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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  CASE RESOURCE MANAGER (CRM)  **DDA Youth Transitional Care Facility Admission Checklist** | | | | | | | | | | | | |
| **To Be Completed by Facility Staff.** | | | | | | | | | | | | | |
| YOUTH’S NAME | | | | | | | | ADSA ID NUMBER | | DATE OF BIRTH | | AGE | |
| YOUTH’S HEIGHT / WEIGHT | | PARENT OR LEGAL GUARDIAN’S NAME | | | | | | PARENT OR LEGAL GUARDIAN’S PHONE NUMBER (INCLUDE AREA CODE) | | | | | |
| PARENT OR LEGAL GUARDIAN’S ADDRESS | | | | | | | PARENT OR LEGAL GUARDIAN’S EMAIL ADDRESS | | | | | | |
| DATE DECISION APPROVED | | | | PRE-ADMISSION MEETING DATE | | | | | ADMISSION DATE | | | | |
| **Field Services CRM:** Provide the following in the referral packet. | | | | | | | | | | | | | |
| **EVALUATION / ASSESSMENT** | | | **RECEIVED** | | **N/A** | **EVALUATION / ASSESSMENT** | | | | | **RECEIVED** | | **N/A** |
| DDA Assessment | | |  | |  | Incident Report | | | | |  | |  |
| Behavior Support Plan | | |  | |  | Individual Education Plan | | | | |  | |  |
| Cross Systems Crisis Plan | | |  | |  | Pending Criminal Charges | | | | |  | |  |
| Current Court Orders | | |  | |  | Psychiatric Evaluation | | | | |  | |  |
| Guardianship Document (certified) | | |  | |  | SOTP Risk Assessment | | | | |  | |  |
| Health and Physical - annual | | |  | |  | Other: | | | | |  | |  |
| **Field Services CRM:** Support the facility to receive the following documents **before admission**. | | | | | | | | | | | | | |
| **IDENTIFICATION** | | | **RECEIVED** | | **N/A** | **IDENTIFICATION** | | | | | **RECEIVED** | | **N/A** |
| Birth Certificate (certified preferred, copy acceptable) | | |  | |  | Medicaid / ProviderOne Card | | | | |  | |  |
| Current state Identification Card | | |  | |  | Medicare and/or Private Insurance card | | | | |  | |  |
| Immunization records | | |  | |  | Social Security Card | | | | |  | |  |
| **LBTCF: Before admission,** mark applicable box when the document is received or N/A, if applicable. | | | | | | | | | | | | | |
| **CONSENT FORM** | | | **RECEIVED** | | **N/A** | **CONSENT FORM** | | | | | **RECEIVED** | | **N/A** |
| Consent, DSHS 14-012 | | |  | | **Required** | Informed Consent | | | | |  | |  |
| Costs of Care, DSHS 16-279 | | |  | | **Required** | POLST or Advance Directive, if applicable | | | | |  | |  |
| Dental Consent | | |  | | **Required** | Resident Accounts / Rep Payee, if applicable | | | | |  | |  |
| DSHS Notice of Privacy Practices for Client Medical Information, DSHS 03-387 | | |  | | **Required** | Consent and Treatment Agreement | | | | |  | | **Required** |
| School enrollment | | |  | |  |  | | | | | | | |
| FIELD SERVICES CRM SUPPORT THE FACILITY TO OBTAIN THE FOLLOWING RECORDS **BEFORE ADMISSION**:  Current verified (i.e., by pharmacy) medication list and orders  Any adverse drug reactions or allergies, if known  Dietary related needs  Family history (major cardiovascular, respiratory, diabetes, stroke, intellectual or developmental disabilities, psychiatric illnesses)  Previous medications, if any, for psychiatric related issues  Birth and developmental history (i.e., type of birth - vaginal, C-section; trauma or complications during pregnancy or delivery, early childhood development, onset of delays, etc.)  Date of last dental visit  Date of last ophthalmology / optometry visit, if applicable  Date of last audiology visit, if applicable  Past medical history (major childhood illnesses, surgeries) | | | | | | | | | | | | | |