

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, if they move into a nursing facility, 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.)*

If the answer to this question is No, explain why in the space below. *(Use the back of the page, if needed.)*

Signature and Title of Person Completing Form

Date

Division for Developmental Disabilities Approval

Date

DETERMINATION OF NEED FOR NURSING FACILITY

1. By checking the space at the beginning of this item, you are confirming that you reviewed the information about the proposed nursing facility that is posted on the Colorado Department of Public Health and Environment (CDPHE) web site at <http://www.cdphe.state.co.us/hf/static/ncf.htm>.

2. 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. Include in your explanation whether your No answer means no nursing facility is appropriate, or whether it means this particular facility is not appropriate but another may be.)*

(If yes, proceed to the remaining questions.)

3. Describe all the less restrictive community-based residential settings that have been explored for this person and explain why each setting is not appropriate. Include both existing settings and those that could be created. Be specific. For example, do not say “the person’s medical needs can’t be met.” Say “we do not have and cannot create any setting that can administer IV medication three times a day.” *(Use the back of the page, if needed.)*

4. List all nursing facility services that are required.
(for example, therapies, health rehabilitative services - see manual) (Use back of page if necessary.)

5. Can the nursing facility provide the needed services?

Yes _____ No _____ (If no, please explain.)

Comments:

DETERMINATION OF DESIRE FOR SLS SERVICES

6. OBRA SLS Services Needed? Yes _____ No _____
(If yes, proceed to #7. If no, proceed to #9.)

7. Are OBRA SLS services desired? Yes _____ No _____
(If no for #7, signature of individual, guardian or authorized representative is required.)

Individual/Guardian/Authorized Representative Signature

Date

(If you need this signature and have not obtained it by the due date for this form,
fax the form with a description of what you have done so far to obtain the signature and
keep trying to obtain it.)

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

9. If no for #6, is case management desired? Yes _____ No _____

Case Manager/Resource Coordinator Signature

Date