\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PASRR Individual DOB SSN

**Refusal to Initiate Specialized Services**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been informed that based on the needs

 Individual/Guardian

 identified in my PASRR Evaluation, the following Specialized Services and Supports have been

 recommended, and explained to me:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Specialized Service | Accepted | Refused | Reason for Refusal |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

I understand that these Specialized Services are beyond the care provided by the Nursing Facility and will assist me in gaining or maintaining skills to help with independence. These services are provided at no additional cost. I have the right to accept or refuse all or part of these services now or in the future.

Do you choose to receive specialized services? (MUST check one)

 Yes, I ACCEPT some or all specialized services as indicated above

 No, I DECLINE all specialized services

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CMHC PASRR Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PASRR Individual DOB SSN

**Refusal to Continue Specialized Services**

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ currently receives the Specialized Services

 PASRR Individual

outlined below in my Person Centered Service Plan. These services are beyond the services

provided by the Nursing Facility and are provided to me at no additional charge. I have the right to

refuse all or part of these services now or in the future.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| POC Date  | Specialized Service(Description/details)  | Accepted |  Refused  | Reason for refusal |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

I understand that these Specialized Services are beyond the care provided by the Nursing Facility and will assist me in gaining or maintaining skills to help with independence. These services are provided at no additional cost. I have the right to accept or refuse all or part of these services now or in the future.

Do you choose to continue to receive specialized services? (MUST check one)

 Yes, I ACCEPT some or all continued specialized services as indicated above

 No, I DECLINE all continued specialized services

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CMHC PASRR Representative Date