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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Residential Quarterly Report for Children’s Residential Services** For Licensed Staffed Residential, Group Care Facility, and SOLA |
| CLIENT’S NAME | CONTRACTED / STATE OPERATED PROVIDER |
| PERSON SUBMITTING REPORT | RESIDENCE / HOUSE NAME |
| REPORTING PERIOD | DATE SUMITTED |
| **Shared Parenting and Relationships** |
| **Parent / Guardian 1** | NAME | Number of days visited this quarter:  Number of other contacts this quarter:   |
| **Parent / Guardian 2** | NAME | Number of days visited this quarter:  Number of other contacts this quarter:   |
| **Other Family or Friends** | NAME | Number of days visited this quarter:  Number of other contacts this quarter:   |
| SUMMARIZE THE PARENT INVOLVEMENT IN THIS QUARTER. |

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| HOW HAS THIS CLIENT PARTICIPATED IN THEIR PERSONAL CULTURE, TRADITIONS, AND EVENTS THIS QUARTER? |

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| **Independent Living Skills / Skills Acquisition / Teaching Strategies** |
| **Target Skill 1** | GOAL |
| **Target Skill 2** | GOAL |
| **Target Skill 3** | GOAL |
| **Target Skill 4** | GOAL |
| **Target Skill 5** | GOAL |
| **Target Skill 6** | GOAL |
| **Target Skill 7** | GOAL |
| **Target Skill 8** | GOAL |
| SUMMARIZE THE CLIENT’S PROGRESS WITH INDEPENDENT LIVING SKILLS. REFER TO SKILL DEVELOPMENT TRACKING DATA AND INCLUDE CHARTS OR GRAPHS AS APPLICABLE. |

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| **Behavior Support** |
| DATE OF CURRENT PLAN | PLAN AUTHOR AND AGENCY | Has the plan been updated in the last quarter: [ ]  Yes [ ]  No |
| **Target Behavior 1** | GOAL |
| **Target Behavior 2** | GOAL |
| **Target Behavior 3** | GOAL |
| **Target Behavior 4** | GOAL |
| **Target Behavior 5** | GOAL |
| **Target Behavior 6** | GOAL |
| **Target Behavior 7** | GOAL |
| **Target Behavior 8** | GOAL |
| SUMMARIZE PROGRESS WITH THE TARGET BEHAVIORS AND ANY NOTABLE OBSERVATIONS. REFER TO BEHAVIOR TRACKING DATA AND INCORPORATE CHARTS OR GRAPHS, IF APPLICABLE. SUMMARIZE CHANGES THAT OCCURRED TO THE BEHAVIORAL PLAN, IF ANY. |

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| **New Behaviors** | GOAL |
| DESCRIBE ANY NEW CHALLENGING BEHAVIORS THAT HAVE NOT BEEN ADDRESSED BY THE BEHAVIORAL PLAN, HOW DIRECT CARE STAFF ARE RESPONDING TO THESE BEHAVIORS AND WHETHER ADDITIONAL SUPPORT OR PLANNING IS NEEDED. |

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| **Significant Incidents** |
| SUMMARIZE CLIENT INCIDENTS THAT OCCURRED IN THIS QUARTER AND ANY RELATED TRENDS OR OBSERVATIONS. LIST THE NUMBER OF TIMES EACH TYPE OF INCIDENT OCCURRED. FOR EXAMPLE, HOW MANY INCIDENTS WERE RELATED TO SIB, ASSAULTS, HOSPITALIZATIONS, MED ERRORS, ETC. |

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| **Health / Medical / Treatments or Therapies** |
| Current weight:  |
| SUMMARIZE THE CLIENT’S HEALTH THIS QUARTER. INCLUDE ANY NEW DIAGNOSES OR SIGNIFICANT CHANGES IN THE CLIENT’S FUNCTIONING OR CONDITION. DESCRIBE ANY SIGNIFICANT ILLNESSES, THEIR EFFECTS, AND ANY INTERVENTIONS. |

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| WHAT ONGOING SERVICES OR TREATMENTS DOES THIS CLIENT RECEIVE (ABA, WISe, ETC.)? WHAT ADDITIONAL SERVICES ARE NEEDED, IF ANY? |

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| SUMMARIZE THE CLIENT’S TYPICAL SLEEP PATTERN IN THIS QUARTER. INCLUDE NIGHTTIME SLEEP AND DAYTIME NAPS. IF APPLICABLE, ALSO EXPLAIN NIGHTTIME BEHAVIORS OR OTHER FACTORS THAT INTERFERE WITH SLEEPING. |

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| Compared to the previous quarter, the sleep pattern is generally: [ ]  The same [ ]  Changed |
| REPORT ANY SPECIAL DIETARY OR NUTRITIONAL NEEDS AND HOW THEY ARE BEING MET. |

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| Compared to the previous quarter, the diet is generally: [ ]  The same [ ]  Changed |
| **Appointments** | List each medical, dental, mental health, therapy session that occurred this quarter. Include appointments that occurred in the residence, clinic, community, or other locations. Add copies of this chart or attach a separate log if needed to report all appointments in this quarter. |
| DATE | PROVIDER | REASON | COMMENTS(OUTCOME, RECOMMENDATIONS, FOLLOW UP, ETC.) |
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| **Medications** | List all current prescribed medications, supplements, or PRNs given. Add copies of this chart or attach a separate log if needed to report all medications. |
| CURRENT MEDICATIONS | PURPOSE | DOSAGE AND FREQUENCY | CHECK IF NEW, CHANGED, OR DISCONTINUED THIS QUARTER |
| N | C | D |
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| **Education / Transitional Services** |
| SCHOOL DISTRICT OR TRANSITION SERVICE AGENCY | SCHOOL OR PROGRAM | GRADE |
| TEACHER OR PRIMARY CONTACT | DATE OF CURRENT IEP | HAS THE PROVIDER RECEIVED THE CURRENT IEP?[ ]  Yes [ ]  No | DATE OF NEXT IEP MEETING (IF KNOWN) |
| Does the client attend a full school day? [ ]  Yes [ ]  No |
| SUMMARIZE UPDATES FROM SCHOOL / TRANSITIONAL SERVICES. INCLUDE ANY CHANGES TO THE CLIENT’S IEP (IF APPLICABLE). |

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| EXPLAIN ANY ABSENCES, INCLUDING ILLNESS, REFUSAL, SUSPENSION, OR OTHER. |

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| **Activities** |
| SUMMARIZE HOW THE CLIENT USUALLY SPENDS THEIR TIME IN THE RESIDENCE. COMMUNITY ACTIVITIES WILL BE REPORTED ON ATTACHMENT 1. |

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| DESCRIBE ANY BARRIERS THAT MAY BE PREVENTING THIS CLIENT FROM ENGAGING IN MORE PREFERRED ACTIVITIES IN THE COMMUNITY OR IN THE RESIDENCE. |

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| WHAT ELSE WILL BE DONE TO HELP THIS CLIENT LIVE THE LIFE THEY WANT? |

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| SUBMITTED BY SIGNATURE DATE | NAME AND ROLE |
| APPROVED BY SIGNATURE (IF APPLICABLE) DATE | NAME AND ROLE |
| DATE SENT TO DDA | DATE SENT TO FAMILY |
| **Attachment 1** |
| **Community Activities / Community Inclusion** |
| This is a report of ALL of the client’s activities in the community except for school attendance, professional appointments, and family visits. School, professional, and family activities may be reported if other community inclusion elements occurred AND a direct support professional was present to facilitate the activity. The use and balance of Community Inclusion Funds is also reported. Add copies of this page as needed. |
| CLIENT’S NAME | CONTRACTED / STATE OPERATED PROVIDER |
| RESIDENCE / HOUSE NAME | LEDGER START DATE | LEDGER START BALANCE**$** |
| DATE | ACTIVITY TYPE / DESCRIPTION (OR REPORT FUNDS ADDED OR HOW FUNDS WERE USED) | PARTICIPATED, ATTEMPTED, OR DECLINED | STAFF NAME AND SIGNATURE FOR FUNDS USED | $ AMOUNT | BALANCE |
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|  | LEDGER END DATE | LEDGER END BALANCE**$** |
| SIGNATURE OF PERSON SUBMITTING THIS FORM DATE  | NAME AND ROLE |