Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	COMMUNITY RESIDENTIAL SERVICES: REFERRAL, ACCEPTANCE, AND CHANGE IN RESIDENTIAL PROVIDER	4.02

Authority:		
	Chapter 70.02 RCW	*Medical Records – Health Care Information Access and Disclosure*
	Title 71A RCW	*Developmental Disabilities*
	Chapter 388-825 WAC	*Developmental Disabilities Services*
	Chapter 388-101 WAC	*Certified Community Residential Services and Support*
	Chapter 388-101D WAC	*Requirements for Providers of Residential Supports*

PURPOSE

This policy establishes standards for Developmental Disabilities Administration (DDA) clients to promptly obtain or transition to community residential services consistent with the health and welfare needs identified in their person-centered service plan. This policy also establishes procedures for providers to give sufficient service termination notice.

SCOPE

This policy applies to DDA staff and the following DDA-contracted residential service programs for adults:

- Group homes (GH);
- Group training homes (GTH);
- State-operated living alternatives (SOLA); and
- Supported living (SL).

DEFINITIONS

Business Days means weekdays, excluding weekdays when DDA office is closed.

Case manager (CM) means the case carrying DDA case manager who is the liaison to the client.

Habilitation means services delivered by community residential service providers to assist people with developmental disabilities to acquire, retain, and improve upon the self-help, socialization, and adaptive skills necessary to reside successfully in the community.

Resource manager (RM) means the DDA liaison to the service provider who establishes rates and monitors contract compliance.

Resource management administrator (RMA) means the DDA administrator who manages budgetary and programmatic practices of community residential services within an assigned region.

POLICY

A. DDA clients approved to receive community residential services will be promptly provided the opportunity to live in a manner that meets their residential support needs and preferences. Services must be timely and delivered in cost-effective manner. Based on the habilitation benefits and efficiencies of sharing households and staffing, clients assessed as needing 24-hour daily support typically live in households with one to three other clients.

B. For a single-person household, the RM must complete an exception to policy annually. A client lives in a single-person household if the client:

   1. Has an assessed support level in CARE of 4, 5, or 6 as defined in WAC 388-828-9540; and

   2. Does not share their home with another client.

C. When referring a client for residential services, DDA will ensure that:

   1. The client, and the client's legal representative, receives necessary information to maximize available service options that provide choice and to make an informed choice when selecting an available service.

   2. The service provider receives information about the client's strengths, needs, and preferences in order to make an informed decision when reviewing referrals.

   3. The service provider has the necessary contract and certification or license. Licensed facilities must operate within their licensure capacity.

   4. Services are offered in integrated settings that reflect client choice and preferences.

5. The residential agency supports the client to access the greater community to engage in community life.

D. The RM and the CM must work collaboratively on the client referral process.

1. The CM must:

a. Complete the DDA assessment and person-centered service plans;

b. Verify the client is approved for the Core or Community Protection waiver;

c. Prepare the pre-referral packet; and

d. Prepare the full referral packet.

2. The RM must distribute the pre-referral and the full referral packet to potential service providers and document the distribution and responses in the residential referral database.

E. Clients have the right to change residential service providers without retaliation from their current provider. A client, or their legal representative if they have one, may request the case manager to keep their request confidential until a new provider is identified.

F. A supported living service provider, administrator, or owner must not own a home rented by a client the provider supports.

G. For a supported living service provider who owned a residence rented by a client they supported before July 1, 2013, the following exception to policy (ETP) process must be completed annually:

1. The service provider must complete DSHS 27-124, *Provider Owned Housing Memorandum of Understanding Residential Provider Attestation* and submit it to the RM.

2. The CM must work with the client or the client's legal representative to identify alternative housing options or complete DSHS 27-123, *Provider Owned Housing Memorandum of Understanding Renter Attestation* and submit it to the RM.

3. The RM must attach both of these documents to the ETP and submit it to the Office Chief for Residential Services for approval.

4. The RM must keep a signed copy of an approved ETP in the client's file and forward a copy to the service provider no more than 30 days after submitting the request to the Office Chief for Residential Services.

PROCEDURES

A. Identifying Potential Providers

1. Group Homes and Group Training Homes who wish to receive referrals for new clients must complete and submit DSHS 15-360, *Residential Services Capacity Profile*.

2. An SL provider with specific capacity, including a vacancy in a home where clients are currently being served or plans to open a new household, who wish to receive referrals for new clients may complete and submit DSHS 15-360, *Residential Services Capacity Profile*.

3. The RM will provide to the CM who will then share with the clients:

   a. A list of contracted residential providers open to new referrals; and
   b. Along with relevant information as available about providers.

3. A client, and their legal representative if they have one, will be provided information regarding supported living, group training home, and group home residential providers. This is available online using the Supported Living Program Locator. Agency provides information regarding their location and contacts. They may include unique areas of expertise and other details about the agency.

4. The RM must obtain consent from the client, and the client's legal representative if they have one, to initiate referrals by providing the client and members of the client's extended support team with the following information about each proposed provider:

   a. The provider's ability to meet the client's health, safety, and residential support needs;

   b. The provider's areas of specialty, if any;

   c. The provider's interest and ability to expand services;

   d. Certification enforcement action in place;

   e. Capacity in existing homes;

f. Provider policies upon request as required under WAC 388-101D-0060.

B. Pre-referrals

For clients who are eligible to receive residential services, this step in the process is designed to send a short summary to inform the potential agency to review and inform the RM if the agency would accept a full referral for evaluation.

1. Before sending the pre-referral information to the agency the CM obtains a signed copy of DSHS 14-012, *Consent*, from the client or the client's legal representative. The form must have been signed within the last 12 months. The consent will include an attached list of what will be included in the referral packet.

2. The CM completes DSHS 15-358, *Client Referral Summary*, within five business days after receiving the client's request and signed consent for residential services and sends to their supervisor for review. The supervisor sends the packet electronically to the regional referral mailbox for distribution. For clients in the community protection program, if consented to by the client or their legal representative if they have one, the risk assessment will be included with the *Client Referral Summary*.

   a. Region 1 Referrals – Region1Referrals@dshs.wa.gov
   b. Region 2 Referrals – R2Referrals@dshs.wa.gov
   c. Region 3 Referrals – R3Referrals@dshs.wa.gov

3. The RM must send providers a completed consent form, DSHS 15-358, *Client Referral Summary* (pre-referral), and document that they sent the referral to that provider in the residential referral database. The RM must send to all providers agreed to or requested by the client, advocate, or legal representative.

4. The service provider must maintain confidentiality of all information disclosed.

5. The service provider must review the *Client Referral Summary* (pre-referral) and respond to the RM within five business days:

   a. Stating

      i. They want to receive a full referral packet; or

      ii. A reason for declining the referral.

b. The provider must complete the bottom portion of DSHS 15-358, *Client Referral Summary* and return to the RM.

6. The RM will

a. Follow up with providers based on the reasons given for declines.

b. Record declines and reasons given for declines in the residential referral tracking database.

7. While waiting for provider responses, the CM must work with the client to compile the full referral packet. See Procedures Section E for referral packet contents. The CM must ensure the information is current.

C. Full Referrals

1. If the provider wants to receive the full referral packet, the RM must send the referral packet to the service provider and document that it was sent in the residential referral database and a service episode record.

2. The full referral packet must be sent within two working days of the request from the residential agency.

3. The CM must send the packet electronically to the regional referral mailbox for distribution within two business days of the request from the residential provider.

a. Region 1 Referrals – Region1Referrals@dshs.wa.gov
b. Region 2 Referrals – R2Referrals@dshs.wa.gov
c. Region 3 Referrals – R3Referrals@dshs.wa.gov

4. The RM must update the residential referral database that they sent the referral to the potential provider.

5. The provider must verify receipt of the referral packet by sending an email to the RM.

6. Providers will be encouraged to meet with and/or call the client and members of client extended support team prior to deciding whether to accept or decline the referral. Clients and members of their extended support team may call or meet with services providers who have received the client's referral.

7. The service provider must evaluate the referral packet to make a final decision about whether to accept the referral within ten business days unless the client or legal representative, if they have one, agrees for a longer review period or does not respond to requests to meet with the service provider.

8. If the client or the client's legal representative decides not to select the provider, the RM will notify the provider and send referral packets to additional providers if directed by the client/legal representative. The RM must document the client's response in the residential referral database.

9. If the provider decides not to accept the referral, the provider must send to the RM in writing the decision and reason for the decision. The provider must complete the bottom portion of DSHS 10-232, *Provider Referral Letter for Supported Living/Group Home Providers*, and return to the RM.

10. The provider must destroy or delete the referral information in accordance with WAC and statutes on proper destruction of confidential information.

11. The RM will follow up with providers based on the reasons given for declines. The RM must document provider responses in the residential referral database.

12. The CM must notify the client, or the client's legal representative, of the status of the referral.

13. The provider must follow all relevant statutes and rules regarding confidentiality.

D. Interregional Referrals

For a client who asks DDA to initiate a search for residential services in another region, the following process must be completed:

1. The CM sends the *Client Referral Summary* and the full referral packet to the referral mailbox within the originating region.

2. The RMA or designee from the sending region reviews the referral material and sends it to the referral mailbox of the receiving region.

3. The RM in the receiving region follows the standard referral process under Procedures Section A.

4. The CM of the sending region helps the client and the client's family identify and choose a qualified provider.

5. The field service administrator or designee transfers the client's case file and the CARE record to the receiving region.

6. The CM of the receiving region assumes case management responsibility for the client on the day the client moves.

E. Full Referral Packet Contents

1. In developing the referral packet, the CM must review the file for current and relevant documents and consult with client and their legal representative about the information they would like to share with potential providers. If the client, or the client's legal representative if they have one, has requested to withhold information from the packet, DDA will inform the provider that the referral packet does not contain all of the available information. For items reviewed annually, the document must be dated within the previous 12 months. The referral packet should include current and relevant documents, such as:

   a. DSHS 14-012, *Consent*.

   b. DSHS 10-232, *Provider Referral Letter for Supported Living/Group Home Providers*, which lists the information included in the packet.

   c. Legal representative information and documentation.

   d. The client's current DDA assessment and person-centered service plan. An assessment for a client referred for supported living, group home, or group training home services must indicate the client's residential service level of support under WAC 388-828-9540.

   e. The client's current functional assessment and positive behavior support plan, if they have them.

   f. The client's current or pending cross-system crisis plan, if they have one.

   g. The client's individual technical assistance plan, if they have one.

   h. Dates, sources, and copies of the most recent psychological or mental health evaluations, including any behavioral and psychiatric information and treatment plans.

i. Educational and vocational records, including individual education plan information if available.

j. Financial information (may be found in ACES), such as:

i. Verification of SSI or SSA status;
ii. Eligibility for financial assistance (e.g., food stamps, Medicaid);
iii. Earned and unearned income and resources;
iv. Payee information; and
v. Whether the client is receiving state supplementary payment funds.

k. Legal information.

l. Medical history, immunization records, and medications. Under RCW 70.24.105, a client's Hepatitis B Virus (HBV) and HIV status are confidential and must not be shared.

m. Any messages or information the client wishes to convey, including a video referral made by DDA, if necessary to facilitate client's communication.

n. Nurse delegation assessments and DSHS 01-212, *ALTSA Nurse Delegation Referral and Communication Case / Resource Manager's Request*, when applicable.

o. DSHS 10-234, *Individual with Challenging Support Issues,* for a client with a history of offenses or behaviors that may be of concern. If this form is used the CM must:

i. Identify any significant risks to others posed by the client and what supports are necessary to manage these risks. This must include the risk posed by the client to vulnerable people, such as housemates, children, neighbors, schools, childcare centers.

ii. Provide the names and phone numbers of people to call if the client's behavior becomes dangerous beyond the provider's ability to ensure the safety of the client or others.

p. For a client with community protection issues, DSHS 10-258, *Individual with Community Protection Issues*, and the client's most recent psychological or psychosexual evaluation or risk assessment.

2. If a client or their legal representative wishes to include information that they have created in their referral packet, they may provide them directly to the selected provider or to DDA for inclusion in the referral packet. If submitted to the provider through DDA, the CM must notify the provider that the information is provided by the client or client's legal representative.

F. Transition Planning

1. Following acceptance of the referral, the provider, the client, and the client's legal representative, must meet to discuss the support services that the provider will offer to meet the client's assessed needs.

2. The provider must arrange for the client to visit the home they will be sharing and spend time with their potential housemates.

3. After mutual acceptance from provider, client and legal representative if they have one, the client, RM, and the provider must agree on a timely process to begin services. If the provider is unable to offer services within 60 days of accepting the client's referral, then the provider must provide an explanation to the RM as to why more time is needed and how much time the provider anticipates is reasonably necessary before starting services. The RM must document the reasons and inform the client. If services are not expected to be offered within 60 days or before the client's current services end, then the CM will work with the client and their legal representative to develop an interim support plan under which services will be offered.

4. The provider must ensure nurse delegation services, if necessary, are in place before the client begins receiving residential services.

5. The RM must conduct a rate assessment meeting with the service provider to determine the daily rate for the residential service;

6. The CM must:

   a. Oversee the transition of services to the new location, including new medical and pharmacy providers, leased medical equipment, change in school;

   b. Refer the client to employment or day services;

c. Refer the client for a nurse delegation assessment, if necessary, and ensure the assessment occurs on or before the first day of supported living services;

d. Facilitate transfer of:

i. The client's birth certificate;

ii. The client's finances;

iii. The client's insurance cards for Medicare, Medicaid, and Provider-One;

iv. The client's photo ID card;

v. The client's Social Security card;

vi. Any other legal documents in the previous provider, or client, or family's possession; and

vii. The client's personal property inventory if previously served by a residential provider;

e. Facilitate a plan for moving the client's:

i. Personal items;
ii. Clothing;
iii. Furniture;
iv. Medication;
v. Medical supplies; and
vi. Durable medical equipment; and

f. Facilitate a plan to ensure transfer of the client's representative payee, if needed and inform the client and their legal representative if they have one.

7. When the residential provider changes from one DDA-contracted provider to another DDA-contracted provider, the sending provider must coordinate with the receiving provider to share client records and other client care information, including:

a. Individual Instruction and Support Plan;

b. Risk assessment;
c. Current medical information;
d. Doctors' orders;
e. Medication administration records;
f. Functional assessment;
g. Positive behavior support plan;
h. Any other relevant plans for the client; and
i. DSHS 10-635, *Residential Transition Exchange of Information* (optional).

8. The residential provider must have an approved rate reflected in Contract Exhibit (C), which provides the detail of each rate component and a total daily rate per client, before providing residential support services to a client.

G. Client Request to Change Service Providers

1. Clients have the right to change residential service providers. A client may request the case manager to keep their request confidential until a new provider is identified.

2. If a client requests a change in residential service provider, DDA and the service provider will work together to address the client's request as follows:

   a. A client who is seeking a change in service provider must inform the CM of the desire to change providers. The CM will meet with the client and the client's legal representative to discuss the reasons for the move. The CM will encourage and assist the client and the client's legal representative in meeting with the current residential services provider to talk about whether the client's services can be modified to respond to the client's concerns.

   b. If a mutually acceptable plan cannot be developed, the client will request the CM to initiate the process to seek a new service provider that can address the client's support needs. This process of developing an acceptable plan will include the client, the client's legal representative, others upon client's request, and DDA staff.

   c. DDA will follow procedures regarding referrals noted above.

   d. DDA will develop a transition plan with the client and their extended support team. The plan should include the impact to current housing, supports, and financial implication for the client.

H. Notification to Terminate Services

1. If a provider determines they can no longer meet a client's needs after they have engaged in the Client Critical Case Protocol, the provider may initiate termination of residential services with at least 60 days advance notice to the client and their legal representative. Additionally:

2. The service provider administrator must send a written termination notification, including documentation demonstrating the reason for the termination and efforts to implement additional supports or revised habilitation support plans, to the:

   a. Client;
   b. Client's legal representative if they have one; and
   c. RA with a copy to the RMA and CM.

3. The provider must submit DSHS 15-569, *Notice of Termination* to the RM.

4. The case manager must develop a transition plan, per RCW 71A.26, *Client Rights*, with the client and their extended support team that includes:

   a. The referral process to choose a different provider;

   b. The location of the new residence or facility;

   c. The mode of transportation to the new location;

   d. The name, address, and telephone number of the Developmental Disabilities Ombuds and Protection and Advocacy System; and

   e. Keep the client and current provider informed of the progress of the transition plan.

5. The provider terminating services must participate in a planning meeting with the client and DDA to assist with transition to new provider, if requested by DDA, the client, or new provider.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary or designee.

SUPERSESSION

DDA Policy 4.02
Issued July 1, 2019

Approved: _____ Date: February 26, 2021
Deputy Assistant Secretary
Developmental Disabilities Administration