

Level I PASRR Screen and Determination

This screen is to be completed prior to admission to a nursing facility (NF). Failure to complete this form accurately may result in disallowance of Medicaid payment.

Name: _____ DOB: _____

Address: _____

Is this the applicant's first admission to any NF? Yes No Unknown

Admitting diagnosis to NF: Primary: _____

Secondary: _____

Others: _____

SECTION I: MI/MR

Look for indicators of MI/MR on the Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS) MedServ-3008, DOEA Assessment Instrument (701B), CMAT Assessment and any other medical information provided. Answers to questions on page 3 of this form will also assist in making a determination as to whether the individual has indications of, or a diagnosis of mental illness and/or mental retardation.

Part A - Mental Illness

Does the individual have indications of, or a diagnosis of a major mental illness as defined in the DSM-IV R, limited to schizophrenia, mood disorder, severe anxiety disorder, or a mental illness that may lead to a chronic disability?

The screener must answer all questions on the guide to determine a major/serious mental illness.

Yes No

Part B - Mental Retardation

Does the individual have indications of, or a diagnosis of mental retardation as defined in the AAMR Manual on Classification in Mental Retardation or other related conditions such as cerebral palsy, epilepsy, or any other conditions, including autistic disorders, that are closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior (42 CFR 435.1010) which manifested prior to the age of 22?

The screener must answer all questions on the guide to determine mental retardation or a related condition.

Yes No

If both answers are **No**, **STOP!** Level I Screener can sign and date Level I Screen.

Signature: _____ Date Completed: _____

Title: _____ Agency: _____

If any answer in Section I, Part A or Part B is **Yes**, proceed to Section II.

SECTION II: CATEGORICAL DETERMINATION OF DEMENTIA/RELATED DISORDER

Does the individual have a primary diagnosis of dementia (including Alzheimer's Disease or a related condition) or a non-primary diagnosis of dementia with a primary diagnosis that is not a major mental illness? Yes No

If **Mental Illness** only and answer is **Yes**, **STOP!** Level I Screener can sign and date Level I Screen.

Signature: _____ Date Completed: _____

Title: _____ Agency: _____

If **Mental Illness** only and answer is **No**, proceed to Section III.

If **Mental Illness** and **Mental Retardation** or **Mental Retardation** only, proceed to next question.

Does the individual have a dementia diagnosis that exists in combination with mental retardation or a related condition (i.e. Epilepsy, Cerebral Palsy, Prader-Willi Syndrome, Autism, Spina Bifida)?

Yes No

If **Mental Retardation** only and answer is **Yes**, **STOP!** This individual can be admitted or retained in a NF. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen.

Signature: _____ Date Completed: _____

Title: _____ Agency: _____

If **Mental Retardation** only and answer is **No**, proceed to Section III.

If **Mental Illness** and **Mental Retardation** and any answer is **No**, proceed to Section III.

Name: _____

DOB: _____

SECTION III: EXEMPTED HOSPITAL DISCHARGE

Is the individual being admitted from a hospital after receiving acute inpatient care and requires NF services for the condition for which he or she received care in the hospital and whose attending physician has certified before admission that the individual is likely to require less than 30 days NF services? Yes No

If **Yes, STOP!** This individual can be admitted to a NF. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen. **If the individual is later found to require more than 30 days of NF care, a resident review must be conducted within 40 calendar days of admission.**

Signature: _____ Date Completed: _____

Title: _____ Agency: _____

If **No**, proceed to Section IV.

SECTION IV: ADVANCE GROUP DETERMINATIONS

A provisional admission to a nursing facility can be made under the following time limited categories.

1. Pending further assessment of delirium where an accurate diagnosis cannot be made until the delirium clears, **not to exceed seven days.** Yes No
2. Pending further assessment in emergency situations requiring protective services, with placement in a nursing facility, **not to exceed seven days.** Yes No
3. Brief respite care for in-home caregivers, with placement in a nursing facility twice a year **not to exceed 14 days.** Yes No

If any answer is **Yes, STOP!** This individual can be admitted to a NF. Level I screener can sign and date Level I Screen. **If the individual is later determined to need a longer stay, identified through a resident review, a Level II Evaluation and Determination must be conducted before continuation of the stay may be permitted and payment made for days of NF care beyond the State's time limit.**

Signature: _____ Date Completed: _____

Title: _____ Agency: _____

If all answers in Section IV are **No**, proceed to Section V.

SECTION V: INDIVIDUALIZED EVALUATION DETERMINATION

A Level II Evaluation is required for individuals with MI or MR who meet one of the following advanced group determinations of the need for NF services or for those who do not meet one of the categorical or advanced group determinations in Sections III, IV or V. The Level II Evaluation and Determination must be received prior to NF admission.

1. Does the individual require convalescent care from an acute physical illness that required hospitalization and does not meet all the criteria for an exempt hospital discharge? Yes No
2. Does the individual have a terminal illness as defined for hospice purposes (**life expectancy six months or less**)? Yes No
3. Does the individual have a severe physical illness such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Congestive Heart Failure, which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes No

Signature: _____ Date Completed: _____

Title: _____

Agency: _____

Date of Mental Health Evaluation, if applicable: _____

Date referred for Level II, if applicable: _____

Level II Agency: _____

Level I PASRR Guide for Determining a Diagnosis or Possible Diagnosis of a Serious Mental Illness, Mental Retardation, or a Related Condition

Name: _____

DOB: _____

Please answer all questions on this guide. If any item in number one is checked and any item in numbers two, three or four is checked yes, the individual is suspected to have an indication of, or a diagnosis of a serious mental illness or mental retardation, or a related condition.

1. Does the Level I Screen indicate the individual has a diagnosis or indication of (check those that apply):

- | | |
|--|--|
| <input type="checkbox"/> Severe Anxiety/Panic Disorder | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Schizoaffective Disorder | <input type="checkbox"/> Major Depression |
| <input type="checkbox"/> Psychotic Disorder | <input type="checkbox"/> Somatoform Disorder |
| <input type="checkbox"/> Dysthymia | <input type="checkbox"/> Cyclothymia |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Personality Disorder (specify) _____ |
| <input type="checkbox"/> Prader-Willi Syndrome | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Retardation with an IQ lower than 70 (specify) _____ |
| <input type="checkbox"/> Childhood and Adolescent Disorder (specify) _____ | |
| <input type="checkbox"/> Other _____ | |

2. Does the Level I Screen indicate that this disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage?

- Yes No

3. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.

- Yes No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

- Yes No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

- Yes No

4. Does the Level I Screen indicate the individual has received recent treatment for a mental illness? Does the treatment history indicate that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization).

- Yes No

B. Within the last two years, due to the mental illness, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

- Yes No

Signature: _____ Date Completed: _____

Title: _____