

Colorado Division for Developmental Disabilities
Nursing Facility Annual Resident Review – March 2004

Resident Name _____ Date _____

Date of Birth _____ Age _____ SSN _____

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 _____

(If yes, fill in the items below.)

No _____

(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 the nursing facility?

Yes _____

No _____

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

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

(Use additional sheets, if necessary)

5. List unique service 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

CCB

Printed Name of Case Manager/Resource Coordinator