LEVEL II PREADMISSION AND RESIDENT REVIEW ID/RC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 514 (2-2023)

Clear Fields

Name (Last, First, MI)		Date of Birth		Need for Nursing Facility Level of Care
Date of Assessment	Medicaid ID ND	☐ PAS ☐ RR		☐ Individual requires nursing facility care ☐ PAS/ARR Level I ☐ Other - Specify: _____ ☐ Individual does not require nursing facility care
Date of Admission	Open DDPM ☐ Yes ☐ No	Mental Health Case ☐ Yes ☐ No		
Name of Nursing Facility				
Nursing Facility Address	City	State	ZIP Code	

Diagnosis/Related Conditions

Name of Licensed Psychologist	Date of Evaluation

Need for Active Treatment (check one)

- ☐ 1. Active treatment for intellectual disability or related condition is recommended
- ☐ 2. Active treatment for intellectual disability or related condition is not recommended
- ☐ 3. Active treatment for intellectual disability or related condition is considered subordinate to management of serious medical condition
- ☐ 4. Active treatment for intellectual disability or related condition is recommended, but the individual declines involvement (attach waiver form)

PLACEMENT RECOMMENDATIONS

Check one:

- ☐ 1. Can be admitted to nursing facility (PAS)
- ☐ 2. Cannot be admitted to nursing facility (PAS)
- ☐ 3. Can be considered appropriate for continued placement in nursing facility (RR)
- ☐ 4. Choose to remain in nursing facility to receive active treatment (RR)
- ☐ 5. Inappropriate for continued placement in nursing facility and must be discharged (short-term residents) (RR)
- ☐ 6. Inappropriate for continued placement in nursing facility and must be discharged (long-term residents) (RR)

Comments/Other Services (Time Frame)

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury, that I am the individual completing this application and that I have provided accurate information.

Evaluator Printed Name (DDPM)	Title
Evaluator Signature (DDPM)	Date

FOR STATE OFFICE USE ONLY

PLACEMENT DETERMINATION

Describe Placement Determination

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury, that I am the individual completing this application and that I have provided accurate information.

Signature (ID/RC Authority)	Date