

utah department of  
**human services**  
 SUBSTANCE ABUSE AND MENTAL HEALTH

**PASRR Nursing Facility Update Form**

**PLEASE PRINT LEGIBLY (All Fields are Required)**

1. Name of Nursing Facility: \_\_\_\_\_
2. Business Address: \_\_\_\_\_
3. Business Phone Number: \_\_\_\_\_
4. Business E-mail (for correspondence from our system and can not be used as a login):  
 \_\_\_\_\_

5. Please Circle all that your facility specializes:

- |   |                  |                         |                |
|---|------------------|-------------------------|----------------|
| Skilled Nursing                                 | Behavioral Units | Short Term Care         | Long Term Care |
| Locked Units                                    | Locked Buildings | Dementia/Alzheimer Care |                |
| Other (please describe special services): _____ |                  |                         |                |

6. Staff Authorized to access the PASRR System (administrator's information is entered above their signature).  
 Suggestions: Admissions, BOM/Medical Records, Resident Advocate/SSW, DON/ADON, etc.  
**Please note that names and emails must match the UMD login and should not be hotmail accounts.**

_____	_____	_____	_____
Position	Name	Phone	E-mail Address
_____	_____	_____	_____
Position	Name	Phone	E-mail Address
_____	_____	_____	_____
Position	Name	Phone	E-mail Address
_____	_____	_____	_____
Position	Name	Phone	E-mail Address

I understand that it is my responsibility to notify the State PASRR office immediately upon a change of authorization.

I understand that changes not made through the quarterly change report must be done on Nursing Facility letterhead, signed by the Administrator, and email to pasrradmin@utah.gov.

\_\_\_\_\_

Print Administrator's Name	Phone	E-mail Address
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Administrator's Signature	Date
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State PASRR Office use only		
Facility number: _____	Date received: _____	Date entered: _____
Notes: _____		