Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

# COUNTY SERVICE AUTHORIZATION
## For FY2006

| STAFF COMMENTS |
|---|
| |

| 1. CLIENT NAME | 2. DD CASE NUMBER |
|---|---|
| | |

| 3. STREET ADDRESS | APT. NO. | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

| 4. BIRTHDATE | 5. SOCIAL SECURITY NUMBER | 6. TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) |
|---|---|---|
| | | |

| 7. CONTACT PERSON | 8. RELATIONSHIP TO CLIENT | 9. TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) |
|---|---|---|
| | | |

10. **SERVICES AUTHORIZED**:

- ☐ Group Supported Employment
- ☐ Pre-Vocational Services
- ☐ Child Development
- ☐ Community Access
- ☐ Person to Person
- ☐ Individual Employment
- ☐ Individual and Family Assistance

The definitions for these services and funding sources are online at http://intra.ddd.dshs.wa.gov/program_support/county.shtml

Waiver descriptions are online at: http://intra.ddd.dshs.wa.gov/directors/waiver.shtml

11. **FUNDING SOURCE**: (Check one only. See Funding Source definitions.)

- ☐ **8** State Only
- ☐ **AF** IMR Client
- ☐ **BAS** Basic Waiver
- ☐ **BA9** Basic Waiver Emergency Asst.
- ☐ **B+** Basic Plus Waiver
- ☐ **B+9** Basic Plus Waiver Emergency Asst.
- ☐ **CO** Core Waiver
- ☐ **CP** Community Protection Waiver
- ☐ **8YP** State Only Client Proviso
- ☐ **BAP** Basic Waiver Proviso
- ☐ **B+P** Basic Plus Waiver Proviso
- ☐ **COP** Core Waiver Proviso
- ☐ **CPP** Community Protection Waiver Proviso
- ☐

ALTERNATIVE FUNDING SOURCES:

- ☐ **CC** Community College
- ☐ **CM** County Millage Money
- ☐ **DL** Department of Services for the Blind
- ☐ **EM** Employer Support
- ☐ **MH** Mental Health Division
- ☐ **PA** PASS/IRWE
- ☐ **PI** Superintendent of Public Instruction
- ☐ **PV** Private or Other Sources
- ☐ **VR** Division of Vocational Rehabilitation
- ☐

| 12. VENDOR AGENCY NAME | 13. AMOUNT AUTHORIZED |
|---|---|
| | |

| 14. BEGINNING DATE | 15. ENDING DATE | 16. DD CASE MANAGER SIGNATURE | DATE |
|---|---|---|---|
| | | | |

**TO BE COMPLETED BY COUNTY**

| 17. VERIFIED AMOUNT | 18. COUNTY SIGNATURE | DATE |
|---|---|---|
| $ per: ☐ Month ☐ Day ☐ Hour ☐ Contact ☐ Project ☐ Week | | |

**TO BE COMPLETED BY VENDOR AGENCY**
**Must be returned before billing for services.**

19. ☐ Client accepted for services: BEGINNING DATE

New Hire Benefits (check all that apply): ☐ A. Medical/Dental ☐ B. Vacation ☐ C. Sick Leave ☐ D. Retirement ☐ E. Other (specify):

20. ☐ Client not accepted: REASON NOT ACCEPTED

21. ☐ Client terminated from services: TERMINATION DATE | REASON FOR TERMINATION

22. ☐ Client has changed program: OLD PROGRAM | NEW PROGRAM | DATE OF CHANGE

| 23. VENDOR AGENCY SIGNATURE | DATE |
|---|---|
| | |

DISTRIBUTION: DDD Case File Client County Vendor

INSTRUCTIONS Division of Developmental Disabilities County Service Authorization, DSHS 14-219

**Purpose**

This form is used by the DDD Case Manager to authorize county contracted services per DDD Policy 4.11. The Vendor agency is responsible for meeting with the client and completing the vendor agency portion. The County is responsible for verifying the amount and unit of service.

**DD Case Manager Instructions**

The DD Case Manager completes items #1 - #16 as follows:

1. **Client Name** -- Enter the client's full name.
2. **DD Case Number** -- Enter the client's 6-digit DD case number.
3. **Address** -- Enter the client's address.
4. **Birthdate** -- Enter the client's birth date.
5. **Social Security Number** -- Enter the client's social security number.
6. **Telephone Number** -- Enter the telephone number where the client can be reached.
7. **Contact Person** -- Enter the name of the parent, guardian, or other residential care provider.
8. **Relationshi**p -- Enter the contact person's relationship to the client.
9. **Telephone Number** -- Enter the phone number of the contact person.
10. **Services Authorized** -- Check the type of county-contracted service to which the client is being referred. Authorize additional services only when the plan is written for multiple services. Refer to DD Policy on County Services for Working Age Adults.
11. **Funding Source** -- Check the appropriate funding source for the client. If not sure, please check with your resource manager for Source of Funds definitions. The boxes marked "Alternative Funding Sources" are not for billing purposes and the division inputs these for information only.
12. **Vendor Agency Name** -- Enter the name of the organization to which the client is being referred.
13. **Amount – Enter the amount authorized to be paid by the County.**
14. **Beginning Date** -- Enter the date the Vendor Agency is authorized to begin providing and billing for services.
15. **Ending Date** -- Enter the date services are to end if the referral is for a specific period of time. If services are to be provided on an ongoing basis, enter "ongoing."
16. **DD Case Manager Signature** -- Sign and date the form.

**County Instructions**

17. **Verified Amount** – Verify the amount and unit of service.
18. **County Signature** -- Sign and date the form.

**Vendor Agency Instructions**

19. **Accepted for Services** -- Check this box if the client is accepted to begin services and enter the beginning date. For a new hire, indicate employment benefits received.
20. **Not Accepted for Services** -- Check this box if the Vendor Agency cannot provide service to the client at this time and explain. Attach additional pages if necessary.
21. **Terminated From Services** -- If the client stops receiving a service, check this box. Show termination date and explain why the client is no longer being served. Attach additional pages if necessary.
22. **Client Has Changed Programs** -- Check this box if a program change has occurred and show the old and new program names.
23. **Vendor Agency Signature** -- The Vendor Agency employee authorized to accept or reject a referral should sign and date the form.