NURSING FACILITY IDENTIFICATION SCREEN (LEVEL I PASRR)

Section 1: The Individual's Admission Information

This form shall be completed by nursing facility personnel prior to admission of the applicant to the nursing facility.

First Name: MI : Last Name:

Address: City: State: Zip:

Mailing Address: (if different from above):

City: State: Zip:

Phone:

Date of Birth: Social Security #: Medicaid ID if Applicable:

Typical living situation over the past year:

☐ Lives Alone ☐ At Home with Family ☐ Home w/paid support ☐ Homeless/Shelter

☐ Hospital ☐ Nursing Facility ☐ Assisted Living Facility ☐ Waiver Services in the community

☐ Other:

Will be admitted from:

Reason NF Admission Sought:

Expected Length of Stay: Expected Date of Admission:

Admitting Nursing Facility:

Region: Phone:

Address: City State: Zip:

Does this individual have a legally appointed Guardian, POA, or a Chosen Healthcare Advocate: ☐ Yes ☐ No

Name: Designation:

Contact information for Guardian:

Who is providing this information to the Nursing Facility:

What is their relationship to the person being admitted:

Section 2: Mental Illness

2a: Diagnosis

Identify whether the individual has a current diagnosis for, or is suspected to have a diagnosis of a major mental illness (such as psychotic disorder, mood, paranoid, panic or other severe anxiety disorder, or PTSD)
If none identified, check "No" in box 2d and continue to section 3.

Name of Condition	Source of Information

2b. Level of Impairment

Within the last 6 months, has the individual experienced significant difficulty in 1 or more areas of functioning below due to the above listed condition(s) : (check all that apply)
If none identified, check "No" in box 2d and continue to section 3.

- ☐ **Interpersonal functioning** such as serious difficulty interacting with other, difficulty communicating with others, altercations, evictions, unstable employment, frequent isolation, avoids others, or fear of strangers.
- ☐ **Concentration, persistence and pace** such as serious difficulty in focusing and concentrating, requiring assistance with completing tasks, and the inability to complete simple tasks within an established time period without assistance.
- ☐ **Adaption to change** that shows serious difficulty adapting to changes involving work, school, family, or social interactions through agitation, self-harm, suicidal/homicidal ideation, physical violence or threats, appetite disturbances, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or intervention by mental health or judicial system.

2c. Treatment

In the last 2 years, due to above listed conditions and related impairments in functioning, has the individual: (check all that apply)
If none identified, check "No" in box 2d and continue to section 3.

- ☐ Required intensive psychiatric treatment (more intensive than outpatient care) in order to maintain or restore functioning such as psychiatric hospitalization, partial hospitalization/day treatment, residential treatment.
- ☐ 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?

2d. SMI indication

Was there a response provided in each section (**a, b, and c**)?

☐ Yes ☐ No

Section 3: Intellectual Disability (ID)

3a: Diagnosis and intellectual functioning

Does the individual have an intellectual disability diagnosis, or have deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience with onset prior to age 18?

☐ Yes ☐ No

3b: Adaptive functioning

Does the individual have deficits in adaptive functioning due to the intellectual impairment, with onset prior to age 18, such as:

1. Failure to meet developmental and sociocultural standards for personal independence and social responsibility.
2. Limited independent functioning in one or more activities of daily life such as – communication, social participation, and independent living; and across multiple environments, such as home, school, work, and community.

☐ Yes ☐ No

Section 4: Related Condition (RC)

4a: Diagnosis and relation to ID

Identify whether the individual has a diagnosis of a condition found to be closely related to an intellectual disability such as cerebral palsy, Down Syndrome, fetal alcohol syndrome, seizure disorder, and traumatic brain injury with onset prior to age 22. (note that this is not an exhaustive list)

If none identified, continue to section 5.

Type of Diagnosis	Source of Information

4b: Intellectual functioning

Did the above diagnosis result in impairments in general intellectual functioning similar to an intellectual disability that is expected to continue indefinitely?

☐ Yes ☐ No

4c: Adaptive functioning

Did the above diagnosis result in substantial functional limitations in 3 or more of the following areas of major life activities that requires treatment or services similar to those required by persons with an intellectual disability:
(1) Self-care; (2) understanding and use of language; (3) learning; (4) mobility; (5) self-direction; or (6) capacity for independent living?

☐ Yes ☐ No

Section 5: Exempted or delayed Level II Referrals

5a: Person Is an Exempted Hospital Discharge

Although identified as an individual with mental illness, intellectual disability, or other related condition, an applicant who is not dangerous to self and/or others may be directly admitted for nursing facility services from an acute care hospital **for a period up to thirty (30) days** without a Level II PASRR if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization. An Exempted Hospital Discharge Physician Certification form shall be completed and maintained in the resident's clinical record at the nursing facility.

☐ Yes ☐ No

* *If an individual who enters the nursing facility as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the nursing facility must then refer the individual for a PASRR Level II evaluation as soon as it is known.*

5b: Person Requires Respite Care

Although identified as an individual with mental illness, intellectual disability, or other related condition, an applicant who is not dangerous to self or others may be admitted for Respite Care **for a period up to fourteen (14) days** without a Level II PASRR. A Provisional Admission Form shall be completed and maintained in the resident's clinical record at the nursing facility.

☐ Yes ☐ No

* *If the individual is not discharged within 14 days of this provisional admission, the nursing facility must refer for a PASRR Level II evaluation. The nursing facility will not be eligible for reimbursement after the 14th day of admission until a PASRR determination is made authorizing nursing facility level of care.*

5c: Person Has a Diagnosis of Delirium

An individual suspected of having Delirium may be admitted without the level two evaluation pending a definitive diagnosis once the condition clears, and may receive nursing facility services **for a period up to fourteen (14) days** without a Level II PASRR, if certified by the referring or attending physician A Provisional Admission Form shall be completed and maintained in the resident's clinical record at the nursing facility.

☐ Yes ☐ No

* *If the individual is not discharged within 14 days of this provisional admission, the nursing facility must refer for a PASRR Level II evaluation. The nursing facility will not be eligible for reimbursement after the 14th day of admission until a PASRR determination is made authorizing nursing facility level of care.*

Section 6: Level II Referral Designation

If not exempted or delayed:

Were any responses in sections 2 (MI), 3 (ID), or 4 (RC) marked "**yes**"?

☐ Yes - the nursing facility staff shall **refer the applicant to the Community Mental Health Center for a Level II PASRR**. The Level II PASRR determination shall be completed prior to the nursing facility admitting the applicant.

☐ No - The nursing facility is required to contact the PRO for the Medicaid level of care determination prior to admission.

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate, and complete.

Signature	Title	Date	Telephone Number

Facility Name _____ Medicaid Provider Number _____

Original – Nursing facility record
COPY TO CMHC if referral made