Out of Home Placement Request

Developmental Disabilities Division Phone (307) 777-7115 Fax (307) 777-6047

Date Submitted to DDD:		Chi	Adult DD: ☐ ildren's DD: ☐ ABI: ☐
Waiver Specialist:	Case Manager: (Name and Agency)		_
Participant Name:	Participant Age:		
IMPORTANT: No request for out of hon documentation from professionals outside Department of Family Services (DFS) to coplacement will not be considered without significant to the considered with significant to the considered without significant to the consider	e the DD system. The onduct a review of the h	e Division reserves the rinder of the common	ight to request
Waiver participants, who are not receiving extraordinary needs that cannot be me Habilitation services if the participant meet	et in current living a	arrangement, may requ	
Mark the most accurate descriptio documentation. <i>No request will be proc</i>			the required
 A substantial threat to a person's life or corroborated by the Department of Fan Note: Homelessness is defined by the in homelessness or inability to live sat jail, institution, nursing home, or reside Submit documentation from Department Protection & Advocacy Systems, Inc. 	mily Services or Protect death or incapacitation of fely in the home. Situation of the fely in the home of Family Services and the fely services and the f	tion & Advocacy Systems of the person's primary care ons that would not qualify in mbers who no longer wish t es, Developmental Disabi	s, Inc. egiver that results nclude living in an to be responsible. ilities Division or
 Situations where the person's condition documented that waiver residential ser Submit documentation from a physici person's life or health is in jeopardy. 	vices are the least rest	trictive, most appropriate	solution.
 Situations where a person has caused the home, or the person's condition proof others in the home. Submit documentation specific to the type 	esents a substantial ris	sk of physical threat to hi	mself, herself or
Situations where there are significant at to the person's health and safety, or the Submit documentation specific to the and/or professionals have been involved.	nd frequently occurring e health and safety of type and frequency of	g behavior challenges resothers in the home. behavioral challenges. What	sulting in danger
 Situations where the person's critical supervision to maintain the person's he Submit documentation from a physical person's situation that family and other 	ealth and safety. cian or medical profess	ional explaining what has	
 Loss of primary caregiver due to care inability to provide continuous care. Submit documentation from a professional from the mental health field 	sional from the medical	field, Department of Fami	ily Services, or a

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Plan of Care Date					
Date of psychological or neuropsychological report:		Diagnosis:			
Date of ICAP		Associated staffing ratio:	-		
ICAP Service Score (adults)		Requested staffing ratio:	-		
ICAP Adaptive Behavior Quotient (under 21)					
Current IBA	\$				
Additional Funding Requested:	\$				
Total Request:	\$				
	Home Plac	cement Decision			
Name:	R	eview Date:			
Presented by Case Manager: Via: (circle one) phon	e video in p	erson written			
Approves with request	Approves	Approves lesser Dollar amount			
Denies request	Requires more information				
Reason:					
Change in IBA:	Total Bud	dget Approved:			
Waiver Program Manager C	Date D	ivision Financial Manager	 Date		
Signature of DDD Administrator [Date				