PASRR CATEGORICAL ADVANCE GROUP DETERMINATIONS
EVALUATION REPORT

Name of Individual_____ DOB_____ SSN_____

Admitting Nursing Facility_____Date of Admission_____

Applicable Categorical Advance Group Determination (check all that apply and complete the applicable information):

☐ Provisional admissions in emergency situations not to exceed seven days in cooperation with Adult Protective Services.

Name of APS Contact_____ Jurisdiction_____ Email_____

☐ Respite stays not to exceed 30 days - Anticipated length of stay_____ Reason for respite_____

☐ Severe physical illness – Applicable diagnoses _____

☐ Convalescent care not to exceed 120 days *(Specialized Services referral required)*

Diagnoses for which convalescent care is required_____

☐ Terminal illness (life expectancy of less than 6 months) certified by a physician *(Specialized Services referral required)*

Diagnoses_____Contract hospice _____

If NF does not have a contract with a hospice, has the terminal illness been documented and has the individual waived hospice services?_____

SERVICES TO BE PROVIDED

Modality	Brief Description of Service	Frequency	Anticipated Duration
Physical therapy			
Occupational therapy			
Supportive Mental Health Services (e.g., medication management, referral for evaluation)			
Other therapy/treatment (specify)			

I certify that the foregoing information is true to the best of my knowledge. I also certify that if CAGD is being applied due to the need for convalescent care or terminal illness, the individual has been referred to the local health department Adult Evaluation and Review Services unit for evaluation of the need for Specialized Services.

Signature of Evaluator_____ Date_____

Name of Evaluator (print)_____ Title_____ Phone_____ E-mail_____

Evaluating Source (NF or Hospital)_____