

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 cannot 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: Admission, 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

 Administrator's Signature Date

State PASRR Office use only

Facility number: _____ Date received: _____ Date entered: _____

Notes: _____