

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 account.

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 within one business day upon a change in authorization of access to the PASRR System via email to pasrradmin@utah.gov. I agree to abide by Federal and State of Utah privacy and confidentiality law and non-compliance from any individual listed on this form may result in loss of access to the State PASRR System.

 Print Administrator's Name Phone E-mail Address

 Administrator's Signature Date

State PASRR Office use only

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

Notes: _____