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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)  NURSING FACILITY (NF)  RESIDENTIAL HABILITATION CENTERS (RHC) | | | | | | | | |
| **Request for ICF/IID or NF Services at an RHC Admission Application**  Upon CRM completion of this application, the CRM Supervisor must submit the packet to [RHCAdmission@dshs.wa.gov](mailto:RHCAdmission@dshs.wa.gov). | | | | | | | | | |
|  | | | | | | | | | |
| CLIENT’S NAME | | | ADSA ID NUMBER | | | Male  Female | | DATE OF BIRTH | AGE |
| NAME(S) CLIENT PREFERS TO BE CALLED | | | | | | | | DATE OF REQUEST | |
| Does this client have a court appointed guardian?  No  Yes; if yes, provide contact information and copy in the referral packet. | | | | | | | | | |
| GUARDIAN’S NAME | | | GUARDIAN’S PHONE | | | GUARDIAN’S EMAIL | | | |
|  | | | | | | | | | |
| INTERPRETER SERVICES  No Yes; if yes, specify language: | | | | | | | | | |
|  | | | | | | | | | |
| DDA CRM | | | | REGION | | TELEPHONE (WITH AREA CODE) | | | |
| **Current setting; start date:** | | | | **Identify the associated setting primary contact information:** | | | | | |
| Family home  Own home (including Supported Living);  Adult Family Home  Hospital (admitted or emergency room)  Psychiatric Facility or Jail  Other: | | | | PROVIDER / PRIMARY CAREGIVER / FACILITY NAME | | | | | |
| ADDRESS | | | | | |
| CONTACT NAME AND TITLE | | | | | |
| CONTACT PHONE (WITH AREA CODE) | | | | | |
| CONTACT EMAIL | | | | | |
| **RHC requested service(s) and location(s) (Check all that apply)** Reference [DDA Policy 17.01.02](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf) | | | | | | | | | |
| ICF/IID:  Fircrest School  Lakeland Village  Rainier School  Documented SER in CARE: Client and legal representative have received the RHC [ICF brochure](https://www.dshs.wa.gov/os/publications-library?combine=&field_program_topic_value=All&field_job__value=22-1885&field_language_available_value=All) and have been informed that ICF/IID services are temporary and once discharge criteria has been met transition will begin.  Documented SER in CARE: Client and legal representative have been provided information on applicable crisis stabilization services (i.e: waiver stabilization, diversion beds, IHS, SAIF).  NF:  Fircrest School  Lakeland Village  Crisis Stabilization at Yakima Valley School | | | | | | | | | |
| **Indicate applicable documents provided with this application with the date the document was last updated:** | | | | | | | | | |
| Current DDA Assessment:  Consent (DSHS 14-012):  Cross Systems Crisis Plan:  Guardianship documents:  Hospital / medical records: | | | | | Incident reports  Psychiatric evaluation(s):  Positive Behavior Support Plan:  SOTP Risk Assessment:  Other description: | | | | |
| **Social Summary** | | | | | | | | | |
| Relevant history: Please identify the unmet need and/or skills required for supports in the community to be achieved and include pertinent hospitalizations, mental health information, such as prescriber, DDA and community services received to date, recent changes in residence settings and significant events that lead to this request and indicate, if known, the discharge plan: | | | | | | | | | |
| **Challenging Behaviors OR**  **No Challenging Behaviors** | | | | | | | | | |
| 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  Anorexia  Biting  Bulimia  Elopement  Encopresis / enuresis  Head banging | | CURRENT PAST  Loud vocalizations  Physical aggression  PICA  Property destruction  Self-injurious  Sexually inappropriate | | | | | CURRENT PAST  Suicidal action(s)  Takes other’s property  Verbal aggression  Wandering  Other (specify) | | |
| **Support Needs** | | | | | | | | | |
| For clients currently or within the past six months receiving community residential habilitation services, CRM please work with the applicable Resource Manager to complete 1 – 5 from the residential rate assessment:   1. Effective date: 2. Single Person Household (SPH) 4, 5, 6:  No  Yes, if yes, comments: | | | | | | | | | |
| 1. Exception to Policy (ETP) for SPH or Tier 9:  No  Yes, if yes, comments: | | | | | | | | | |
| 1. Two – one support column needs:  No  Yes, if yes, list domain with correlating hours per week: | | | | | | | | | |
| 1. Additional comments related to specialized supervision and supports: | | | | | | | | | |
| For clients currently or within the past six months receiving Out-of-Home (OHS) Services, please attach the staffed residential rate assessment (DSHS 10-326) with this application.  Yes, attached.  For clients receiving services in any other setting:  Identify awake, night and community supervision needs: | | | | | | | | | |
| Restrictions in place at current setting (door / window alarms, food restrictions, mechanical restraints etc.): | | | | | | | | | |
| Describe any medical and accessibility support needs and/or adaptive equipment required (ramp, roll-in shower, shower chair, Hoyer lift, etc.): | | | | | | | | | |
| Select the type of assistance needed to take medications, apply medicated ointments or administer drops  None (if applicable):  Supervision only  Verbal prompts  Hand in cup  Crushed in food  Physical assistance  Medications administered via enteral feeding  Other: | | | | | | | | | |
| **Other Information** | | | | | | | | | |
| List any other pertinent information including preferred activities, like / dislikes, strengths, abilities: | | | | | | | | | |