



PASRR LEVEL II REFERRAL FORM

Date Referral Received: _____

DDRO: _____

Name of PASRR Coordinator Telephone# Fax#

=====

So that we may begin the PASRR Level II evaluation process, please complete and return this form along with copies of the specified documents to the DDRO PASRR Coordinator listed above.

Name of Individual being referred: _____ Home Phone# _____
Male ___ Female ___ Date of Birth: _____

Home Address: _____ Zip Code _____

Service Coordinator ___ DDRO ___ Voluntary ___ None
Name: _____ Telephone# _____

Contact Person: (Specify relationship: legal guardian, parent, family member: _____

Address: _____ Telephone: _____

Referral Contact: _____
(Please print, first and last name)

Referral Organization: _____

Address: _____

Zip Code: _____

Phone# _____ (include area code) Fax # _____

Statement of reason for referral to nursing home _____

Photocopy the following documents and forward to the DDRO PASRR Coordinator:

- H/C PRI or PRI + Screen
- Complete Medical History including results of most recent physical examination
- Psychosocial evaluation including current living arrangements, medical, support systems, and day program information (if available)
- Supportive documentation for diagnosis of mental retardation or other developmental disability
- List of current medications

SEE ATTACHED: Eligibility for OPWDD Services Important Facts Sheet

REMINDER: Contact the DDRO PASRR Coordinator as soon as possible with the following:

Date of Hospital Discharge: _____

Date of NF Admission: _____

Name of Nursing Facility: _____