

PASRR Addendum

NAME		GUARDIAN'S / NSA NAME	
DATE OF PASRR LEVEL II	DATE OF ADDENDUM	FACILITY NAME (IF APPLICABLE)	
REASON FOR ADDENDUM			
SOURCE OF ADDITIONAL INFORMATION			
DESCRIBE ANY CHANGES TO RECOMMENDATIONS FOR PROFESSIONAL ASSESSMENTS BELOW. <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Mental Health / Behavior Support <input type="checkbox"/> Other (specify):			
Comments			
DESCRIBE ANY CHANGES TO RECOMMENDATIONS FOR SPECIALIZED SERVICES BELOW. <input type="checkbox"/> Community Access <input type="checkbox"/> Transportation <input type="checkbox"/> Vocational Training <input type="checkbox"/> Staff / Family Consultation and Training <input type="checkbox"/> Specialized Medical Equipment and Supplies (based on professional recommendation) <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Community Guide <input type="checkbox"/> Therapeutic Equipment and Supplies (based on professional recommendation) <input type="checkbox"/> Other (specify):			
Comments			
SIGNATURE OF PERSON COMPLETING ADDENDUM		DATE OF COMPLETION	
PRINTED NAME OF PERSON COMPLETING ADDENDUM		PHONE NUMBER (INCLUDE AREA CODE)	
EMAIL	ADDRESS	CITY / STATE / ZIP	

cc: Nursing facility applicant or resident
 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)