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# STATE OF TENNESSEE

DEPARTMENT OF DISABILITY AND AGING (DDA)

FAMILY MODEL HOME (FMH) PLACEMENT REQUEST PACKET

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CONFIDENTIAL – FOR OFFICIAL USE ONLY

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## SECTION 1: INDIVIDUAL IDENTIFICATION

Full Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

DDA ID Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

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## SECTION 2: REQUESTING PARTY INFORMATION

Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## SECTION 3: SUPPORT COORDINATION (IF APPLICABLE)

Support Coordinator Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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**SECTION 4: PURPOSE OF REQUEST**

**Reason for Family Model Home Placement (attach additional pages if needed):**

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**Is the individual's current placement at risk?**

Yes  No

If yes, describe:

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**SECTION 5: CURRENT LIVING ARRANGEMENT**

- Family Residence
- Independent Living
- Hospital / Acute Care
- Group Home
- Other: \_\_\_\_\_

Length of Time at Current Placement: \_\_\_\_\_

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**SECTION 6: ELIGIBILITY & WAIVER STATUS**

DDA Eligibility Status:

Approved  Pending  Not Determined

Waiver Enrollment:

- ECF CHOICES
- CAC (Comprehensive Aggregate Cap)
- Self-Determination Waiver
- Other: \_\_\_\_\_

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## SECTION 7: MEDICAL AND FUNCTIONAL SUPPORT NEEDS

Primary Diagnosis / Disability:

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Secondary Diagnoses (if applicable):

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### **Mobility Status:**

Independent  Requires Assistance  Wheelchair  Bedbound

### **Level of Care Required:**

Minimal  Moderate  Extensive  24-Hour Supervision

### **Support Needs (check all that apply):**

- Medication Administration
- Behavioral Support
- Seizure Precautions
- Mobility Assistance
- Activities of Daily Living (ADL) Support
- Other: \_\_\_\_\_

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## SECTION 8: BEHAVIORAL AND SAFETY CONSIDERATIONS

- None Identified
- Elopement Risk
- Aggressive Behavior
- Self-Injurious Behavior
- Other: \_\_\_\_\_

Additional Details:

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## **SECTION 9: RISK SCREENING TOOL (REQUIRED)**

**Instructions: Check the highest applicable level in each category.**

### **A. Medical Risk**

- 0 – Stable, no skilled needs
  - 1 – Chronic condition, controlled
  - 2 – Requires routine monitoring or nursing oversight
  - 3 – High medical complexity (frequent intervention)
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### **B. Behavioral Risk**

- 0 – No behaviors
  - 1 – Mild (redirectable)
  - 2 – Moderate (episodic aggression, disruption)
  - 3 – Severe (frequent aggression, safety risk)
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### **C. Mobility / Fall Risk**

- 0 – Independent
  - 1 – Needs minimal assistance
  - 2 – Requires device or supervision
  - 3 – Non-ambulatory / high fall risk
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### **D. ADL Dependency**

- 0 – Independent
  - 1 – Needs cueing
  - 2 – Needs hands-on assistance
  - 3 – Fully dependent
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**E. Supervision Needs**

- 0 – None
  - 1 – Periodic checks
  - 2 – Frequent supervision
  - 3 – Continuous (24-hour)
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**TOTAL RISK SCORE:** \_\_\_\_\_ / 15

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**LEVEL OF CARE GUIDELINES**

- Level 1 (0–4 points) – Low Support Needs
  - Level 2 (5–8 points) – Moderate Support Needs
  - Level 3 (9–12 points) – High Support Needs
  - Level 4 (13–15 points) – Intensive / 24-Hour Care Required
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**SECTION 10: PLACEMENT PREFERENCES**

Preferred Geographic Location (Tennessee):

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Gender Preference for Household:

- Male  Female  No Preference

Environmental Preferences (pets, smoking, accessibility, etc.):

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**SECTION 11: FUNDING SOURCE**

- TennCare (Medicaid)
  - Private Pay
  - Other: \_\_\_\_\_
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**SECTION 12: REQUESTED TIMEFRAME**

- Immediate Need (0–7 Days)
  - Urgent (Within 30 Days)
  - Routine / Flexible
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**SECTION 13: ADDITIONAL INFORMATION**

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**SECTION 14: AUTHORIZATION**

I certify that the information provided is accurate to the best of my knowledge and is submitted for the purpose of determining appropriate placement through DDA services.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**FOR DDA / PROVIDER USE ONLY**

Date Received: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Risk Score Verified:  Yes  No

Level of Care Assigned:  1  2  3  4

Eligibility Verified:  Yes  No

Placement Status:

Approved  Pending  Denied

Notes:

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