CRITERIA FOR EVALUATION
DEVELOPMENTAL DISABILITIES
July 1, 2025

CRITERIA FOR ALL SERVICES

A. SERVICES ACCORDING TO INDIVIDUAL NEED -- The service provider documents:

1. That services the client is receiving relate to the client's Individual Habilitation Plan (IHP) (ICF/ID), PASRR Level II Assessment, DDA Assessment including the Person-Centered Service Plan (PCSP) and/or Individualized Family Service Plan (IFSP).

2. A copy of the current annual DDA Assessment, Service Summary, and Employment Summary or PASRR Level II Assessment or IHP or IFSP if applicable, will be maintained in the client's file, or clear evidence that the provider has requested this documentation from the appropriate DDA Case Manager.

3. There is a County approved grievance process for clients that:

   a) Is explained to clients and others in accordance with DDA Policy 5.02, *Necessary Supplemental Accommodation*;
   b) Negotiates conflicts;
   c) States advocates are available and clients are encouraged to bring advocates to help negotiate;
   d) Provides a mediation process using someone who is unaffected by the outcome if conflicts remain unresolved (a DDA Case Resource Manager may be included as an alternative option);
   e) Prohibits retaliation for using the grievance process; and
   f) Includes a process for tracking and reporting grievances.

4. Clients and others, in accordance with DDA Policy 5.06, *Client Rights*, have been informed of their rights, what services and benefits may be expected from the program, the program's expectations of them, and if necessary, the client's family, guardian or advocate is also informed.

5. Reason for client exit from service.

B. HEALTH AND SAFETY -- The service provider has a policy that addresses confidential / private information for and documents:

1. Incidents involving injury, health or safety issues are reported to DDA and the County reference DDA Policy 6.08, *Mandatory Reporting Requirements for Employment and Day Program Services Providers*.

2. Incident reports are tracked and analyzed for potential trends and patterns.

3. Mandatory reporting is done in accordance with Chapter 74.34 RCW, *Abuse of Vulnerable Adults* and Chapter 26.44 RCW, *Abuse of Children*.

4. Current emergency contact and medical information (medications, diet, allergies, etc.) needed during the hours of service is readily available for each client.

5. Evidence that it employs typical safety protection based upon the environment the client is working or receiving services in.

C. POLICIES PROTECTING INDIVIDUAL RIGHTS -- The service provider has policies that protect individual rights that include but are not limited to:

1. Respectful staff-to-client interactions;
2. A person's right to be treated with dignity, respect and free of abuse;
3. A person's right to privacy; and
4. Safeguarding personal information.

D. ORGANIZATIONAL DESIGN -- The service provider documents:

1. The date policies are implemented or date they are revised.
2. A written performance plan which describes program objectives, expected outcomes, how and when objectives will be accomplished, and that the plan is evaluated at least biennially and revised based on actual performance. The performance plan must include performance indicators that address diversity, equity and inclusion efforts. Document progress on performance indicators identified in DDA Policy 6.13, *Provider Qualifications for Employment and Day Program Services*.
3. Direct service staff are trained and has experience in accordance with DDA Policy 6.13.
4. That it is able to account for and manage public funds compliance with Generally Accepted Accounting Principles "GAAP" provide financial statements within nine months subsequent to the close of the subcontractor's fiscal year. An agency, for-profit or non-profit, who receives in excess of $100,000 in DDA funds during its fiscal year from the County, shall provide Certified Public Accountant reviewed or audited financial statements.
5. An administrative/organizational structure that clearly defines responsibilities.
6. Each employee has a current (within three years) DSHS background check in accordance with RCW 43.43.830-845, RCW 74.15.030 and WAC 388-825. Child Development Service providers may submit background checks directly to the BCS at DSHS or they may submit background checks to the Department of Children, Youth and Families, for processing by the DSHS BCCU.
7. Equal access to persons who do not speak or have a limited ability to speak, read, or write English well enough to understand and communicate effectively (reference DDA Policy 5.05, *Limited English Proficient (LEP) Clients*).

CRITERIA FOR SPECIFIC SERVICES

E. CHILD DEVELOPMENT SERVICES (Birth to Three) -- The County evaluates, in collaboration with the Local Lead Agency, that service providers document:

1. The child and family received timely services. (Services are considered timely if they begin within 30 days of the start date on the signed IFSP unless documented that there was an exceptional family circumstance).

2. Services are in compliance with the natural environments criteria for IDEA, Part C and Washington State's federally approved Early Intervention Plan.

3. Training, experience, and expertise of staff meet the highest entry level requirements in Washington State for Early Intervention professionals and relate to the needs of the child.

4. Evaluation (eligibility), assessment (child and family need) and the Individualized Family Service Plan (IFSP) was conducted within 45 days of receipt of referral. (Referral is defined as the date the family resources coordinator or lead agency received referral)

5. The family was assisted to ensure the child obtained an evaluation by a multidisciplinary team.

6. Contractor received from the parent, in writing, consent for all activities related to the provision of Early Intervention Services in the family's native language or other mode of communication.

7. The IFSP was reviewed every six months with a new plan written annually.

8. Progress toward the child and family outcomes within the IFSP are assessed on an ongoing basis and documented at least annually.

9. Child and family outcomes within the IFSP are functional and based on the individualized needs of the infant or toddler and the concerns and the priorities of the family. Child specific outcomes reflect the child's participation in everyday routines and activities. Family specific outcomes address the capacity of the family to enhance their child's development.

10. Services and supports were provided, to the maximum extent appropriate for the individual child, in naturally occurring environments and occurs in a setting other than a natural environment only when early intervention cannot be achieved satisfactorily for an infant or toddler in a natural environment.

11. A transition plan for each child participating in the early intervention program was developed at least 90 days prior to the child's third birthday.

F. ALL EMPLOYMENT SERVICES-- The service provider documents:

1. Adult Employment plans will include the information listed below and should be developed by the provider in collaboration with the Case Resource Manager, client and their family (the team). Initial plans will be completed within 60 days from date of service authorization and must be signed by the client and/or their guardian, if any. Copies of the initial and subsequent revised

plans will be distributed as appropriate to all team members. Plans will be reviewed and signed annually. All employment plans should address how the client will pursue and maintain a community paid job, increased wages, and increased work hours towards a living wage.

a) Current date;
b) Timeline for the plan;
c) Client's name first and last;
d) Client ADSA ID;
e) Employment goal;
    i. The preferred (job type) the client wishes to obtain or maintain;
    ii. The preferred wages/salary the client wishes to earn;
    iii. The number of hours the client prefers to work;
    iv. The agreed upon timeline to achieve the employment goal.
f) The client's skills, gifts, interests and preferred activities;
g) Measurable strategies and timelines (action steps and supports) to meet the employment goal;
h) Identification of persons and/or entities available to assist the client in reaching their employment goal (example: a family member, Vocational Rehabilitation services, etc.) and;
i) Identification of other accommodations, adaptive equipment and/or supports critical to achieve employment goal.

2. All services relate to the client's individually identified goal(s) as outlined in the employment plan.

3. The identification and provision of supports necessary for job success have been provided to each client. Supports may include, but are not limited to, identification of resources necessary for transportation, job restructuring, work materials or routine adaptation, work environment modifications, identification of job counseling needs, etc.

4. Supports, which include training and support to employers and co-workers, have been provided in each job placement to ensure jobs are maintained and fading is occurring. This also includes the development of natural supports.

5. Employment service activities and the outcome of those activities are documented.

6. Six-month progress reports describing the progress made towards achieving client's goal will be provided by the service provider to the Case Resource Manager, client, and/or guardian if any within 30 days following the six-month period.

7. Training and support is provided as a part of a client's pathway to integrated employment in accordance with DDA Policy 4.11, *County Services for Working Age Adults*.

8. Information about wages, benefits, and work hours for each client.

9. Progress in achieving increased wages and work hours for each client.

10. Evidence that services the agency provides adhere to the Medicaid HCBS settings requirements of 42 C.F.R Section 441.301(c)(4) including: is integrated in the greater community and supports individuals to have full access to the greater community; ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS; the setting provides opportunities to seek employment and work in competitive integrated settings; and the setting facilitates individual choice regarding services and supports~~,~~ and who provides them.

11. Identifying settings that isolate people from the broader community or that have the effect of isolating individuals from the broader community of individuals who do not receive Medicaid HCB services. These settings are presumed not to be home and community-based.

G. GROUP SUPPORTED EMPLOYMENT-- The service provider documents:

1. Clients in Group Supported Employment shall be compensated in accordance with applicable State and Federal laws and regulations and the optimal outcomes of the provision of Group Support Employment services is permanent integrated employment at or above minimum wage in the community.

2. The direct service staff hours supporting the group.

3. Clients' identified goal(s) include pathway strategies leading to Individual Supported Employment.

4. Service is in accordance with the DDA Group Supported Employment Service Guidelines.

H. INDIVIDUAL SUPPORTED EMPLOYMENT SERVICES-- The service provider documents:

1. Service is in accordance with the DDA Employment Activities – Strategies and Progress/Outcomes Measures document.

2. State-adopted self-employment guidelines are followed for any individual who owns and operates a business. In addition, at minimum, any self-employment venture must include a business plan, established benchmarks for financial gain, and show that progress is being made towards providing a living wage.

I. COMMUNITY INCLUSION SERVICES -- The service provider documents:

1. Adult Community Inclusion plans will include information that identifies and addresses the individualized goal and support needs for each client. Plans must consider individualization, integration, and safety and should be developed by the provider in collaboration with the Case Resource Manager, client and their family (the team). Initial plans will be completed within 60 days from date of service authorization and must be signed by the client and/or their guardian if any. Copies of the initial and subsequent revised plans will be distributed as appropriate to all team members. Plans will be reviewed and signed annually. Plans will include the information listed below:

    a) Current date;
    b) Timeline for the Plan;
    c) Client's name first and last;
    d) Client's ADSA ID;
    e) The client's skills, gifts, interests, and preferred activities.
    f) The Community Inclusion goal. The goal needs to relate to the following (per the County Guide to Achieve Developmental Disability Administration Guiding Values):
        i. Identify integrated community places where the client's interest, culture, talent, and gifts can be contributed and shared with others with similar interests.
        ii. Identify typical community clubs, associations, and organizations where the client can be a member and have decision making capacities.

iii. Identify opportunities where the client can contribute to the community doing new and interesting things or things the client enjoys.
iv. Building and strengthening relationships between family members and members of the local community who are not paid to be with the person.

g) The Support Assessment subscale that most relates to the goal (Community living; Lifelong learning; Employment; Health & Safety; Social; and Protection & Advocacy)
h) Measurable strategies and timelines (action steps and supports) to meet the goal.
i) Identification of persons and/or entities available to assist the client in reaching their long-term goal.
j) Identification of other accommodations, adaptive equipment and/or conditions critical to achieve the goal.

2. All services relate to the client's individually identified goal(s) as outlined in their plan.

3. Six-month progress reports describing the progress made towards achieving the client's goal, service activities and the outcome of those activities will be provided by the service provider to the Case Resource Manager, client, and/or guardian if any within 30 days following the six-month period.

4. Each client is assisted to participate in typical and integrated activities, events and organizations in the client's neighborhood or local community in ways similar to others of same age.

5. Each client is assisted to take part in activities on an individualized basis.

6. The opportunity is provided for connection and relationship building between the client and people without disabilities and who are not paid to provide services to the client. This also includes the development of natural supports and fading of paid staff support.

7. Volunteer opportunities comply with U.S. Department of Labor standards and applicable state standards.

8. Service activities and the outcome of those activities are documented.

9. Evidence that services the agency provides adhere to the Medicaid HCBS settings requirements of 42 C.F.R. Section 441.301 (c)(4) including: is integrated in and supports full access to the greater community; ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS; and provides opportunities to seek employment and work in competitive integrated settings.

10. Identifying settings that isolate people from the broader community or that have the effect of isolating individuals from the broader community of individuals who do not receive Medicaid HCB services. These settings are presumed not to be home and community-based.