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|  | 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 | | | |
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| **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: | | | | | | | | | | | | WHO ACTS | | | | | STATUS | |
| PROFESSIONAL EVALUATION | | | | | SPECIALIZED SERVICE | | | | | COMMUNITY TRANSITION | |
|  | | |  | | | |  | | | | |  | | | | |  | | Self  Nursing Facility  Provider  Other (specify who): | | | | | Met  Ongoing  Withdrawn | |
|  | | |  | | | |  | | | | |  | | | | |  | | Self  Nursing Facility  Provider  Other (specify who): | | | | | Met  Ongoing  Withdrawn | |
|  | | |  | | | |  | | | | |  | | | | |  | | Self  Nursing Facility  Provider  Other (specify who): | | | | | Met  Ongoing  Withdrawn | |
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|  | | |  | | | |  | | | | |  | | | | |  | | Self  Nursing Facility  Provider  Other (specify who): | | | | | Met  Ongoing  Withdrawn | |
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|  | | |  | | | |  | | | | |  | | | | |  | | Self  Nursing Facility  Provider  Other (specify who): | | | | | Met  Ongoing  Withdrawn | |
|  | | |  | | | |  | | | | |  | | | | |  | | 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) | | | | | | | | | | | | | | | | | | | | | | | | | |