]  Transportation needs: [ ]  School [ ]  Work [ ]  Community activities [ ]  Medical appointmentsAdditional transportation needs information: [ ]  Other (specify):  |
| REFERRAL CONSIDERATIONS (SELECT ALL THAT APPLY)[ ]  Wheelchair / ADA accessible home [ ]  Home with few / no stairs[ ]  Single room ONLY [ ]  Provider with nursing background[ ]  Male or [ ]  Female **residents** ONLY:  [ ]  Male or [ ]  Female **AFH staff** ONLY: [ ]  Roll-in shower [ ]  Must be close to bus line[ ]  Nurse Delegation required [ ]  Smoker / other substance use: [ ]  Medical needs / specialized equipment: [ ]  Requires awake night staff because: [ ]  Client has pet(s); specify types of pet(s): [ ]  **Please specify if client needs a home without pets due to allergies and/or preference**:  |
| COMMENTS |