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 Indivdual: _____

Diagnosis:

Name of Nursing Facility: _____ Admission Date: _____

Individual's Residence: _____ Phone No. *(Include area code)*: _____

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 Mental Retardation (MR) before age 22.
☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ N/A

☐ Individual has a history of ID or a developmental disability identified in the past.

☐ Individual exhibits cognitive or psychological behaviors that may indicate ID or developmental disability.

☐ Individual has a diagnosis of seizure disorder before age 22.

☐ Individual has a diagnosis of cerebral palsy before age 22.

☐ Individual has a diagnosis of autism before age 22.

If any of the above are checked, continue.

See page 7 for EOE/ADA disclosures

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

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 or G Tube ☐ IV Nutrition
3. Hydration: ☐ Encourage Fluids ☐ 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

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

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

Extent to Which of the Following Devices Can Improve the Functional Capacity of the Individual *(Be specific)*

Non-Oral Communication System:

Amplification Device (e.g., Hearing Aid) or A Program of Amplification:

E. 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

F. 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
☐ Understands Cause and Effect

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

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

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

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

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

☐ Maintains Good Relationship ☐ Accepts Disappointment Appropriately ☐ Expresses Emotions
☐ Accepts Invitation ☐ Accepts Criticism ☐ Lives Independently

J. 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:

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: _____