


**Ohio Department of Mental Retardation and Developmental Disabilities  
OBRA PREADMISSION SCREENING EVALUATION SUMMARY**

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

**IDENTIFY CURRENT LOCATION OF INDIVIDUAL:**

- |                              |                          |                               |                            |
|------------------------------|--------------------------|-------------------------------|----------------------------|
| a. Unknown                   | e. RFW                   | i. Developmental Center       | m. Other Govt. Facility    |
| b. Independent (Self)/Friend | f. Nursing Facility      | j. CBMR/DD Facility           | n. Out-of-State            |
| c. Family/Relative           | g. No Permanent Dwelling | k. Priv. Psych. Hospital/Unit | o. ODMH State Facility     |
| d. Foster Care Placement     | h. Community ICF/MR      | l. General Hospital           | p. Priv./Comm. MH Facility |
|                              |                          |                               | q. Other (not listed here) |

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 - 5<sup>th</sup> Floor, Columbus, Ohio 43215-3434 within seven (7) 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 PREADMISSION SCREENING 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	Patient Care & Plan of Treatment (ODJFS 03697) ( <i>RN signed and dated</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	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 for admission to a NF who has MR/DD and who is determined to require the level of services provided by a NF based upon the documentation described in Rule 5123:2-14-02 of the Administrative Code may be admitted to a NF or approved for PASSPORT HCBS waiver enrollment in accordance with Chapter 5101:3-3-31 of the Administrative Code.

Identify level of care medical needs: \_\_\_\_\_

**Does not need level of NF services** – Any applicant for admission to a NF who has MR/DD and who is determined not to require the level of service provided by a NF based on the documentation described in Rule 5123:2-14-02 is inappropriate for NF placement and shall not be admitted or approved for the PASSPORT HCBS waiver enrollment.

**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.

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

<b>ODMR/DD Determination of NF &amp; SS Needs</b>			
<b><u>Determinations:</u></b>			
Nursing Facility Needed:	<b>YES</b>	<b>NO</b>	_____
PASSPORT Waiver	<b>YES</b>	<b>NO</b>	Name (Print) _____ Title _____
ICF/MR or Other Residential Option:	<b>YES</b>	<b>NO</b>	_____
Specialized Services Needed:	<b>YES</b>	<b>NO</b>	Signature _____ Date _____