RESIDENT REVIEW REQUIRED DOCUMENTATION

A RESIDENT REVIEW is required when an individual, in a Nursing Facility, with a PASRR determination letter that authorized a temporary stay and the persons stay requires an extended length of time or a change in a resident's status.

_____ Current Release of Information (ROI) dated/signed within the last year.

_____ Current Guardianship, DPOA documents (if changed since last review)

_____ Current History & Physical (H & P) (one year or less)

_____ Current Medication Administration Record (MAR)

_____ Current Care Plan

_____ Progress Notes in the last 90 days or since change of condition (Physician, Nursing, SS etc.)

_____ MDS (change of status ONLY- the most recent MDS before and after the Change of Status)

_____ Discharge summary from any State Hospital, Psych Unit or BHU since the original Level II screen or last resident review. Documentation from nursing and/ or social services on recent functioning, status of ADL's and a brief summary of why the person has had a change of status or is unable to discharge to a lower level of care.

I have attached the required documentation for the Resident Review Assessment

Name/Title_____date_____

Phone/email:_____

Please send information to KDADS.CARE@ks.gov attention Susan. Or Fax to 785-291-3427

If you have further questions please call Susan Cunningham @ 785-291-3360

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Social Security Number: __ __ - __ __ - __ __ __ __ DOB ___/____/___
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary.

Providing the information:
Person(s)/Organization(s) (check all that applies)
____ Community mental health center(s)
name _____
____ Intermediate care facility/nursing facility/hospital
name _____
____ State Agency/Department
name _____
____ Community developmental disability organization(s)
name _____
____ Aging and Disability Resource Center
Other(s): name/address/phone_____
_____

Receiving the information:
Person(s)/Organization(s) (check all that applies)
____ Aging and Disability Resource Center
name _____
____ Kansas Department for Aging and Disability Services

Other(s): name/address/phone_____
_____
_____
_____
_____

Description of Information to be Used or Disclosed (place a check mark or an "x" next to the item(s) to be used or disclosed):
___ *Recent History and Physical, signed by a physician within the last 6 months* ___*Listing of in patient or partial psych stays*
___ *List of SPMI Diagnosis* ___*List of IDD/RC Diagnosis* ___*With dates and locations in the last 2 years.*
___ *Substantiation of increase in supportive services (30 days) in the last 2 years.* ___ *LEO/APS/Housing Interventions*

The purpose of the Use or Disclosure: *Completion of a Level II PASRR Evaluation*
****Return requested documentation to: ATTN: Susan at* KDADS.CARE@KS.GOV *or FAX to (785)291-3427*

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(Initials)* I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

_____ *(Initials)* I understand this Release is valid for one year from today's date.

_____ *(Initials)* I understand that I may revoke this Release at any time by notifying the **providing organization** in writing. It will not have an effect on actions that were taken prior to the revocation.

_____ *(Initials)* I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

_____ *(Initials)* This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing).

_____ _____
Signature Date

_____ _____ _____
Signature of Personal Representative (if applicable) Date Description of Authority