

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  
**Provider Referral Letter for Supported  
Living / Group Home Providers**

PROVIDER NAME AND ADDRESS

Dear \_\_\_\_\_,

I am referring \_\_\_\_\_ to you for :

Choose one. <input type="checkbox"/> CORE <input type="checkbox"/> Non-waiver <input type="checkbox"/> CPP <input type="checkbox"/> RCL <input type="checkbox"/> Other waiver awaiting approval for CORE or CPP		CLIENT NAME _____	Choose one. <input type="checkbox"/> As soon as possible <input type="checkbox"/> 60 – 90 days <input type="checkbox"/> Within one month <input type="checkbox"/> Long term planning
WAIVER STATUS (SL ONLY)		SERVICES NEEDED	
INCLUDED IN REFERRAL PACKET			
ENCLOSED	NOT AVAILABLE	TYPE OF INFORMATION	
<input type="checkbox"/>	<input type="checkbox"/>	History of residential services received from other providers	
<input type="checkbox"/>	<input type="checkbox"/>	Legal representative information and documentation	
<input type="checkbox"/>	<input type="checkbox"/>	Marital status and ages of children, if any	
<input type="checkbox"/>	<input type="checkbox"/>	The client's current DDA Assessment and Individual Support Plan (ISP)	
<input type="checkbox"/>	<input type="checkbox"/>	Dates, sources, and copies of the most recent psychological and/or mental health evaluations, including any behavioral and psychiatric information and treatment plans.	
<input type="checkbox"/>	<input type="checkbox"/>	A summary of incidents that warranted an Incident Report (IR) within the past 12 months.	
<input type="checkbox"/>	<input type="checkbox"/>	Criminal history, if applicable	
<input type="checkbox"/>	<input type="checkbox"/>	Educational and vocational records, including IEP information if available.	
<input type="checkbox"/>	<input type="checkbox"/>	Financial information (may be found in ACES), such as verification of SSI/SSA status, eligibility for financial assistance (e.g., food stamps, Medicaid), earned and unearned income and resources, payee information, and whether client is receiving SSP funds.	
<input type="checkbox"/>	<input type="checkbox"/>	Legal information, such as copies of court orders or legal action involving the client and names of perpetrator or victims of crime (if known, <u>need to know basis only</u> ). The client's expressed consent must be obtained before sharing this information. <u>Note</u> : The client cannot give consent to release names of victims	
<input type="checkbox"/>	<input type="checkbox"/>	Medical history, immunization records, and medications. <u>Note</u> : A client's Hepatitis B Virus (HBV) and HIV status are confidential and cannot be shared ( <a href="#">RCW 70.24.105</a> ).	
<input type="checkbox"/>	<input type="checkbox"/>	Nurse delegation assessments, when applicable.	
<input type="checkbox"/>	<input type="checkbox"/>	List of family members and names and addresses of all significant people in the client's life.	
<b>For individuals with Challenging support Issues:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<a href="#">DSHS 10-234, Individual with Challenging Support Issues</a>	
<input type="checkbox"/>	<input type="checkbox"/>	Describe the level of supervision and support needed by the client as identified in their DDA Assessment.	
<input type="checkbox"/>	<input type="checkbox"/>	Identify any significant risks to others posed by the client and what supports are necessary to manage these risks. This must include the risk posed by the client to vulnerable people (e.g., housemates, children, neighbors, schools, childcare centers, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Provide the names and phone numbers of people to call if the client's behavior becomes dangerous beyond the provider's ability to ensure the safety of the client or others.	
<b>For individuals with Community Protection Issues:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<a href="#">DSHS 10-258, Individual with Community Protection Issues</a>	
<input type="checkbox"/>	<input type="checkbox"/>	Most recent psychological and/or psychosexual evaluation/risk assessment.	

**To expedite this referral, please do the following:**

- Read through the referral packet and request any further documentation needed.
- Meet the client, family, legal representative, current provider, etc.
- Contact the Case Resource Manager to discuss client support needs.

\_\_\_\_\_  
CRM NAME

\_\_\_\_\_  
TELEPHONE NUMBER

- Inform the Resource Manager (RM) of your interest in pursuing this referral within 10 days of receipt of this packet.

\_\_\_\_\_  
RM NAME

\_\_\_\_\_  
TELEPHONE NUMBER

- Sign the cover letter and return an original signature to me.
- Destroy referral information if you are not interested in pursuing referral or do not place referral.

Thank you for considering this individual for services.

Sincerely,

\_\_\_\_\_  
CASE / RESOURCE MANAGER'S SIGNATURE

\_\_\_\_\_  
TELEPHONE NUMBER

**I have received the referral information for the individual named above. I have not yet accepted the individual for placement. If the person is not accepted, I will return all referral information to DDA.**

\_\_\_\_\_  
PROVIDER'S SIGNATURE

\_\_\_\_\_  
DATE

The residential service provider must evaluate the referral for service to determine whether the service provider has the resources to meet the client's needs. Within ten (10) working days of receipt of the referral packet, the service provider must notify the RM whether or not they accept the referral for further evaluation. If a decision is not possible within ten (10) days, the service provider will consult with the RM to mutually agree on an extended timeframe.