



# Developmental Educational Assistance Program

2200 Box Elder, Miles City, MT 59301  
Phone: (406) 234-6034, Fax: (406) 234-7018

## PASARR/MR INTERVIEW FORM

Date of Interview: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Nursing Facility Applicant or Resident: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Location of Interview: \_\_\_\_\_

### Persons Interviewed:

Name	Address	Phone	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Residential History: \_\_\_\_\_

\_\_\_\_\_

School services: \_\_\_\_\_

\_\_\_\_\_

Special or DD Services: \_\_\_\_\_

\_\_\_\_\_

Reason for NF application or placement: \_\_\_\_\_

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Description of Nursing Facility Applicant or Resident:

Physical Appearance: \_\_\_\_\_

Communication: \_\_\_\_\_

Cognitive: \_\_\_\_\_

Motor: \_\_\_\_\_

Affective: \_\_\_\_\_

Self-Help Skills: \_\_\_\_\_

Behavioral: \_\_\_\_\_

Input from persons interviewed:

Applicant or Resident: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Other (specify): \_\_\_\_\_

PASARR/MR Evaluator: \_\_\_\_\_

Agency: \_\_\_\_\_ Date: \_\_\_\_\_