Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL II

PASRR Level 2 Evaluation and Determination

NAME	ADSA ID	LEVEL II DETERMINATIONS DATE

ADDRESS	CITY	STATE	ZIP CODE

GUARDIAN'S / NSA NAME

ADDRESS	CITY	STATE	ZIP CODE

Level 2 (A) – Data Elements

Identify the areas that were used to obtain information about the client and this particular assessment.

	REVIEWED	UNABLE TO OBTAIN
1. Ability to monitor health	☐	☐
2. Academic / educational development	☐	☐
3. Affective development	☐	☐
4. Current medications used by the individual	☐	☐
5. Independent Living development	☐	☐
6. Mental status	☐	☐
7. Physical status	☐	☐
8. Self-help development and functional status	☐	☐
9. Sensorimotor development	☐	☐
10. Social development	☐	☐
11. Speech and language (communication development)	☐	☐

Explain why any of the data elements were unobtainable.

Level 2 (B) – Interviews

INTERVIEWEE'S LAST NAME	FIRST	RELATIONSHIP	INTERVIEW DATE

Level 2 (C) – Evaluative Report
General Information
In what neighborhood, town, or geographic area would this person prefer to live?
What are the most important considerations for the person's physical health at this time? What is needed for the person to attain / maintain the highest practicable level of health?
Who does the individual enjoy spending time with?
Does the person identify any recent or current significant life events?
What is the individual good at?
What is important to this individual (what helps him/her to be satisfied, fulfilled, and happy)?
What is important to this individual (supports needed for health and safety)?
What community activities is the person interested in?
Summarize your findings regarding the person's current physical, mental, and psychosocial status, including the positive traits or developmental strengths, and developmental needs of the individual. Include any information related to the data elements not already mentioned.
Goals
Discuss any new goals identified by the resident, including supports needed to achieve goals and who can help. What are the individual's wishes, interests, and dreams?
What works well for the individual?
What doesn't work well for the individual?

List new goals identified:

NEW GOALS	DECISION DATE	CHECK IF GOAL ASSOCIATED TO A: PROFESSIONAL EVALUATION	CHECK IF GOAL ASSOCIATED TO A: SPECIALIZED SERVICE	CHECK IF GOAL ASSOCIATED TO A: COMMUNITY TRANSITION	WHO ACTS	STATUS
1.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
2.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
3.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
4.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
5.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
6.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
7.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn
8.		☐	☐	☐	☐ Self ☐ Nursing Facility ☐ Provider ☐ Other (specify who):	☐ Met ☐ Ongoing ☐ Withdrawn

Community Information

What strengths does the person have related to community integration?

Can this person's needs be met in a community setting at this time (even if person meets NFLOC)? ☐ Yes ☐ No

If this person can currently be supported in a community setting, what supports and services are needed for the person to live as safely and independently as possible? How would this combination of supports and services meet the person's needs?

If the person's needs can't currently be met in a community setting, what are the barriers to NF discharge:

- ☐ 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 cover in a community setting.
- ☐ Currently experiencing frequent acute medical crises requiring intervention.
- ☐ New health status requires modifications 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):

Is community transition requested? ☐ Yes ☐ No

Is a referral being made to the Roads to Community Living Program? ☐ Yes – DDA ☐ Yes – HCS ☐ No

Is a community transition in process? ☐ Yes ☐ No

Community transition comment:

COMMUNITY TRANSITION DESIRED?	NEEDS CAN BE MET IN COMMUNITY?	DECISION DATE	ANTICIPATED TRANSITION DATE	ACTUAL START DATE	ASSOCIATED ASSESSMENT DATE
☐ Yes ☐ No	☐ Yes ☐ No				

Level 2 (D) – Recommended Professional Evaluations

If any of the indicators below are present, a professional evaluation by a physical therapist, occupational therapist, behavior support professional, or a speech and language therapist is required. Check the box next to any of the following that apply to this individual, if the need is not already being adequately addressed:

- ☐ Communication challenges
- ☐ Contractures
- ☐ Significant change due to medical condition
- ☐ Evaluation needed for adaptive equipment
- ☐ Difficulty with, or avoidance of, fine motor activity
- ☐ Recent history of choking
- ☐ History of aspiration pneumonia, pneumonia, or respiratory issues
- ☐ Changes in social engagement
- ☐ Changes in behavior
- ☐ Loss of mobility or change in baseline ability to move or ambulate
- ☐ Loss of interest in preferred activities
- ☐ Specialized equipment is lost or broken
- ☐ Behavioral health concerns
- ☐ Quality of life limited by physical condition or disability
- ☐ Used assistive device in the past
- ☐ Individual, guardian, or family member requests service or communicates need or goal
- ☐ Other relevant health history and/or risk (describe):

Are professional evaluations required? ☐ Yes ☐ No

If any of the indicators is checked, but a professional evaluation is not recommended, why not?

The following professional evaluations are recommended (check all that apply).

PE TYPE	DATE RECOMMENDED	DATE RECEIVED	REASON FOR RECOMMENDATION	ASSOCIATED GOAL NUMBER (FROM GOALS TABLE IN LEVEL 2 (C)	CHECK, IF DECLINED
☐ PT ☐ OT ☐ Speech ☐ Behavioral Support / Mental Health ☐ Other (Specify					☐
☐ PT ☐ OT ☐ Speech ☐ Behavioral Support / Mental Health ☐ Other (Specify					☐
☐ PT ☐ OT ☐ Speech ☐ Behavioral Support / Mental Health ☐ Other (Specify					☐
☐ PT ☐ OT ☐ Speech ☐ Behavioral Support / Mental Health ☐ Other (Specify					☐
☐ PT ☐ OT ☐ Speech ☐ Behavioral Support / Mental Health ☐ Other (Specify					☐

Any professional evaluations recommended by the PASRR Assessor are to be arranged by the nursing facility. Evaluation reports and nursing facility service plan are to be forwarded to the PASRR Assessor within 30 days of the date of this document. Any specialized rehabilitative services identified by the recommended professional assessments will be provided by the nursing facility per 42 C.F.R. §483.45.

Level 2 (E) – Specialized Services

If the individual will receive NF services, are specialized services required? ☐ Yes ☐ No

The following professional evaluation are recommended (check all that apply.)

SS TYPE	SERVICE RECOMMENDED DATE	SERVICE START DATE	SERVICE END DATE	ASSOCIATED GOAL NUMBER (FROM GOALS TABLE IN LEVEL 2 (C)	CHECK, IF DECLINED
☐ AT ☐ Behavior Support ☐ Community Guide / Community Engagement ☐ Community Inclusion ☐ Family Mentor ☐ GSE ☐ Habilitative Therapy ☐ IE ☐ ITA ☐ Nurse Delegation ☐ Other DDA Svc (Specify) ☐ Other Hab Svcs (Specify) ☐ Other Svc – Non-DDA (Specify) ☐ Peer Mentor ☐ Person Centered Planning ☐ Skilled Nursing ☐ Specialized Equipment ☐ Staff / Fam Consult and Training ☐ Therapeutic Equip and Supplies					☐
☐ AT ☐ Behavior Support ☐ Community Guide / Community Engagement ☐ Community Inclusion ☐ Family Mentor ☐ GSE ☐ Habilitative Therapy ☐ IE ☐ ITA ☐ Nurse Delegation ☐ Other DDA Svc (Specify) ☐ Other Hab Svcs (Specify) ☐ Other Svc – Non-DDA (Specify) ☐ Peer Mentor ☐ Person Centered Planning ☐ Skilled Nursing ☐ Specialized Equipment ☐ Staff / Fam Consult and Training ☐ Therapeutic Equip and Supplies					☐

☐ AT ☐ Behavior Support ☐ Community Guide / Community Engagement ☐ Community Inclusion ☐ Family Mentor ☐ GSE ☐ Habilitative Therapy ☐ IE ☐ ITA ☐ Nurse Delegation ☐ Other DDA Svc (Specify) ☐ Other Hab Svcs (Specify) ☐ Other Svc – Non-DDA (Specify) ☐ Peer Mentor ☐ Person Centered Planning ☐ Skilled Nursing ☐ Specialized Equipment ☐ Staff / Fam Consult and Training ☐ Therapeutic Equip and Supplies					☐
☐ AT ☐ Behavior Support ☐ Community Guide / Community Engagement ☐ Community Inclusion ☐ Family Mentor ☐ GSE ☐ Habilitative Therapy ☐ IE ☐ ITA ☐ Nurse Delegation ☐ Other DDA Svc (Specify) ☐ Other Hab Svcs (Specify) ☐ Other Svc – Non-DDA (Specify) ☐ Peer Mentor ☐ Person Centered Planning ☐ Skilled Nursing ☐ Specialized Equipment ☐ Staff / Fam Consult and Training ☐ Therapeutic Equip and Supplies					☐
☐ AT ☐ Behavior Support ☐ Community Guide / Community Engagement ☐ Community Inclusion ☐ Family Mentor					☐

☐ GSE ☐ Habilitative Therapy ☐ IE ☐ ITA ☐ Nurse Delegation ☐ Other DDA Svc (Specify) ☐ Other Hab Svcs (Specify) ☐ Other Svc – Non-DDA (Specify) ☐ Peer Mentor ☐ Person Centered Planning ☐ Skilled Nursing ☐ Specialized Equipment ☐ Staff / Fam Consult and Training ☐ Therapeutic Equip and Supplies					

Reason(s) for no specialized services assigned (check all that apply):

☐ Experiencing delirium
☐ Too ill to participate
☐ Dementia with severe level of impairment
☐ Pending professional evaluation
☐ Admission expected to be of such short duration, additional services would not be beneficial
☐ Stamina level does not allow participation at this time
☐ No additional unmet needs identified
☐ ID/RC needs being met by other support(s) (describe):

If no specialized services are recommended, list sources of evidence or key documents supporting this determination.

Specialized services comment:

SIGNATURE OF PERSON COMPLETING EVALUATION		DATE OF COMPLETION
PRINTED NAME OF PERSON COMPLETING EVALUATION	PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE ZIP CODE

cc: Nursing facility applicant
Guardian or NSA
Client file (if DDA client)
Admitting or retaining NF
Attending physician or ARNP
Discharging hospital (if person is discharging from a hospital)