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| Transforming Lives | Level II Pre-Admission Screening and Resident Review (PASRR) Follow-Up | NAME | |
| FACILITY NAME | |
| ADDRESS LINE 1 | |
| This review applies to all individuals who are confirmed to have an intellectual disability or related condition and who continue to reside in a nursing facility (NF) 90 days after the admission Level II or a significant change Level II. Follow-up will occur within 90 days of the Level II, and at least every six months thereafter, as long as the person remains in the nursing facility. | | ADDRESS LINE 2 | |
| ADSA ID | DATE OF BIRTH (MM/DD/YYYY) |
| PASRR ASSESSOR | | PHONE (WITH AREA CODE) | PHONE (WITH AREA CODE) |
| Admission Level II Significant change Level II  Date of admission:  Date of most recent Level II:  Date of previous follow-up:  For a significant change, indicate the  date of the significant change: Follow-up date: | | LEGAL REPRESENTATIVE OR NSA | |
| RELATIONSHIP | PHONE (WITH AREA CODE) |
| ADDRESS CITY STATE ZIP CODE | |

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| Section I. Follow-up Not Completed Within Timeframe | | | |
| Complete this section only if the Level II follow-up is not completed within established timeframes (within 90 days of the Level II, and at least every six months thereafter, as long as the person remains in the nursing facility).  Reason follow-up not completed within timeframe: | | | |
| NF resident refuses to participate. | | |  |
| NF resident’s medical condition is so severe that he or she is unable to participate at this time. | | |  |
| NF resident or guardian has asked for postponement of the meeting until a future date. | | |  |
| Other (describe below) | | |  |
| Comments: | | | |
| **IF FOLLOW-UP NOT COMPLETED WITHIN TIMEFRAME, SIGN AND DATE FORM AND SEND COPIES TO NF RESIDENT AND GUARDIAN OR NSA. FOR ALL OTHER FOLLOW-UP, CONTINUE TO SECTION II.** | | | |
| NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT) | TITLE | | |
| EMAIL | | TELEPHONE NUMBER (INCLUDE AREA CODE) | |
| SIGNATURE OF PERSON COMPLETING THIS FORM DATE | | | |

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| Section II. Follow-up By Phone or In-Person – Initial follow-up must be in person. Other follow-up must be in person if requested by NF resident or guardian. | |
| PHONE | IN-PERSON |

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| Section III. Participants | |
| NAME | ROLE |
| NAME | ROLE |
| NAME | ROLE |
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| Section IV. Documents Reviewed –Level II, professional evaluations, NF care plan, specialized service plans, etc. | |
| DOCUMENT NAME | DOCUMENT DATE |
| DOCUMENT NAME | DOCUMENT DATE |
| DOCUMENT NAME | DOCUMENT DATE |
| DOCUMENT NAME | DOCUMENT DATE |
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| Section V. Professional Evaluations – Document discussion of each professional evaluation recommended by PASRR. |
| Were any professional evaluations recommended in the most recent Level II or addendum or Level II follow-up?  Yes No |
| Describe any recommendations made by professional evaluations. |
| What goals were identified? |
| What actions are being taken by the NF to meet these goals? |
| Are the actions taken in response to the professional evaluations helping the NF resident meet the identified goals?  Yes No |
| Are any changes needed?  Yes No |
| If changes are needed, describe: |
| Does the NF resident identify any new goals?  Yes No |
| If so, what actions are required and by whom? |
| What is the planned interval until the next contact? |
| If any **new** professional evaluations are needed at this time, indicate below. |
| Physical therapy evaluation Reason:  Date of recommendation:  Date received: |
| Occupational therapy evaluation Reason:  Date of recommendation:  Date received: |
| Communication therapy evaluation Reason:  Date of recommendation:  Date received: |
| Behavior/mental health evaluation Reason:  Date of recommendation:  Date received: |
| Other evaluation Specify: Reason:  Date of recommendation:  Date received: |

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| Section VI. Specialized Services – Document discussion of each specialized service recommended by PASRR. | | | | |
| Are any specialized services in place?  Yes | | | No |  |
| What are the goals of each specialized service (SS)? | | | | |
| Are the specialized services helping the NF resident to meet the goals?  Yes | | | No |  |
| What actions are being taken by the NF to meet these goals? | | | | |
| Are the services and the service schedule working well for the individual? Yes No | | | | |
| Are any changes needed? | | | | |
| Does the NF resident identify any new goals?  Yes | | | No |  |
| If so, what actions are required and by whom? | | | | |
| What is the planned interval until the next contact? | | | | |
| Are any changes to specialized services needed?  Yes No  If so, check boxes and describe below. (Changes must also be recorded in DPMS): | | | | |
| **Assistive Technology**  Add Terminate  Change No change | Date Recommended: | Proposed Start Date: | | Actual Start Date |
| Comment: | | | | |
| **Behavior Support and Consultation**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | | Actual Start Date |
| Comment: | | | | |
| **Community Access**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | | Actual Start Date |
| Comment: | | | | |

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| **Community Engagement**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Community Guide** Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Family Mentor** Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Group Supported Employment**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Habilitative Therapy**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Individual Employment**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Individual Technical Assistance**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |

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| **Peer Mentor** Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Skilled Nursing** Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Specialized Equipment**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Staff/Family Consultation and Training**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Other DDA Service – specify in comments**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |
| **Other Service – Payment not DDA- authorized – specify in comments**  Add Terminate Change  No change | Date Recommended: | Proposed Start Date: | Actual Start Date |
| Comment: | | | |

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| Section VII. Community Transition – Document discussion of community transition options. |
| Is the individual interested in transitioning to a community setting?  Yes No |
| Is a community transition in process?  Yes No |
| If so, please describe discharge plan. |
| Could the person’s health and safety needs be optimally met in a community setting at this time?  Yes No |
| If the person’s health and safety needs can’t be optimally met in a community setting at this time, what are the barriers?  Currently needs a higher level of nursing supports, therapies, and/or medical supervision than is practical in a community setting or than the person’s medical plan would allow.  Currently experiencing frequent acute medical crises requiring intervention. New health status requires modification to home setting.  Current condition is not stable and predictable (unstable diabetes, unresolved wound, inability to reposition, choking/aspiration pneumonia risk, serious behaviors requiring inpatient evaluation and/or treatment, medically fragile condition paired with wandering behavior).  Previous home setting is inappropriate; appropriate setting being developed.  Other (describe): |
| Has the person/family/guardian met with a peer or family mentor?  Yes No |
| Describe discussion of family or peer mentorship. |
| Have referrals been made to DDA or HCS intake or other programs?  Yes No |
| Has a case manager been assigned?  Yes No |
| If the person is interested in transitioning to a community setting, what next steps are planned and who is responsible? |
| What is the planned interval until the next contact? |

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| NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT) | TITLE | |
| EMAIL | | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| SIGNATURE OF PERSON COMPLETING THIS FORM DATE | | |
| ADDITIONAL COMMENTS | | |

This form, along with documents listed in Section IV, must be forwarded to client and guardian or NSA.

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| **Planned Action** |

Based on a review of your records and conversations with you and others involved in your care, DDA has made the following determinations, effective as of the date of this notice.

## DDA has determined that:

* You do do not have an intellectual disability or related condition, as defined in federal regulations (42 C.F.R.

§483.102(3) and 42 C.F.R. §435.1010).

* You do do not meet the requirements for nursing facility level of care, as defined in WAC 388-106-0355.
* If you have an intellectual disability or related condition and you meet the requirements for nursing facility level of care, you do do not currently require specialized services in order to acquire skills or behaviors that will enable you to function with as much self-determination and independence as possible, and/or in order to prevent or slow the loss of your current functional status, while you reside at a nursing facility.

o If you have not been determined to require specialized services, that determination is based on the following reason(s):

You have a serious physical illness which results in a level of impairment so severe that you are not expected to benefit from specialized services.

You have a diagnosis of dementia which results in a level of impairment so severe that you are not expected to benefit from specialized services.

You are experiencing a delirium that prevents an accurate diagnosis.

DDA has not identified any services in addition to services provided by the nursing facility that will assist you to function with as much independence as possible, and/or prevent or slow any loss of your functional ability.

You are entering the nursing facility for 30 days or less to provide respite to in-home caregivers. You are entering the nursing facility for 7 days or less in an emergency situation requiring protective services.

* Your specialized service(s) is/are terminated for the following reason(s): You or your representative have requested this action.

The service goal or maximum therapeutic benefit of the service has been reached.

## Specialized services will be arranged or provided by DDA per 42 C.F.R. §483.120.

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| Assessor Signature: |
| Assessor Printed Name: |
| Assessor Title: |
| Assessor Phone: |
| Assessor Fax: |
| Assessor Email: |

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| **Notice to Nursing Facility:** The following professional evaluations are recommended to assess the individual’s current status  and make recommendations. Please forward completed evaluation and **updated** patient care plan to the PASRR Assessor within 30 days. |
| Physical therapy |
| Occupational therapy |
| Speech/communication therapy |
| Mental health/behavior support |
| Other *(specify)* |
| Comment: |
| **Any specialized rehabilitative services identified by the recommended professional assessments will be provided by**  **the nursing facility per 42 C.F.R. §483.45**. |

**This action is being taken per the following authority:**

WAC 388-106-0355

Am I eligible for nursing facility care services?

WAC 388-97-1920

Preadmission screening—Level I. WAC 388-97-2000

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| Preadmission screening and resident review (PASRR) determination and appeal rights.  WAC 388-97-1940 |
| Advanced categorical determinations, not subject to preadmission screening—Level II. |

WAC 388-97-1960

Preadmission screening—Level II.

# Your Appeal Rights

You have ninety (90) days from the receipt of this notice to appeal any of the following decisions:

* + That you do not have an intellectual disability or related condition;
  + That you do not meet the requirements for nursing facility level of care; or
  + That you are not in need of specialized services.

You have the following rights:

* + To decline or terminate services at any time.
  + To have another person represent you (DSHS does not pay for attorneys, but free or low cost legal assistance may be available in your community. For additional information call 1-888-201-1014);
  + To receive copies of all information used by DDA in making its decisions, and to view and copy your ADSA file (except for any documents that are exempt from disclosure under state or federal law or parts of the file that contain confidential information about other clients). Your assessor can assist you to obtain this information;
  + To submit documents into evidence;
  + To testify at the hearing and to present witnesses to testify on your behalf; and
  + To cross examine witnesses testifying for the department.

A form for requesting an administrative hearing is included.

# Residential Services

Residential programs and services that may be available to DDA clients include:

## Adult Family Homes

Adult Family Homes are regular neighborhood homes where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided. Some provide occasional nursing care. Some offer specialized care for people with mental health issues, developmental disabilities or dementia. The home can have two to six residents and is licensed by the state.

## Alternative Living Services

Alternative Living Services are instructional services provided by an individual contractor. The service focuses on community-based individualized training to enable a client to live as independently as possible with minimal residential services.

## Community Protection Program

The DDA Community Protection Program provides intensive 24-hour supervision for clients who have been identified as posing a risk to their community due to the crimes they have committed. This program is an opportunity for participants to live successfully in the community and continue to remain out of prison or other justice system settings.

Environmental and programmatic safeguards are in place to protect neighbors and community members, to the extent possible, from behaviors that pose a risk to people or property and/or interfere with the rights of others. This structured, specialized environment gives participants the opportunity to make positive choices to resolve or manage the behaviors that require intensive intervention and supervision.

## Companion Homes

Companion Homes provide residential services and supports in an adult foster care model to no more than one adult DDA client. The services are offered in a regular family residence approved by DDA to assure client health, safety, and well-being. DDA reimburses the provider for the instruction and support service. Companion homes provide 24-hour available supervision.

## Group Homes

Group Homes are community-based residences serving two or more adult clients and are licensed as either an assisted living facility or an adult family home. Group Homes contract with DDA to provide 24-hour instruction and support. The provider owns or leases the facility. Clients must pay participation for room and board to the service provider.

## Supported Living Services

Supported Living services offer instruction and support to persons who live in their own homes in the community. Supports may vary from a few hours per month up to 24 hours per day of one-to-one support. Clients pay for their own rent, food, and other personal expenses. DDA contracts with private agencies to provide Supported Living services.

## State Operated Living Alternatives (SOLA)

SOLA programs offer Supported Living services. SOLA programs are operated by DDA with state employees providing instruction and support to clients.

## Voluntary Placement Services (VPS)

Voluntary Placement Services offer a variety of supports to eligible children living in a licensed setting outside the family home, when the placement is due solely to the child's disability [(RCW 74.13.350).](http://apps.leg.wa.gov/rcw/default.aspx?cite=74.13.350) Services may include:

* Case management by a DDA social worker
* Residence in a DSHS Division of Licensed Resources (DLR) [foster home,](http://www.dshs.wa.gov/ca/fosterparents/index.asp) group care facility, or staffed residential home
* Respite care to the licensed provider
* Nursing, therapies and behavior supports not already covered through Foster Care Medical Unit (FCMU) or schools
* Shared Parenting Plan with the provider and the child's biological/adoptive parent that is designed and implemented to support the family unit while the child lives outside the family home



## DEVELOPMENTAL DISABILITIES ADMINISTRATION REQUEST FOR HEARING

Per Chapter 182-526 for DSHS hearing rules

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|  | | | | FOR AGENCY USE ONLY  Oral request taken | | |
| Name | | |
| Telephone Number | | |
| MAIL YOUR REQUEST TO THIS ADDRESS: OR FAX TO THIS NUMBER: OFFICE OF ADMINISTRATIVE HEARINGS (OAH) (360) 586-6563  PO Box 42489  Olympia, WA 98504-2489  I am requesting a hearing because I want to challenge the following decision made by the Developmental Disabilities Administration: | | | | | | |
| PRINT YOUR NAME HERE | | | | | | |
| ADDRESS OF PERSON REQUESTING HEARING | | CITY | | STATE | | ZIP CODE |
| TELEPHONE NUMBER (INCLUDE AREA CODE) | | | | | | |
|  | | | | | | |
| I am represented by (if you are going to represent yourself do not fill in the next two lines): | | | | | | |
| YOUR REPRESENTATIVE’S NAME | ORGANIZATION | | | TELEPHONE NUMBER | | |
| ADDRESS | CITY | | STATE | | ZIP CODE | |
|  | | | | | | |
| Do you need an interpreter or other assistance or accommodation for the hearing?  Yes No | | | | | | |
| If yes, what language or assistance? | | | | | | |