Colorado Division For Developmental Disabilities

PASARR Nursing Facility Transfer Form

(August, 2006)

This form must be completed for all individuals requesting a transfer from one nursing facility to another.

PASARR/DD Instructions:

1. Fill in the demographic information on this page and answer all questions on pages two and three of the form.
2. The CCB Case Manager/Resource Coordinator must sign the completed form.
3. Fax this form to the Division for Developmental Disabilities.

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INDIVIDUAL INFORMATION

Name____

Guardian? ___**Yes** ___**No**

If yes, guardian name and address (please print legibly)

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Date of Birth_______________________________ **Age**_________ **Sex**_________

Social Security Number_____________________________________

Proposed New Nursing Facility____

(facility must have agreed to accept the individual)

____
Community Centered Board

____ _________________
Signature of Case Manager/Resource Coordinator **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.)*

   (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. **Why does the individual want to move to the new nursing facility?**

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

6. **Can the new nursing facility provide the needed services?**

Yes__________ No__________ *(If* no*, please explain.)*

Comments:

DETERMINATION OF DESIRE FOR SLS SERVICES

7. **OBRA SLS Services Needed? Yes__________ No__________**
(If no, stop at this question, sign form. If yes, proceed. to #8.)

8. **Are OBRA SLS services desired? Yes__________ No__________**
(If no for #8, signature of individual, guardian or authorized representative is required if it has not already been obtained.)

____ _______________________
Individual/Guardian/Authorized Representative Signature **Date**

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

10. **If no for #8, is case management desired? Yes__________ No__________**

____ _______________________
Case Manager/Resource Coordinator Signature Date

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Case Manager/Resource Coordinator Name (Please Print)