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|  | | | DEVELOPMENTAL DISABILITIES ADMINISTRATION  AGING AND LONG-TERM SUPPORT ADMINISTRATION  **Individual With Challenging Support Issues** | | | | CLIENT’S NAME | | | |
| DATE OF BIRTH | | | |
| MENTAL HEALTH DIAGNOSIS  Yes  No | | PSYCHOLOGICAL/BEHAVIORAL ASSESSMENT  Yes  No Date: | | | DDA IDENTIFICATION NUMBER | | CLIENT ACES ID NUMBER | | | REGION |
| **Section 1. Check one or all that apply (documentation must be present in file** | | | | | | | | | | |
| HISTORY OF OCCURRENCE Check all relevant boxes below. INDICATE FREQUENCY AS  DAILY, WEEKLY, OR MONTHLY  1 – 2 YEARS 3 – 5 YEARS 5+ YEARS | | | | | | | | | | |
| **Assaultive** (significant aggression or physical abuse toward others)  Describe: | | | | | | Frequency: | | | | |
| **Destructive** (significant property destruction which puts self or others at risk)  Describe: | | | | | | Frequency: | | | | |
| **Self-Injurious** (suicidal behavior; significant self-injury, danger to self)  Describe: | | | | | | Frequency: | | | | |
| **History of misdemeanor-type behavior. May or may not have been charged** (shoplifting, theft, trespassing, buying liquor for minors, forgery, malicious mischief, motor vehicle citations, disturbing the peace, etc)  Describe: | | | | | | Frequency: | | | | |
| **Inappropriate sexual behaviors** (that are not for sexual gratification: e.g., exposing, undressing in public)  Describe: | | | | | | Frequency: | | | | |
| **Section 2. (Only complete if agency requires) Addendum** | | | | | | | | | | |
| INFORMATION VERIFICATION BY:  Police report  Court records  Self-report  Parent/guardian  Psycho-sexual assessment  Other (specify): | | | | COOPERATION WITH SUPERVISION  Yes  No  Unknown  Other (specify): | | | | CURRENT DAY PROGRAM  Employment  School  Community access  None Other | | |
| CURRENT RESIDENCE (SEE STAFF INSTRUCTIONS)  AFH  AL  ARC  CFH  CH  CPRS  DOC  EARC  ESF  ESH  GH/GTH  ICF/ID   JRA  SL  WSH  Own home  Parent/relative home  Other (specify): | | | | | | | | | | |
| SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, ETC.) | | | | | | | | | | |
| GUARDIANSHIP  Yes  No | NAME | | | | | | | | TYPE  Full  Limited | |
| LEGAL STATUS  Current charge pending; if checked, specify:  Competent to stand trial  Incompetent to stand trial  Not Guilty by Reason of Insanity (NGRI)  Current Less Restrictive Alternative (LRA) (attach copy of court order)  Currently in jail; projected release date:  Probation/parole (attach conditions of probation)  Conditional release (attach conditions of release) | | | | | | | | | | |
| **This form was completed based on available information.** | | | | | | | | | | |
| CASE/RESOURCE MANAGER’S SIGNATURE DATE | | | | | | | | | | |
| **DISTRIBUTION:** Case Management File Client File Agency File | | | | | | | | | | |

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| Instructions for Individual with Challenging Support Issues  This form must be part of the client’s referral packet provided to residential providers.  Copies will be kept in the:   * Client record; and * Client file maintained by the residential program.   Case manager/social worker responsibilities:   * Provide the forms/copies to the residential provider; and * Keep the client information on the form current.   Residential provider responsibilities:   * Maintain the client files; * Ensure the safety of all clients; and * Inform DSHS of any change of condition with regard to the person’s challenging support issues.   DEFINITIONS:  Mental Health Diagnosis: Indicate only “Yes” or No.” Additional information about mental health is in the client’s record.  DDA Identification Number: This number is the case identifier of the authorizing agency.  RESIDENCE TYPES:  AFH Adult Family Home  AL Alternate Living  ARC Adult Residential Care facility licensed as an Assisted Living facility  CFH Children’s Foster Home  CH Companion Home (contracted with DDA)  CPRS Community Protection Residential Services (Supported Living)  DOC Department of Corrections  EARC Enhanced ARC facility  ESF Enhanced Services Facility  ESH Eastern State Hospital  GH Group Home (contracted with DDA) with an Assisted Living license  GTH Group Training Home  ICF/ID Intermediate Care Facility for Individuals with Intellectual Disabilities  JRA Juvenile rehabilitation facility  SL Supported Living Services  WSH Western State Hospital  SIGNATURES:  Case / Resource Manager’s signature: Signature of the staff completing the form. |