Developmental Educational Assistance Program

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PASARR/MR
Annual Resident Review
ARR

DATE of ARR _____

I. RESIDENT INFORMATION

NAME: _____ DOB: _____ AGE: _____

FACILITY:_____

(Address): _____

_____

_____

(NF Administrator): _____

(Social Services Contact Person): _____ (***Please Print Name)***

Currently attending DDP funded day program: Yes ☐ No ☐

If yes, name and type of program:_____

Comments from service provider about progress:

_____

_____

_____

Legal Guardian: No ☐ Yes ☐ Name: _____

Guardian Address:_____

Case Manager: No ☐ Yes ☐ Name:_____

II. RESIDENT'S DAILY SCHEDULE AND PREFERRED ACTIVITIES IN THE NURSING FACILITY:

Describe normal daily routine and activities: _____

_____

_____

_____

Community Outings:_____

_____

Visits from Family and Peers/Friends:_____

_____

III. DETERMINATION OF NEED FOR SPECIALIZED SERVICES:
(Answer all the questions and brief examples of behavior or explanation to justify response <u>are required</u>.)

YES NO

☐ ☐ 1. Does the person care for most of their personal needs?

_____

_____

_____

YES NO

☐ ☐ 2. Does the person understand simple commands?

_____

_____

_____

YES NO

☐ ☐ 3. Does the person communicate basic needs and wants? How?

_____

_____

_____

YES NO

☐ ☐ 4. Is the person capable of learning new skills without aggressive and consistent training?

_____

_____

_____

YES NO

☐ ☐

5. Does the person, without direct supervision, demonstrate behavior appropriate to the time, situation or place?

_____

_____

_____

YES NO

☐ ☐

6. Is the person capable of making decisions requiring informed consent?

_____

_____

_____

YES NO

☐ ☐

7. Does the person demonstrate severe maladaptive behaviors which place themselves or others in jeopardy to health and safety? (If yes response, provide example.)

_____

_____

_____

YES NO

☐ ☐

8. Does the person have other specific skill deficits or needs requiring specialized training delivered by specially trained DD staff to teach these functional skills? (If yes response, provide example.)

_____

_____

_____

==========

YES NO

☐ ☐

9. Based upon the information collected and the responses to the above questions, does this person require specialized services?

_____

_____

IV. NEEDED SPECIALIZED SERVICES FOR PERSONS WITH MENTAL RETARDATION:

1. Self-Help: _____
2. Social/Leisure: _____
3. Communication: _____
4. Vocational: _____
5. Behavior Management:_____
6. Other: _____

V. NOTED CHANGES IN THE INDIVIDUAL=S PHYSICAL, MEDICAL OR SERVICE NEEDS DURING THE PAST YEAR:

1. Physical: _____

   _____
2. Medical: _____

   _____
3. Service Needs: _____

   _____
4. Other (such as Med. Changes)_____

   _____

VI. REVIEW OF THE INDIVIDUAL'S CHOICE FOR PLACEMENT AND SPECIALIZED SERVICES:

1. Previous Choice:

   [ ] NF only (elderly [ ] NF with Specialized Services

   [ ] Alternative Placement:

   Type of Services: _____

   _____

   Location: _____

2. Change in Previous Choice: [ ] No [ ] Yes

   Individual's/Family's comments: _____

   _____

   _____

Case Manager's comments: _____

_____

Quality Improvement Specialist's comments: _____

_____

3. Referral for Documentation of Choice needed:
   - [ ] No
   - [ ] Yes, comment: _____

     _____

VII. REVIEW OF SPECIALIZED SERVICE OBJECTIVES:

1. Service Objectives Set: _☐_ No _☐_ Yes
2. Service Objective Review Attached: _☐_ No _☐_ Yes
3. Comments on Status of Completed Service Objectives:

_____

_____

_____

_____

VIII. COMPLETED CONTINUED STAY REVIEW OR LEVEL OF CARE:

Report dated _____ is attached.

_____ _____

PASARR Evaluator Date

_____ _____

Quality Improvement Specialist Date