**Department of Human Services**

**Division of Developmental Disabilities**

**SNF/OLMSTEAD UNIT**

**RESIDENT REVIEW**

|  |  |
| --- | --- |
| TCM: Click here to enter text. | DDD CM:  |
| TCM Telephone: : Click here to enter text. | DDD CM Telephone: Click here to enter text. |
|  | Region:  |

|  |  |
| --- | --- |
| Individual’s Name: Click here to enter text. | Date of Review: Click here to enter text. |
| DDD ID: Click here to enter text. | DOB: Click here to enter text. |
| Date of Admission to SNF: Click here to enter text. |  |
| Name of SNF: Click here to enter text. | SNF Address: Click here to enter text. |
| Guardian Name: Click here to enter text. | Family Contact Name: Click here to enter text. |
| Guardian Address: Click here to enter text. | Family Contact Address: Click here to enter text. |
| Guardian Telephone: Click here to enter text. | Family Telephone: Click here to enter text. |
| Relationship to Individual: Click here to enter text. | Relationship to Individual: Click here to enter text. |

1. **Primary Exemption Criteria :**

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| Name of Staff Person Completing Section I and II: Click here to enter text. |
| Date of Face to Face meeting with individual: Click here to enter text. | Location of Meeting (If not at SNF): Click here to enter text. |
| Indicate name(s) of respondent(s), if applicable:Click here to enter text. |
| Indicate **diagnosis** and records that were reviewed to support the existence of above criteria (Copies of referenced records with dates must be submitted. Examples are Physicians Physical, Nursing Care Plan and other Pertinent Evaluations):Click here to enter text. |
| **Individual meets the exemption criteria for Terminal Illness:** [ ] **Yes** [ ] **No****Note:** If the above criteria has been met, **STOP** and complete the section below. If it does not apply, GOTO Section II |

1. **Secondary Exemption Criteria:**

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|  |
|[ ]  **Severe physical illness**Is a long term care assessment recommended?[ ] Yes [ ] No [ ]  N/A |
|[ ]  **Dementia with DD**Is a long term care assessment recommended?[ ] Yes [ ] No [ ]  N/A |

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| Indicate name(s) of respondent(s), if applicable:Click here to enter text. |
| Indicate **diagnosis** and records that were reviewed to support the existence of above criteria (Copies of referenced records with dates must be submitted. Examples are Physicians Physical, Nursing Care Plan, Care Conference Reports for the most current year, Consultation Reports and other Pertinent Evaluations):Click here to enter text. |
| Individual meets the exemption criteria for severe physical illness: [ ] Yes [ ] No |
| Individual meets the exemption criteria for Dementia with DD: [ ] Yes [ ] No |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of OSNF Staff Person Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of OSNF Director Date |

**DETERMINATION SUMMARY**

|  |  |
| --- | --- |
| Individual met Primary Exemption Criteria:  | [ ] Yes [ ] No |
| Individual appeared to meet Secondary Exemption Criteria:  | [ ] Yes [ ] No [ ] NA |
| If Yes, secondary review was completed on (Enter Date):  | Click here to enter text. |
| Secondary review was completed by (Print Name) | Click here to enter text. |
| Individual meets exemption criteria at this time: | [ ] Yes [ ] No |
| Has individual been in Nursing Facility for 30 consecutive months? | [ ] Yes [ ] No |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Signature of OSNF Director Date** |

**III. Future Planning**

**Complete this section if individual does not meet any of the Exemption Criteria listed above**

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| Name of Staff Person Completing Section III: Click here to enter text. |
| Date of Face to Face meeting with individual: Click here to enter text. | Location of Meeting (If not at SNF): Click here to enter text. |
| Referred to DDPI for assessment? | [ ] Yes [ ] No [ ] NA |
| Date of Referral to DDPI? | Click here to enter text. |
| Include Levels (If available): Click here to enter text. |

**Community Planning meeting with the SNF Treatment Team**

|  |
| --- |
| Date: Click here to enter text. |
| Guardian in agreement to transition to the community? | [ ] Yes | [ ] No |
| Individual in agreement to transition into the community? | [ ] Yes | [ ] No |
| **IDT Minutes (HSRS/ABS Reviewed, Individual Habilitation Plan/Comprehensive Functional Assessment Tool Initiated, Support Needs Identified)**Click here to enter text. |

**Geographic Preference:**

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| **□ Northern Region** |
| Bergen County  | Somerset County |
| Essex County | Sussex County |
| Hudson County | Union County |
| Morris County | Warren County |
| Passaic County |  |
|  |
| **□ Southern Region** |
| Atlantic County | Hunterdon County |
| Burlington County  | Mercer County |
| Camden County  | Middlesex County |
| Cape May County  | Monmouth County |
| Cumberland County  | Ocean County |
| Gloucester County  | Salem County |

***For Official Use Only***

**Signature Page**

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| **Name** | **Title** | **Signature** |
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