


**Ohio Department of Mental Retardation and Developmental Disabilities
OBRA RESIDENT REVIEW EVALUATION SUMMARY**

Last Name	First Name	Middle Name	Gender F M	County Board
Date of Birth (MM/DD/YYYY) ____/____/____	Social Security No. ____-____-____	Medicaid No. _____		
Guardian's Name		Guardian's Telephone No. ()		
Guardian's Street Address		City	State	Zip Code
Admission Date	Cty. Bd. Local Evaluator	Cty. Bd. Telephone Number ()		
Nursing Facility Name		Nursing Facility County		
Nursing Facility Street Address	City	Zip Code	Nursing Facility Telephone No. ()	
Please identify county of residence prior to NF placement				
THESE BOXES MUST BE ANSWERED			30+ Month Resident Y N	Sermak Case Y N

Does the individual meet the mr or dd eligibility criteria? _____ Yes _____ No

If you answered no, no further review is required.

Please complete the Rule Out section and sign below then **SUBMIT THIS PAGE ONLY.**

Yes, This Application Is A Rule Out

Based on the documentation submitted, a Determination by the Ohio Department of Mental Retardation and Developmental Disabilities is not warranted. For additional information regarding criteria for mental retardation or developmental disabilities, please refer to OAC 5123:2-14-01, OAC 5123:2-14-02, and/or OAC 5123:2-14-03.

County Board Local Evaluator

Phone # _____

Name (Print)

Title

Signature

Date

Submit the completed evaluation and supporting documentation to: ODMR/DD, PASRR Unit, 35 East Chestnut Street - 5th Floor, Columbus, Ohio 43215-3434 within nine (9) working days of receipt of the PASRR ID referral.

ODMR/DD Determination of Rule Out (Not MR or DD)

Name (Print)

Title

Signature

Date

**Ohio Department of Mental Retardation and Developmental Disabilities
OBRA RESIDENT REVIEW EVALUATION SUMMARY**

Last Name	First Name	Middle Name
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If you have answered yes to meet the mr or dd eligibility, please proceed with the appropriate evaluation on this page and upon completion sign and submit both pages to ODMR/DD.

Please complete and review PAS-MRDD documentation elements.

Included	ASSESSMENTS	COMPLETED BY	DATE COMPLETED
Y N	OBRA PASRR Evaluation Summary (<i>all pgs</i>)		
Y N	PAS ID Screen (JFS 03622) (<i>all pgs</i>)		
Y N	Social History (<i>include current situation</i>)		
Y N	Disability Assessment (psychological or medical report)		
Y N	MR/DD county board eligibility verification		
Y N	Medical Reports (<i>all pgs</i>)		
Y N	Minimum Data Set (MDS) Report		
Y N	Current Physician's Orders		
Y N	List of Medications		
Y NA	Ongoing Therapy Reports:		

County Board of MRDD supports the following based upon the documentation reviewed:

(Check only the section that applies)

Needs level of NF services – Any applicant residing in a NF who has MR/DD and who is determined to require the continued level of services provided by a NF based upon documentation described in Rule 5123:2-14-03 of the Administrative Code may remain in a nursing facility.

Identify level of care medical needs: _____

Does not need level of NF services based on your medical needs assessment it has been determined that continued NF services are no longer required based upon documentation described in Rule 5123:2-14-03 of the Administrative Code. You would benefit from services and supports designed and coordinated specifically to promote the acquisition of skills and to decrease or prevent regression in the performance of tasks related to the major life areas ... where significant functional limitations were identified as defined in the OAC 5123:2-14-02 or OAC 5123:2-14-03.

County Board of MRDD – Specialized Services Recommendation

Is the county board of mr/dd recommending specialized services? **YES NO**

If Yes, Appropriate Areas Must Be Checked:

Vocational Behavioral Intervention Habilitation Ancillary Services Other

For Other, please specify: _____

Specialized services shall be delivered and monitored in accordance with rule 5123:2-14-04 of the Ohio Administrative Code.

<u>County Board Local Evaluator</u>			
			Phone # _____
_____	_____	_____	_____
Name (Print)	Title	Signature	Date
Submit the completed evaluation and supporting documentation to: ODMR/DD, PASRR Unit, 35 East Chestnut Street - 5 th Floor, Columbus, Ohio 43215-3434 within seven (7) working days of receipt of the PASRR ID referral.			

ODMR/DD Determination of NF & SS Needs			
<u>Determinations:</u>			
Nursing Facility Needed:	YES	NO	_____
Nursing Facility (30+ Month Rule)	YES	NO	Name (Print) _____ Title _____
ICF/MR or Other Residential Option:	YES	NO	_____
Specialized Services Needed:	YES	NO	Signature _____ Date _____