



**DETERMINATION OF NEED FOR OBRA SLS SERVICES**

(Answer all the questions and **provide brief explanations or examples of behavior to justify each no response**. Use additional sheets if necessary.)

YES NO

\_\_\_\_\_

1. Does the person have the ability to care for most of their personal needs?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

2. Is the person able to understand simple instructions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

3. Is the person able to communicate basic needs and wants?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

4. Is the person able to be employed at a productive wage level without systematic long-term supervision or support?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO

\_\_\_\_\_

5. Is the person able to learn new skills without aggressive and consistent training?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

6. Is the person able, without aggressive and consistent training, to apply skills learned in a training situation to other environments or settings?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

7. Is the person able, without direct supervision, to demonstrate behavior appropriate to the time, situation or place?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

8. Is the person able to make decisions requiring informed consent?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO

\_\_\_\_\_

9. Does the person demonstrate severe maladaptive behaviors that place self or others in jeopardy with regard to health and safety? *(If yes, provide example)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

10. Does the person have other specific skill deficits or other specialized training needs that necessitate the availability of staff trained in developmental disabilities, 24 hours/day, to teach functional skills? *(If yes, provide example.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

11. Based upon the information collected and the responses to the above questions does this person require OBRA SLS services? *(OBRA SLS services are day services provided out of the nursing facility. Typically these services are funded by DDD but may also be mental health services, public school services, dental services or vision services.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature and Title of Person Completing Form**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Division for Developmental Disabilities Approval**

\_\_\_\_\_  
**Date**

**COLORADO DIVISION FOR DEVELOPMENTAL DISABILITIES  
PASARR NURSING FACILITY CHOICE FORM**

**DETERMINATION OF NEED FOR NURSING FACILITY**

**1. Is placement in the nursing facility appropriate?**

**Yes**\_\_\_\_\_ **No**\_\_\_\_\_ *(If no, do not answer the remaining questions on this form. Instead, please explain your answer– use back or attach separate sheet, as needed. Then sign the form and submit to DDD.)*

*(If yes, proceed to the remaining questions.)*

**2. What alternate community settings were explored? Please explain why other options are not appropriate.** *(Use the back of the page, if needed.)*

**3. List all nursing facility services that are required.**

*(for example, therapies, health rehabilitative services - see manual) (Use back of page if necessary.)*

**4. Can the nursing facility provide the needed services?**

Yes \_\_\_\_\_ No \_\_\_\_\_ *(If no, please explain.)*

**Comments:**

**DETERMINATION OF DESIRE FOR SLS SERVICES**

**5. OBRA SLS Services Needed? Yes \_\_\_\_\_ No \_\_\_\_\_**  
*(If no, stop at this question, sign form and complete bill. If yes, proceed. to #6.)*

**6. Are OBRA SLS services desired? Yes \_\_\_\_\_ No \_\_\_\_\_**  
*(If no for #6, signature of individual, guardian or authorized representative is required.)*

\_\_\_\_\_  
**Individual/Guardian/Authorized Representative Signature**

\_\_\_\_\_  
**Date**

**7. If no for #6, is case management desired? Yes \_\_\_\_\_ No \_\_\_\_\_**

**8. If OBRA SLS services are needed and desired, what type of services are needed?**

\_\_\_\_\_  
**Case Manager/Resource Coordinator Signature**

\_\_\_\_\_  
**Date**

**COLORADO DIVISION FOR DEVELOPMENTAL DISABILITIES**

**OBRA BILLING (February, 2004)**

**INDIVIDUAL INFORMATION**

Name \_\_\_\_\_

**SERVICES** (Check all that were provided.)

	<u><b>Amt. Due</b></u>
Referral and Eligibility Determination - \$126.19	\$_____
Psychological Evaluation (not to exceed \$360.00)	_____
Colorado PASARR Assessment - \$45.42	_____
New Referral: Preadmission Screening & Determination of Need for OBRA State SLS Services - \$126.19	_____
Nursing Facility Annual Resident Review (NFARR) - \$53.95	_____
<b>TOTAL</b>	<b>\$_____</b>

\_\_\_\_\_  
**Name of Community Centered Board**

\_\_\_\_\_  
**Signature of CCB Business Manager**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**DDD Approval**

\_\_\_\_\_  
**Date**