

**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 OH	Zip Code	
Nursing Facility Name				Nursing Facility Street Address			
City		State OH		Zip Code		Nursing Facility Telephone No.	
Admission Date	Nursing Facility County		Please identify county of residence prior to Hospital or NF placement				

Current Living Arrangement - Select one

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> a. Unknown | <input type="checkbox"/> e. Nursing Facility | <input type="checkbox"/> i. Developmental Center | <input type="checkbox"/> m. Out-of-State |
| <input type="checkbox"/> b. Independent (Self)/Friend | <input type="checkbox"/> f. No Permanent Dwelling | <input type="checkbox"/> j. DODD Group Home | <input type="checkbox"/> n. ODMH State Facility |
| <input type="checkbox"/> c. Family/Relative | <input type="checkbox"/> g. Community ICF/IID | <input type="checkbox"/> k. General Hospital | <input type="checkbox"/> o. Comm. MH Facility |
| <input type="checkbox"/> d. Foster Care Placement | <input type="checkbox"/> h. Correctional Facility | <input type="checkbox"/> l. Private Psych. Hosp/Unit | <input type="checkbox"/> 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 SUBMIT PAGE ONE OF THIS FORM WITH SUPPORTING DOCUMENTATION. (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) or email PASRRDOC@dodd.ohio.gov 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 <i>(as reviewed & dated by a professional per rule)</i>		
Y N	Social History <i>(include current situation)</i>		
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) or email PASRRDOC@dodd.ohio.gov 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