



DIVISION OF DEVELOPMENTAL DISABILITIES  
Olympia, Washington

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TITLE: REFERRAL AND PLACEMENT INTO COMMUNITY POLICY 4.02  
RESIDENTIAL SERVICES

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Authority: 42 CFR 483.440 (b)  
Chapter 71A RCW Developmental Disabilities  
Chapter 388-825 WAC DD Services

For Adult Family Homes and Adult Residential Care facilities:

Chapter 70.129 RCW Long Term Care Resident Rights  
Chapter 388-76 WAC Adult Family Home Minimum Licensing  
Requirements  
Chapter 388-101 WAC Certified Community Residential Services and  
Support

**PURPOSE**

This policy provides the opportunity for persons who are eligible for services from the Division of Developmental Disabilities (DDD) to live in a manner that meets their needs and preferences, and ensures that the service provider is aware of the individual's needs prior to admission.

**SCOPE**

This policy applies to clients in DDD community residential services, which includes Supported Living (SL), Companion Homes (CH), Group Homes (GH), Group Training Homes (GTH), Alternative Living (AL), State Operated Living Alternatives (SOLA), Licensed Staffed Residential Programs for Children and Youth (LSR), Adult Family Homes (AFH), and Adult Residential Care (ARC) facilities.

Note: Individual providers and personal care services are outside the scope of this policy.

## **POLICY**

- A. When referring or placing a DDD enrolled client into residential services, the division will ensure that:
1. The individual and the service provider are provided the necessary information and opportunities to make an informed decision; and
  2. The program has the necessary licensure, contract, or certification, and is within its contracted capacity.
- B. DDD may make referral for an opening within thirty (30) days based on the capacity profile information received from the service provider. The service provider may use [DSHS 15-360, Residential Services Capacity Profile](#) (see Attachment A).

## **PROCEDURES**

- A. When referring a client to residential service providers, the DDD Case Resource Manager (CRM) must obtain a [DSHS 14-012, Consent](#) form signed by the client and/or his or her legal representative within the last ninety (90) days. The CRM must also consider the:
1. Personal preference of the individual being referred;
  2. Personal preference of potential housemate(s);
  3. Ability of the service provider to meet the person's health, safety, and program needs; and
  4. Needs of all persons in the residence, including safety and protection needs.
  5. For DDD residential services, the CRM will document these preferences on [DSHS 15-358, Client Referral Information](#) (see Attachment B).
- B. Referral packets must include all required forms and available information as follows:
1. [DSHS 10-232, Provider Referral Letter for Supported Living/Group Home Providers](#), listing the information included in the packet. The service provider will send a copy of the signed form to the CRM for inclusion in the client's record.
  2. [DSHS 15-358, Client Referral Information](#).

3. Financial information, such as:
  - a. Verification of SSI/SSA status;
  - b. Eligibility for financial assistance, (e.g., food stamps, Medicaid);
  - c. Earned and unearned income and resources;
  - d. Payee information;
  - e. Client receiving SSP funds; and
  - f. ACES information.
4. History of residential services received from other providers.
5. Legal information, such as:
  - a. Legal representative/guardian information and documentation;
  - b. Marital status, children, family members, and names and addresses of all significant people in the person's life;
  - c. Copies of court orders or legal action involving the client;
  - d. Names of perpetrator or victims of crime (if known); this must be based upon a need to know. The client's expressed consent must be obtained before sharing this information [Note: The client cannot give consent to release names of victims]; and
  - e. Whether the client is an *Allen* or *Marr* class member.
6. The client's current assessment and Individual Support Plan (ISP) as identified in DDD Policy 3.01, *Service Plans*.
7. Health information, such as:
  - a. Medical history, immunization records, and medications

Note: A client's Hepatitis B Virus (HBV) and HIV status are confidential and cannot be shared (RCW 70.24.105); and

- b. Dates, sources, and copies of the most recent psychological and/or mental health evaluations, including any behavioral and psychiatric information and plans.
  8. Nurse delegation assessments when applicable. These must be provided no later than the day of placement in the program. The contracted registered nurse (RN) must use [DSHS 10-217, Nurse Delegation: Nursing Assistant Credentials and Training](#).
  9. Educational and vocational records.
  10. Current information regarding other program services and agencies serving the client.
- C. The residential service provider must evaluate the referral for service to determine whether the service provider has the resources to meet the client's needs. Within ten (10) working days of receipt of the referral packet, the service provider must notify the CRM whether or not they accept the referral for further evaluation. If a decision is not possible within ten (10) days, the service provider will consult with the CRM to agree on a mutually extended timeframe.
1. Following acceptance for further evaluation, the service provider will arrange a pre-placement visit during which the residential service provider must describe to the client the services that will be provided in their program and provide access to the program's written policies upon request.
  2. If the service provider decides not to accept the referral, the service provider must put their decision and reason for not accepting the client in writing and return the referral information to the CRM.
  3. The service provider must adhere to all relevant statutes and WACs regarding confidentiality.
  4. If the service provider accepts the referral, the provider, the client, and the CRM must agree on a timely process to complete the placement.
  5. For DDD residential services, the CRM will conduct a rate-setting meeting with the service provider.
  6. DDD will provide an authorization for service the working day immediately following the date of placement. For SL providers, DDD will provide authorization for services on the date of placement.

- D. Emergency placements are situations where the immediate placement needs of the person do not allow for the standard referral process described in Sections B and C of this policy to occur. In these situations, the CRM must:
1. Provide the DDD Assessment to the residential service provider; or
  2. Attach any client information immediately available and include the [DSHS 10-232, Provider Referral Letter for Supported Living/Group Home Providers](#), to document the information given and received;
  3. Document conversations with the residential service provider in the client's service episode record (SER); and
  4. Provide complete written information within five (5) working days of the placement (i.e., social, medical, and criminal history, and an updated ISP).
- E. Individuals with challenging support issues have a history of offenses and/or behaviors that may be of concern. Such clients must be identified on [DSHS 10-234, Individual with Challenging Support Issues](#), and are subject to the following additional procedures when being referred for placement. The CRM will:
1. Provide a copy of the [Individual with Challenging Support Issues](#) form to the residential service provider;
  2. Describe in writing the level of supervision and support needed by the client;
  3. Identify in writing any significant risks to others posed by the client, and what supports are necessary to manage these risks. This must include the client's issues regarding access to vulnerable people (e.g., housemates, children, neighbors, schools, childcare centers, etc.);
  4. Provide the names and phone numbers of people to call if the client's behavior becomes dangerous beyond the residential service provider's ability to ensure the safety of the client or others;
  5. Obtain the residential service provider's signature on the client's ISP and/or contract. The service provider signature is confirmation that the service provider agrees that the supervision and supports outlined in the ISP can be provided within the DSHS/DDD reimbursement rate; and
  6. Implement the procedures outlined in Sections E and G of this policy for crisis and emergency placements.

7. For clients with community protection issues, the CRM must complete [DSHS 10-258, Individual with Community Protection Issues](#) and give a copy of the form and the most recent psychosexual evaluation/risk assessment to the residential service provider.
- G. Crisis/Respite Mental Health Diversion services provided by DDD certified residential service providers are available as deemed appropriate by DDD. These services are available to clients who are being diverted from psychiatric inpatient treatment through the provision of this service. The following procedures are specific to the placement of these clients:
1. DDD Field Services offices that contract with residential service providers for respite/mental health crisis diversion services must have in place written procedures and interagency agreements between DDD, the Regional Support Network (RSN), and, if appropriate, the Aging and Disability Services Administration (ADSA).
  2. The interagency agreements must address the following:
    - a. Release of information by local mental health authorities;
    - b. Clear procedures on whom to contact when a person's behavior becomes dangerous beyond the service provider's capacity to ensure the safety of the person or others; and
    - c. A schedule for regular meetings between DDD, the RSN, and the contractor to revise and update common understandings and procedures regarding:
      1. Placement of persons into crisis and diversionary care;
      2. Mental health supports needed while in crisis care; and
      3. Plans to return home or to an alternative placement.

### **EXCEPTIONS**

Any exceptions to this policy must have the prior written approval of the division director.

### **SUPERSESSION**

DDD Policy 4.02  
Issued July 1, 2007

DDD Policy 4.02  
Issued September 1, 2005

DDD Policy 4.02  
Issued November 1, 2003

DDD Policy 4.02  
Issued January 1, 2002

DDD Policy 4.02  
Issued April 13, 2000

DDD Policy 4.02  
Issued August 5, 1998

DDD Policy 4.02  
Issued April 7, 1997

Policy Directive 545  
Issued October 1984

Policy Directive 538  
Issued December 1982

Approved: /s/ Linda Rolfe  
Director, Division of Developmental Disabilities

Date: July 1, 2008

Attachment A – DSHS 15-360, *Residential Services Capacity Profile*

Attachment B – DSHS 15-358, *Client Referral Information*

Attachment C – DSHS 10-232, *Provider Referral Letter for Supported Living/Group Home Providers*

# ATTACHMENT A



## DIVISION OF DEVELOPMENTAL DISABILITIES Residential Services Capacity Profile

AGENCY NAME		AGENCY CONTACT PERSON		TELEPHONE NUMBER	
AGENCY ADDRESS			CITY	STATE	ZIP CODE
DATE VACANCY IS AVAILABLE		PROGRAM TYPE (Check One) <input type="checkbox"/> Supported Living <input type="checkbox"/> Group Home <input type="checkbox"/> IMR-E <input type="checkbox"/> Other:			
For Supported Living, indicate the number of staff hours per day that support is available:					
BRIEFLY DESCRIBE THE RESIDENCE AVAILABLE					
RESIDENCE IS WHEELCHAIR ACCESSIBLE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Interior <input type="checkbox"/> Exterior		MAXIMUM OCCUPANCY OF RESIDENCE		PRESENT OCCUPANCY OF RESIDENCE	
<b>CURRENT TENANTS</b>					
NAME		AGE	GENDER M/F	NAME	
DESIRED REFERRALS <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either Gender		DESIRED REFERRALS <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Either		INDIVIDUALS REFERRED WILL HAVE <input type="checkbox"/> Private Bedroom <input type="checkbox"/> Shared Bedroom	
Describe the preferred skill level of desirable referrals:					
Describe the level of assistance available to referred individuals, including any professional or specialized services that are also available:					
Other characteristics of desired referrals:					
A current staffing schedule is also attached: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Additional comments, if any:					

DSHS 15-360 (06/2008)



# ATTACHMENT B



## Client Referral Information

CLIENT NAME	DATE															
<b>CLIENT PREFERENCES</b>																
<p><b>Program Type:</b></p> <input type="checkbox"/> SL (Supported Living) <input type="checkbox"/> GH (Group Home) <input type="checkbox"/> GTH (Group Training Home) <input type="checkbox"/> CH (Companion Home) <input type="checkbox"/> AL (Alternative Living) <input type="checkbox"/> CP (Community Protection) <input type="checkbox"/> SR (Staffed Residential) <input type="checkbox"/> AFH (Adult Family Home) <input type="checkbox"/> ARC (Adult Residential Care) <p><b>Location:</b></p> <input type="checkbox"/> Region <input type="checkbox"/> City/County: <input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> Central <input type="checkbox"/> South <input type="checkbox"/> Out of Region      Sent to Region: <input type="checkbox"/> Statewide <p><b>Housing Type:</b></p> <input type="checkbox"/> Apartment <input type="checkbox"/> House <p><b>Accessibility and Environmental Accommodation Issues:</b></p>  <p><b>Housemate Preferences:</b></p> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Smoking <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker Bedroom <input type="checkbox"/> Private <input type="checkbox"/> Shared	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%; text-align: center;">NEGOTIABLE</td> <td style="width: 25%; text-align: center;">NON-NEGOTIABLE</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		NEGOTIABLE	NON-NEGOTIABLE		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
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<b>LEVEL OF ASSISTANCE EXPECTED</b>																
With daily living skills:																
With behavioral supports																

DSHS 15-358 (05/2008)

## ATTACHMENT B

With activities		
Specialized services needed (nursing, skin care, nurse delegation, communication, etc.)		
Why is the current situation not working?		
What do you value most with respect to the services you are receiving now?		
What needs to be different that didn't happen?		
What one thing is the most important to you in selecting a new provider? Please indicate level of involvement if a guardian is established.		
CASE MANAGER SIGNATURE	TELEPHONE NUMBER	DATE

DSHS 15-358 (05/2008)

# ATTACHMENT C

## Provider Referral Letter for Supported Living/Group Home Providers



### DIVISION OF DEVELOPMENTAL DISABILITIES

## Provider Referral Letter for Supported Living/Group Home Providers

PROVIDER NAME AND ADDRESS

Dear

I am referring \_\_\_\_\_ to you for :

CLIENT NAME			
WAIVER STATUS (SL ONLY)		PLACEMENT NEEDED	
Choose one <input type="checkbox"/> CORE <input type="checkbox"/> Non waiver <input type="checkbox"/> CPP <input type="checkbox"/> Basic Plus <input type="checkbox"/> Other waiver awaiting approval for CORE or CPP		Choose one <input type="checkbox"/> As soon as possible <input type="checkbox"/> Within one month <input type="checkbox"/> 60 – 90 days <input type="checkbox"/> Long term planning	
INCLUDED IN REFERRAL PACKET			
ENCLOSED	NOT AVAILABLE	TYPE OF INFORMATION	
<input type="checkbox"/>	<input type="checkbox"/>	Release of Information, DSHS 14-012(X)	
<input type="checkbox"/>	<input type="checkbox"/>	Individual Support Plan	Date:
<input type="checkbox"/>	<input type="checkbox"/>	Financial information	
<input type="checkbox"/>	<input type="checkbox"/>	Health information ( <b>per RCW 70.24.105, HBV/HIV status is confidential</b> )	
<input type="checkbox"/>	<input type="checkbox"/>	Legal information	
<input type="checkbox"/>	<input type="checkbox"/>	Educational/vocational/other agency records	
<input type="checkbox"/>	<input type="checkbox"/>	Individual with Challenging Support Issues, DSHS 10-234 (if applicable)	
<input type="checkbox"/>	<input type="checkbox"/>	Positive Behavior Support Plan or Cross Systems Crisis Plan (if applicable)	
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	
<b>To expedite this referral, please do the following:</b> <input type="checkbox"/> Read through the referral packet and request any further documentation needed. <input type="checkbox"/> Meet the client, family, legal representative, current provider, etc. <input type="checkbox"/> Contact the Case Resource Manager to discuss client support needs.			
_____		_____	
CRM NAME		TELEPHONE NUMBER	
<input type="checkbox"/> Inform the Resource Manager (RM) of your interest in pursuing this referral within 10 days of receipt of this packet. <input type="checkbox"/> Submit a proposal to the Resource Manager as soon as possible, considering the time frame indicated above.			
_____		_____	
RM NAME		TELEPHONE NUMBER	
<input type="checkbox"/> Sign the cover letter and return an original signature to me.			
Thank you for considering this individual for services.			
Sincerely,			
_____		_____	
CASE/RESOURCE MANAGER		TELEPHONE NUMBER	

DSHS 10-232 (06/2008)

## ATTACHMENT C

**I have received the referral information for the individual named above. I have not yet accepted the individual for placement. If the person is not accepted, I will return all referral information to DDD.**

PROVIDER'S SIGNATURE

DATE

**The residential service provider must evaluate the referral for service to determine whether the service provider has the resources to meet the client's needs. Within ten (10) working days of receipt of the referral packet, the service provider must notify the RM whether or not they accept the referral for further evaluation. If a decision is not possible within ten (10) days, the service provider will consult with the RM to mutually agree on an extended timeframe.**

DSHS 10-232 (06/2008)