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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Adult Family Home (AFH) Referral Checklist** | | | | | |
| CLIENT NAME | | DDA CASE NUMBER | CRM / SW / SSS NAME | | | |
| ADULT FAMILY HOME (AFH) PROVIDER NAME | | AFH TELEPHONE NUMBER (INCLUDE AREA CODE) | | | CELL PHONE/PAGER NUMBER | |
| PROVIDER’S STREET ADDRESS | | | | | | |
| **Provider Issues** | | | | | | |
| 1. Confirm the following per the DDA PQIS or via the Aging and Disability Services AFH database:  Date:  Current AFH license:  Yes  No MH Specialty designation:  Yes  No  Current DSHS AFH contract:  Yes  No Dementia Specialty designation:  Yes  No  DD Specialty designation:  Yes  No Conditions on license:  Yes  No If yes, specify: | | | | | | |
| Licensed capacity: | | | | | | |
| 2. Per the PQI staff or AFH provider: Number of current residents: | | | | | | |
| **Referral Process** | | | | | | |
| 1. Release of Information form Date:  2. Discuss referral need with AFH PQI staff Date:  3. Discussion of individual’s needs/referral with provider Date:  4. Delivery of referral packet to provider (Form DSHS 10-232A) Date:  5. Pre-move visit Date:  6. Is nurse delegation assessment required:  Yes  No  If “Yes,” give the date of the completed Nurse Delegation assessment Date:  (**this must occur no later than the date of move**)  Is AFH trained and willing to do nurse delegation:  Yes  No | | | | | | |
| **Service Authorization** | | | | | | |
| 1. Date of current DDA assessment:  Daily Rate:  ETR:  Yes  No Amount:  Behavior Point Score:  (if eligible for Meaningful Day, contact MD Specialist)  2.  Basic Plus  Non-Waiver  PCSP includes AFH service:  Yes  No  3. Date of move:  4. Start date of AFH payment authorization: | | | | | | |
| **Comments** | | | | | | |
| LEGAL REPRESENTATIVE | | LEGAL STATUS | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | |
| CLIENT REPRESENTATIVE FOR NSA | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | |
| COMMENTS | | | | | | |
| CRM SIGNATURE | | | | | | DATE |