NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

OPWDD PASRR LEVEL II REFERRAL FORM

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To ensure timely processing of the PASRR Level II evaluation, please complete and return this form along with copies of the specified documents to the DDRO PASRR Coordinator.

Patient's Name: _____ Phone: _____

Home Address: _____ Zip Code: _____

Date of Birth: _____ County of Residence: _____

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Advocate/Contact Person Name: _____ Relationship**:** _____

Home Address**:**_____ Phone:_____

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Referral Organization: _____

Address: _____ Zip: _____

Referral Contact Name: _____ Referral Contact Phone: _____

Referral Contact Email: _____ Fax: _____

Reason for Referral to Nursing Home: _____

Nursing Home Referral Type (Check one): Categorical Determination (YES selected for any of items 27-30 on Level I SCREEN) ☐ Long-Term Care ☐ Significant Change ☐

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Anticipated Hospital Discharge Date: _____ **Anticipated Nursing Facility Admission Date:** _____

Name of Nursing Facility: _____

NF Address: _____

NF Contact Person: _____ **NF Contact Phone:** _____

Please send a copy of the following documents to the DDRO PASRR Coordinator:

- H/C PRI or PRI + SCREEN
- Complete Medical History including results of most recent physical examination
- Psychosocial evaluation including current living arrangements, medical, support systems, and day program information (if available)
- Supportive documentation for diagnosis of intellectual and/or developmental disability
- List of current medications
- Medical documentation supporting the need for nursing home level of care