ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PASRR II ASSESSMENT

Individual's Name *(Last, First)*: _____ Date of Birth: _____

Age: _____ Sex: _____ AHCCCS ID.: _____

ASSISTS ID.: _____ Focus ID: _____

DDD Member: ☐ Yes ☐ No Eligibility *(ALTCS level of care)*: _____

Type of Assessment: ☐ Initial ☐ Revised Location: _____

Date of Referral: _____ Date Received: _____ Date of Screen: _____

DDD Support Coordinator's Name: _____ Phone No. *(Include area code)*: _____

Individual's Health Care Decision Maker: _____ Relationship to Individual: _____

Diagnosis:

See page 7 for EOE/ADA disclosures

Name of Facility: _____ Admission Date: _____

Address *(No., Street, City, State, ZIP Code)*: _____

Physician's Name: _____ Phone No. *(Include area code)*: _____

Address *(No., Street, City, State, ZIP Code)*: _____

IDENTIFICATION CRITERIA

(Check [✓] all that apply):

☐ Individual has a diagnosis of autism before age 22.
☐ Individual has a diagnosis of cerebral palsy before age 22.
☐ Individual has a diagnosis of epilepsy before age 22.
☐ Individual has a diagnosis of Cognitive Disability (CD) before age 22.
☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ N/A
☐ Individual has a history of ID or a developmental disability identified in the past.
☐ Individual has a diagnosis of Trisomy 21 (Down Syndrome) before age 22; or
☐ Individual exhibits cognitive or psychological behaviors that may indicate ID or developmental disability.

If any of the above are checked, continue.

SECTION I – MEDICAL HISTORY

A. PATIENT HISTORY *(Give a brief history, including recent hospitalization)*

B. CURRENT OR RECENT HEALTH PROBLEMS/RISK FACTORS

☐ Heart Disease ☐ Lung Disease ☐ Renal Disease ☐ Diabetes ☐ Cancer ☐ Fall/Unsteadiness
☐ Head Injury ☐ Chronic Pain ☐ Arthritis ☐ Seizures ☐ Amputations ☐ Pressure Ulcer(s)
☐ CVA ☐ Impaired Vision ☐ Food or Fluid Intake Problem ☐ Obesity ☐ Impaired Hearing
☐ Allergies: _____ ☐ Substance Abuse
☐ Pneumonia ☐ Other _____
☐ Alert ☐ Semi-Consciousness ☐ Insulin Sliding Scale ☐ Accu-Chek

C. CURRENT MEDICAL TREATMENT *(Explain)*

Check (✓) all that apply:

1. Skin: ☐ Pressure Ulcer Care ☐ Drainage/Culture ☐ Wound Care
2. Nutrition: ☐ Therapeutic Diet *(specify)* _____
   ☐ NG Feed ☐ IV/TPN ☐ GJ Tube
   ☐ G Tube ☐ IV Nutrition
3. Hydration: ☐ Restrict Fluids ☐ Intravenous Hydration
4. Respiratory: ☐ Oxygen ☐ Ventilator ☐ Tracheotomy ☐ Suctioning
5. Elimination: ☐ Urinary Catheter *(type)* _____
   ☐ Ostomy ☐ Dialysis
6. Skilled Nursing Observations: ☐ Yes ☐ No

D. MEDICATIONS *(The Level II assessment must identify medications in the following groups [1-5] and the current response of the individual to such medications)*

MEDICATION TYPE	NAME OF MEDICATION	RESPONSE
1. Hypnotics		
2. Anti-psychotics		
3. Mood stabilizers/anti-depressants		
4. Anti-anxiety/sedative agents		
5. Anti-Parkinson agents		

Other Medications:

NAME OF MEDICATION	DOSAGE	FREQUENCY	PURPOSE

List all sources of medical information:

DOCTOR'S NAME	PHONE NO.	ADDRESS

☐ Medical File ☐ Patient ☐ Other *(specify)*: _____

Consultation with Family/Guardian *(Include names and dates)*

SECTION I - Medical History Completed By: _____

Title: _____ Date: _____

SECTION II – FUNCTIONAL STATUS

A. SELF-HELP DEVELOPMENT *(Rate level of independence in the following)* **CODES: INDependent; MINimal assistance; defined as including the need for supervision, verbal cueing or minimal physical assistance; MODerate assistance, implies the need for physical assistance; DEPendent.**		**IND**	**MIN**	**MOD**	**DEP**
HEALTH STATUS	Physical functioning, emotional well-being, pain or discomfort and overall perception of health.	☐	☐	☐	☐
MEDICATION	Self –administration, what medications to take and what time to take them.	☐	☐	☐	☐
EATING	Act of bringing food to mouth, chewing and swallowing.	☐	☐	☐	☐
BATHING	Bathing body, shampooing hair.	☐	☐	☐	☐
DRESSING	Setting out clothing and dressing entire body, including any orthosis.	☐	☐	☐	☐
TOILET	Use of toilet, urinal, bedpan, including cleansing self after use and adjusting clothing.	☐	☐	☐	☐
TRANSFER	Transfer to and from bed, chair or wheelchair.	☐	☐	☐	☐
LOCOMOTION	Includes walking, once in a standing position; using a wheelchair indoors.	☐	☐	☐	☐

B. SENSORIMOTOR DEVELOPMENT *(Check [✓] all that apply)*

☐ Ambulatory ☐ Non-Ambulatory ☐ Walks Independently ☐ Transfers without Assistance
☐ Moves from Room to Room ☐ Maintains Positioning ☐ Has Gross Motor Dexterity
☐ Tracks Movement with Eyes ☐ Has Fine Motor Skills ☐ Has Eye-Hand Coordination ☐ N/A

C. COMMUNICATION *(Check [✓] all that apply)*

☐ Verbal ☐ Non-Verbal ☐ Visually Impaired ☐ Hearing Impaired ☐ Uses Communication System
☐ Use Amplification Device ☐ Has Orientation Skills ☐ N/A

D. SOCIAL DEVELOPMENT *(Check [✓] all that apply)*

☐ Initiates Conversation ☐ Responds to Questions ☐ Maintains Eye Contact ☐ Choose Leisure Activities
☐ Indicates Preference of Staff, Family, or Friends ☐ Recognizes Leisure vs. Vocational Activities ☐ N/A

E. ACADEMIC EDUCATIONAL DEVELOPMENT (Check [☐] all that apply)

☐ Identifies Time of Day ☐ Names Day of Week ☐ Has Money Concepts ☐ Maintains A Schedule
☐ Writes Name ☐ Writes Vital Information ☐ Purchases Item Independently ☐ N/A
☐ Understands Cause and Effect

F. INDEPENDENT LIVING DEVELOPMENT *(Check [✓] all that apply)*

- ☐ Prepares Cold Meals
- ☐ Present Neat Appearance
- ☐ Cleans Bedroom
- ☐ Prepare Portion of Hot Meal
- ☐ Purchases Items from Grocery Store
- ☐ N/A
- ☐ Keep House Clean
- ☐ Operates Washer and Dryer
- ☐ Budgets and Manages Money
- ☐ Is Mobile in Neighborhood
- ☐ Crosses Streets Safely
- ☐ Put Clean Clothes Away
- ☐ Select Nutritious Food
- ☐ Recognizes Danger Signs
- ☐ Self-Monitoring of Nutritional Status

G. VOCATIONAL DEVELOPMENT *(Check [✓] all that apply)*

- ☐ Cooperates with Staff
- ☐ Follow Rules and Directions
- ☐ Differentiates Between Size, Textures of Items
- ☐ Does Contract Work
- ☐ Transfer Item Across Midline
- ☐ Assembles Objects
- ☐ Attends to Task
- ☐ Is Punctual
- ☐ Remains at Workstation
- ☐ N/A
- ☐ Completes Tasks with Others in Work Area
- ☐ Completes Repetitive Work with Acceptance Error
- ☐ Grasps Large Items
- ☐ Manipulates Small Items

H. AFFECTIVE DEVELOPMENT *(Check [✓] all that apply)*

- ☐ Maintains Good Relationship
- ☐ Accepts Invitation
- ☐ Accepts Disappointment Appropriately
- ☐ Accepts Criticism
- ☐ Expresses Emotions
- ☐ Lives Independently
- ☐ N/A

I. BEHAVIOR FACTORS *(Check [✓] those behavioral factors which may affect post-discharge care)*

- ☐ Agitation *(Exhibits anxiety, restlessness)*
- ☐ Depression *(Appears sad, hopeless; has problems with sleep, appetite)*
- ☐ Wandering *(Does not understand territorial constrains, leading to unsafe situations)*
- ☐ Verbally Abusive *(Others are threatened, screamed at, or cursed at)*

  Frequency: ☐ Occasionally ☐ Daily ☐ 2+ A Day ☐ 1-3 Per Week
- ☐ Physically Abusive *(Others are hit, scratched, or sexually abused)*

  Frequency: ☐ Occasionally ☐ Daily ☐ 2+ A Day ☐ 1-3 Per Week
- ☐ Self-Abusive *(Bangs, hits, scratches self, or any other self-destructive behaviors)*

  Frequency: ☐ Occasionally ☐ Daily ☐ 2+ A Day ☐ 1-3 Per Week
- ☐ Socially Inappropriate/Disruptive *(Makes disrupting sounds, scream, sexually inappropriate or disrobes in public, smears, or throws food, takes other's belongings.)*

  Frequency: ☐ Occasionally ☐ Daily ☐ 2+ A Day ☐ 1-3 Per Week

  Comments/Acknowledgement:

SECTION II – Functional Status Completed By: _____

Title: _____ Date: _____

SPECIALIZED SERVICES *(Check [✓] all that apply)*

☐ Peer Support ☐ Day Program ☐ Supportive Counseling ☐ Massage ☐ Recreational Therapy
☐ Art Therapy ☐ Aroma Therapy ☐ Spiritual Support ☐ Vocational Rehabilitation
☐ Dementia Biography ☐ Music Therapy ☐ Smoking Cessation
☐ Aqua Therapy ☐ Promotion Persons Choices Increased Control-Meals and Other
☐ Habilitation ☐ Other: _____

Comments:

If no Specialized Services, other recommended services, or lesser intensity:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Restorative Nursing Program
☐ Walk to Dine Program ☐ Behavioral Health Referral ☐ Dental Consult ☐ Audiology Consult
☐ Ophthalmology Consult ☐ Other: _____

Comments:

DETERMINATION

Nursing Facility ☐ Yes ☐ No Future Discharge Plans ☐ Yes ☐ No

Less Restrictive Setting / Community ☐ Yes ☐ No

Comments:

Signature: _____ Title: _____ Date: _____