Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Community Engagement 90-Day (Quarterly) Progress Report

WAIVER PARTICIPANT'S NAME	PROVIDER'S NAME
CASE MANAGER'S NAME	DATE INITIAL PLAN WAS WRITTEN OR REVISED

Goal(s) you have been working on with the client. No more than three per plan.

Goal 1	
Goal 2	
Goal 3	

Treatment strategies utilized and progress for each goal above.		**Goal completion, using a scale from 1 – 10 (10 being goal is met)**
If progress has not been made, please indicate strategies planned to address them further.		
Goal 1		**Goal 1:**
Goal 2		**Goal 2:**
Goal 3		**Goal 3:**

List referral recommendations made if the waiver participant presents with potential underlying medical, mental health, or educational support needs:

Dates / times of service in the past 90 days:

Date: Number of Units (15 minutes):

Date: Number of Units (15 minutes):

Date: Number of Units (15 minutes):

Date: Number of Units (15 minutes):

Date: Number of Units (15 minutes):

Date: Number of Units (15 minutes):

Include additional visits on a separate page and attach to this report.

Total Units (15 minutes of service provided in previous 90 days:

Signatures

PROVIDER'S SIGNATURE	DATE	LEGAL REPRESENTATIVE'S SIGNATURE	DATE
WAIVER PARTICIPANT'S SIGNATURE	DATE	DDA CASE / RESOURCE MANAGER'S SIGNATURE	DATE