Developmental Disabilities Administration (DDA)

Lake Burien Transitional Care Facility
Specialized Treatment Referral

Upon CRM completion of this referral, the CRM must submit the referral and application packet to LakeBurienTCF@dshs.wa.gov.

Youth's Name	ADSA ID Number	☐ Male ☐ Female ☐ Non-Binary	Date of Birth	Age
Name(s) Youth Prefers to be called / Pronouns	Preferred Language of Youth		Date of Request	
Parent / Legal Guardian's Name	Preferred Language of Youth's Parent / Guardian	DDA CRM		Region

Current setting; start date:

- ☐ Family home
- ☐ Out-of-Home Setting such as OHS or DCYF placement
- ☐ Out-of-State Facility or Educational Setting
- ☐ Psychiatric Facility or CLIP
- ☐ Other:
- ☐ Hospital (admitted or emergency room)
- ☐ Residential Habilitation for Dependent Youth
- ☐ Juvenile Detention or Juvenile Rehabilitation Facility

Step 1. Eligibility Criteria (to be determined by DDA CRM)

1. DDA-eligible under Chapter 388-823 WAC or assessed to have a diagnosed neurodevelopmental disorder, another neurological, or other genetic condition: ☐ Yes ☐ No
2. Is age 13 – 17 years old: ☐ Yes ☐ No
3. Has accessed all appropriate and available less restrictive services and the youth's assessed health care needs exceed what is available in the community.
   ☐ Yes (**as evidenced by Step 1.A. and 1.B. below**) ☐ No

Step 1.A. Need for Services (to be completed by DDA CRM)

List treatment services and supports in each domain that have been tried and provide detail as to how these failed to meet the need. Examples may include services provided by private insurance, physical and behavioral health benefits under Medicaid, and DDA services:

☐ Mental Health services:

☐ Behavioral Support services:

☐ Physical Health services:

☐ Educational supports:

☐ DDA services:

☐ Any additional Community services:

☐ Substance Use Disorder services (if applicable):

Step 1.B. Complex Support Needs affecting success in the community setting (to be completed by DDA CRM)

Mark each applicable behavior(s) exhibited, identifying if it is in their current and/or the most recent past setting.
Place an * next to the prominent behavior(s) that impact the client from receiving supports in the community.

	CURRENT	PAST		CURRENT	PAST		CURRENT	PAST
Anorexia	☐	☐	Loud vocalizations	☐	☐	Suicidal action(s)	☐	☐
Arson / Fire Setting	☐	☐	Physical aggression	☐	☐	Takes other's property	☐	☐
Biting	☐	☐	PICA	☐	☐	Verbal aggression	☐	☐
Bulimia	☐	☐	Property destruction	☐	☐	Wandering	☐	☐
Elopement	☐	☐	Self-injurious	☐	☐	Other (specify)	☐	☐
Encopresis / enuresis	☐	☐	Sexually inappropriate	☐	☐			
Head banging	☐	☐	Substance Use Disorder	☐	☐			

☐ Please list all current I/DD diagnosis:

☐ Please list all current Behavioral health diagnosis:

Step 2. Eligibility Criteria to be completed by Regional Clinical Team

- Has a serious psychiatric diagnosis: ☐ Yes ☐ No
- Experiences a severity, intensity, and frequency of behavior that: ☐ Yes ☐ No
  - Significant impairment of a youth's functioning and
  - Prevents the youth from being safely supported in a less restrictive setting.

Recommendation and Signature

The Regional Clinical Team recommends application to Lake Burien Transitional Care Facility: ☐ Yes ☐ No

SIGNATURE OF RCT REPRESENTATIVE	DATE	PRINTED RCT REPRESENTATIVE'S NAME