

Colorado Division for Developmental Disabilities
Nursing Facility Annual Resident Review – January 2005

Resident Name:

Date:

(month ##, 20##)

Date of Birth: / /

Age:

Social Security Number: - -

Name of Nursing Facility:

1. Are OBRA SLS services desired?

Yes

No

2. Is case management/resource coordination desired?

Yes

No

(If no, signature of individual or guardian required – stop at this question and sign on page 2.)

3. Currently receiving DDD-funded OBRA SLS services?

Yes

No

(If yes, answer the items below.)(If no, proceed to #4.)

Type of service *(such as community participation or other day service)*

Provider *(name of organization providing service)*

4. Does the person wish to be placed or remain on a list for movement from a nursing facility?

Yes

No

If yes, indicate the type of service or support needed and the level of funding necessary.

If *No* and the person is under 55 years of age, please explain why continued nursing facility placement is desired and/or considered appropriate.

5. List unique services the nursing facility must provide because the person has a developmental disability. (Services may include health rehabilitative services.)

6. Does the nursing facility provide all needed services? Include services listed above in addition to services enumerated on the nursing facility Plan of Care.

Yes

No

(If no, a plan to provide needed services within 30 days or a plan to seek an alternative setting must be attached.)

Signature of Case Manager/Resource Coordinator

Typed Name of Case Manager/Resource Coordinator