Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Provider Referral Letter for Children's Out-of-Home Services

Date

Dear Provider,

I am referring **Client's Name** to you for Children's Out-of-Home Services. This client is moving from **Setting** and requires supports within **Time Frame**.

FUNDING Choose one: ☐ CORE Waiver ☐ Non-waiver ☐ Roads to Community Living (RCL)	
ENCLOSED	
☐	Current signed and dated consent, DSHS 14-012.
☐	Social Summary that includes a family profile, strengths of the child and family, past and current services and treatments that have been accessed through private insurance, the Medicaid state plan and DDA, hospitalization history and relevant school information (such as specialized program, shortened school day, one on one para educator, etc.).
☐	The client's current DDA Assessment details and Person Centered Service Plan (PCSP).
☐	The client's current behavioral support plan, for example Functional Assessment (FA) and Positive Behavior Support Plan (PBSP), and/or Applied Behavioral Analysis (ABA) plan, if applicable.
☐	Copies of the most recent psychological and/or mental health evaluations, for example, behavioral and psychiatric information, treatment plans, and/or child and family care plans (WISe Services).
☐	Incident Reports (IR) from the past six (6) months, if applicable.
☐	Educational records, including Individualized Education Program (IEP), School Evaluation, and Behavior Intervention Plan (BIP).
☐	Medical history, hospital discharge summaries, medications, and/or specialized protocols for example, seizure protocol or medical device protocol.
☐	Immunizations records.
☐	A nurse delegation assessment if currently receiving nurse delegation services.
For individuals with Challenging support Issues:	
☐	DSHS 10-234, Individual with Challenging Support Issues.
☐	Cross System Crisis Plan (CSCP) and/or Safety Plan, if applicable.
☐	Enhanced Respite Services Data Summary and Recommendations form, DSHS 10-584, if applicable.
Legal Information:	
☐	Parenting plan, guardianship, adoption, and/or court orders, if applicable.
☐	Criminal history, if applicable.

To expedite this referral, please do the following:

☐ Read through the referral packet and request any additional documentation needed.
☐ Meet with the client, family, legal representative, current provider, etc.
☐ Contact the Case Resource Manager (see DDA Assessment for Contract Information) to discuss client support needs.

Thank you for considering this individual for services.

Sincerely,

OHS RESOURCE MANAGER _____ TELEPHONE NUMBER _____

Provider Response

The Children's Out-of-Home Services provider must evaluate the referral and respond to the resource manager within 10 working days of receipt of the referral packet.

If interested in exploring further:

☐ I agree to support this client if the parent or legal guardian agrees.

☐ I would like to discuss additional considerations with the resource manager (RM) such as environmental modifications, 2:1 staffing, single person household, etc).

☐ I would like more information about: _____

If declined:

I decline this referral for the following reason (select one or more):

☐ Agency doesn't not want to pursue licensing of an additional home at this time.

☐ Unable to recruit and retain enough staff within timeline desired for start of services.

☐ Do not have management or program staff or DSP expertise to meet client's unique needs.

☐ Housemate match is not compatible.

☐ Parent or guardian expectations cannot be met.

☐ Other (please explain):

Per my contract, I have ☐ returned or ☐ destroyed the referral packet.

If a decision is not possible within 10 days, the service provider will consult with the RM to mutually agree on an extended timeframe.

AGENCY NAME AND DESIGNEE FOR REFFERAL RESPONSE DATE