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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) CASE RESOURCE MANAGER (CRM) **DDA Youth Transitional Care Facility Admission Checklist** |
| **To Be Completed by Facility Staff.** |
| YOUTH’S NAME | ADSA ID NUMBER | DATE OF BIRTH | AGE |
| YOUTH’S HEIGHT / WEIGHT | PARENT OR LEGAL GUARDIAN’S NAME | PARENT OR LEGAL GUARDIAN’S PHONE NUMBER (INCLUDE AREA CODE) |
| PARENT OR LEGAL GUARDIAN’S ADDRESS | PARENT OR LEGAL GUARDIAN’S EMAIL ADDRESS |
| DATE DECISION APPROVED | PRE-ADMISSION MEETING DATE | ADMISSION DATE |
| **Field Services CRM:** Provide the following in the referral packet. |
| **EVALUATION / ASSESSMENT** | **RECEIVED** | **N/A** | **EVALUATION / ASSESSMENT** | **RECEIVED** | **N/A** |
| DDA Assessment | [ ]  | [ ]  | Incident Report | [ ]  | [ ]  |
| Behavior Support Plan | [ ]  | [ ]  | Individual Education Plan | [ ]  | [ ]  |
| Cross Systems Crisis Plan | [ ]  | [ ]  | Pending Criminal Charges | [ ]  | [ ]  |
| Current Court Orders | [ ]  | [ ]  | Psychiatric Evaluation | [ ]  | [ ]  |
| Guardianship Document (certified) | [ ]  | [ ]  | SOTP Risk Assessment | [ ]  | [ ]  |
| Health and Physical - annual | [ ]  | [ ]  | Other:  | [ ]  | [ ]  |
| **Field Services CRM:** Support the facility to receive the following documents **before admission**. |
| **IDENTIFICATION** | **RECEIVED** | **N/A** | **IDENTIFICATION** | **RECEIVED** | **N/A** |
| Birth Certificate (certified preferred, copy acceptable) | [ ]  | [ ]  | Medicaid / ProviderOne Card | [ ]  | [ ]  |
| Current state Identification Card | [ ]  | [ ]  | Medicare and/or Private Insurance card | [ ]  | [ ]  |
| Immunization records | [ ]  | [ ]  | Social Security Card | [ ]  | [ ]  |
| **LBTCF: Before admission,** mark applicable box when the document is received or N/A, if applicable. |
| **CONSENT FORM** | **RECEIVED** | **N/A** | **CONSENT FORM** | **RECEIVED** | **N/A** |
| Consent, DSHS 14-012 | [ ]  | **Required** | Informed Consent | [ ]  | [ ]  |
| Costs of Care, DSHS 16-279 | [ ]  | **Required** | POLST or Advance Directive, if applicable | [ ]  | [ ]  |
| Dental Consent | [ ]  | **Required** | Resident Accounts / Rep Payee, if applicable | [ ]  | [ ]  |
| DSHS Notice of Privacy Practices for Client Medical Information, DSHS 03-387 | [ ]  | **Required** | Consent and Treatment Agreement | [ ]  | **Required** |
| School enrollment | [ ]  | [ ]  |  |
| FIELD SERVICES CRM SUPPORT THE FACILITY TO OBTAIN THE FOLLOWING RECORDS **BEFORE ADMISSION**:[ ]  Current verified (i.e., by pharmacy) medication list and orders [ ]  Any adverse drug reactions or allergies, if known [ ]  Dietary related needs [ ]  Family history (major cardiovascular, respiratory, diabetes, stroke, intellectual or developmental disabilities, psychiatric illnesses) [ ]  Previous medications, if any, for psychiatric related issues [ ]  Birth and developmental history (i.e., type of birth - vaginal, C-section; trauma or complications during pregnancy or delivery, early childhood development, onset of delays, etc.)[ ]  Date of last dental visit[ ]  Date of last ophthalmology / optometry visit, if applicable[ ]  Date of last audiology visit, if applicable[ ]  Past medical history (major childhood illnesses, surgeries) |