PURPOSE

The purpose of the Developmental Disabilities Administration (DDA) Preadmission Screening and Resident Review (PASRR) Program is to identify individuals with intellectual disabilities or related conditions (ID/RC) who have been referred for nursing facility (NF) care, to determine whether an NF is the most appropriate setting to meet the person’s needs, and to assure that the person receives any specialized services needed for ID/RC while receiving NF care. This policy establishes guidelines and outlines process instructions for DDA staff who work with individuals referred to NFs.

SCOPE

This policy applies to DDA Field Services staff.

DEFINITIONS

Client, for PASRR purposes, means a person who has been confirmed to have an ID/RC by a DDA PASRR Assessor through the PASRR process, regardless of whether the person meets eligibility criteria to receive services from DDA.

DDA PASRR Management System (DPMS) is the tool used by DDA PASRR staff to complete PASRR assessments and store PASRR data.
HCS means the state of Washington State Home and Community Services Division of the Aging and Long Term Support Administration.

PASRR Level I is the screening completed by a referring party when an individual is being referred to a Medicaid-certified nursing facility.

PASRR Level II means the evaluation completed by a DDA PASRR Assessor with a nursing facility resident (potential or current) referred by the PASRR Level I.

Person with an intellectual disability or related condition (ID/RC) or PASRR Client means a person who has an ID/RC as defined in Code of Federal Regulations (C.F.R.) Sec. 483.102.

RCL means the Roads to Community Living Program.

**POLICY**

When a PASRR client is interested in community transition and the PASRR Assessor determines the individual can be optimally supported in a community setting, the PASRR Assessor will make necessary referrals to the appropriate DDA or HCS worker to assist with community transition.

**PROCEDURES**

The PASRR Assessor will:

A. As part of the PASRR Level II process and each subsequent client contact, determine whether the PASRR client desires transition to a community setting and, if so, can currently be optimally served in a community setting.

B. If the individual desires community transition and can currently be optimally served in a community setting, determine whether the individual is a DDA or HCS client.
   1. If the individual is not a DDA client, but wants to apply to be a DDA client, provide the individual and guardian or NSA with any assistance needed to complete and submit the DSHS 14-151, Request for DDA Eligibility form.
   2. If the individual is not an HCS client, but wants to apply to be an HCS client, provide the individual and guardian or NSA with any assistance needed to complete and submit the DSHS 10-570, HCS Intake and Referral form.

C. If the individual is a DDA client, determine whether the individual is expected to need nursing facility care for 90 days or more.
1. If the individual is expected to need nursing facility care for 90 days or more, submit the DSHS 15-493, *PASRR Client Referral*, form by email to the Regional RCL Case Manager and copy the Regional Resource Manager Administrator.

2. If the individual is not expected to need nursing facility care for 90 days or more, submit the DSHS 15-493, *PASRR Client Referral*, form by email to a DDA supervisor for assignment to a DDA Case Manager.

3. The assigned RCL or DDA Case Manager will determine financial program eligibility, complete the DDA Assessment, RCL enrollment or waiver request, and will provide assistance with transition to a community setting.

4. The PASRR Assessor will work with the DDA Case Manager to provide information as needed.

5. The PASRR Assessor, in conjunction with the DDA Case Manager, will continue to follow up with the client as required by [DDA Policy 16.05, Post-PASRR Level II Follow-Up](#).

D. If the individual is an HCS client, the HCS Nursing Facility Case Manager will determine financial eligibility, complete the CARE Assessment, and provide assistance with transition to a community setting per the [Long Term Care Manual](#).

1. The PASRR Assessor will work with the HCS Case Manager to provide information as needed.

2. The PASRR Assessor, in conjunction with the HCS Case Manager, will continue to follow up with the client as required by [DDA Policy 16.05, Post-PASRR Level II Follow-Up](#).

**EXCEPTION**

Any exception to this policy must have the written prior approval of the Deputy Assistant Secretary.

**SUPERSESSION**

None.