Ohio Department of Developmental Disabilities

PASRR EVALUATION SUMMARY

(Please use the fillable form or Print legibly)

Last Name	First Name	Middle Name/Initial	Gender
			○M ○F
Date of Birth (MM/DD/YYYY)	**Social Security No.**	**County Board Completing Assessment**	

Guardian's Name	Guardian's Street Address		
Guardian's Telephone (including area code)	**City**	**State**	**Zip Code**
		OH	

Nursing Facility Name	Nursing Facility Street Address		
City	**State**	**Zip Code**	**Nursing Facility Telephone No.**
	OH		

Admission Date	Nursing Facility County	Please identify county of residence prior to Hospital or NF placement

Current Living Arrangement - Select one

- ☐**a**. Unknown
- ☐**b**. Independent (Self)/Friend
- ☐**c**. Family/Relative
- ☐**d**. Foster Care Placement
- ☐**e**. Nursing Facility
- ☐**f**. No Permanent Dwelling
- ☐**g**. Community ICF/IID
- ☐**h**. Correctional Facility
- ☐**i**. Developmental Center
- ☐**j**. DODD Group Home
- ☐**k**. General Hospital
- ☐**l**. Private Psych. Hosp/Unit
- ☐**m**. Out-of-State
- ☐**n**. ODMH State Facility
- ☐**o**. Comm. MH Facility
- ☐**p**. Other _____

Based on supporting documentation, does the individual meet DD eligibility?

○ Yes ○ No

If "NO" is your answer, no further review is required. Please complete the section below and <u>SUBMIT PAGE ONE OF THIS FORM WITH SUPPORTING DOCUMENTATION</u>. (i.e. FED form, current social history, school records, psychological, guardian/family provided information, explanation of county board investigation.)

☐ Yes, This Further Review Is A Rule Out

For additional information regarding criteria for mental retardation or developmental disabilities, please refer to OAC 5123:2-14-01, OAC 5101:3-3-15.1; OAC 5101:3-3-15.2; and OAC 5101:3-3-14.

Local Evaluator (Print) _____ Title _____ Signature _____ Date _____

Email Address _____ Phone Number _____

Submit all documentation to: The Ohio Department of Developmental Disabilities, MDA/PASRR, 614.995.4877 (Fax number) within ten (10) working days of receipt of the PASRR ID referral.

DODD Determination of Rule Out (Not ID or DD)

Based on the documentation submitted, a determination by the Ohio Department of Developmental Disabilities is not warranted.

DODD Reviewer (Print) _____ Title _____ Signature _____ Date _____

Ohio Department of Developmental Disabilities

PASRR EVALUATION SUMMARY

(Please use the fillable form or Print legibly)

Last Name	First Name	Middle Initial

If you answered yes to the dd eligibility question, please proceed with your local evaluation.
Upon completion submit this form and the supporting documentation (listed below) to the Ohio Department of Developmental Disabilities.

Included	ASSESSMENTS	COMPLETED BY: Name & Title	DATE COMPLETED
☐Y ☐ N	PASRR Evaluation Summary Form ***(2 pgs)***		
☐Y ☐ N	Patient Care & Plan of Treatment (ODJFS 3697) or MDS ***(as reviewed & dated by a professional per rule)***		
☐Y ☐ N	Social History ***(include current situation)***		
☐ Y☐ N	Disability Assessment (psychological or medical report)		
☐ Y☐ N	County Board eligibility verification (FED form)		
☐ Y☐ N	Current Medical Information & List of Medications		
☐Y ☐ N	Current Physician's Orders		
☐Y ☐NA	Current Therapy Evaluations & Current Progress Reports		

County Board of DD recommends the following based upon the documentation reviewed:

☐ **Needs level of NF services –** Identify the specific, current medical needs/services that the NF will provide:

_____

_____

☐ **Does not need level of NF services** – Identify the most appropriate placement option(s) available to meet the individual's needs:

_____

_____

County Board of DD – Specialized Services (SS) Recommendation ☐Yes ☐No (not at this time)

In accordance with 5123:2-14-01, "SS shall be made available for individuals whose needs are such that continuous supervision, treatment, and training by qualified DD personnel are necessary to address needs in each of the life areas for which functional limitations have been identified." [Mobility, Language, Self-Care, Self-Direction, Capacity for Independent Living, Learning, Economic Self-Sufficiency]

If Yes, describe the specialized services to be provided or if No, provide justification as to why individual would not benefit from receiving specialized services:

_____

_____

_____

Provided by whom: _____

Local Evaluator

_____ _____

Local Evaluator (Print) Title Signature Date

_____ _____

Email Address _____ Phone Number _____

Submit the completed evaluation and supporting documentation to: the Department of Developmental Disabilities, MDA/PASRR, (614) 995-4877 (fax number) within ten (10) working days of receipt of the PASRR ID referral.

DODD Determination of NF & SS Needs

Determinations:

Nursing Facility Need ☐**YES** ☐**NO** _____

Name (Print) Title

Specialized Services Need ☐**YES** ☐**NO** _____

Signature Date