# PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW EVALUATION (PASRR-EV) LEVEL II FORM

## PA-PASRR-EV (Revised 1/1/2016)

When a Pennsylvania Preadmission Screening Resident Review Evaluation (PA-PASRR-EV) Level II Form is completed the following documentation must be sent to the appropriate Department of Human Services (DHS) program office (Office of Mental Health and Substance Abuse Services, Office of Developmental Programs, Office of Long-Term Living): completed PA-PASRR-EV Level II Form, all supporting documentation (see list in Section VIII), the assessors' name, and telephone number.

**DATE OF ASSESSMENT:** _____

## SECTION I - DEMOGRAPHICS

| APPLICANT/RESIDENT'S NAME: | SOCIAL SECURITY NUMBER: | AGE: | BIRTH DATE: | COUNTY OF ORIGIN: |
|---|---|---|---|---|
| Is the applicant/resident enrolled in or applying for Medical Assistance (MA)?<br>☐ Yes ☐ No | MA NUMBER: | | | |

## SECTION II - DOCUMENTATION

**II-A: MEDICATIONS**

1. List all current medications the individual is taking related to his/her MI, ID, or ORC diagnosis(es):

| MEDICATION | DOSE | FREQUENCY | SIDE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Does the individual have any allergies or adverse reactions to any medications? ☐ No ☐ Yes - List:

_____

_____

_____

**II-B: SUPPORTS**

List the medical and social supports the individual current receives (include activities of interest that show socialization with others):

_____

_____

_____

**II-C: REVIEW TYPE**

Select type(s) of review: ☐ MI ☐ ID ☐ ORC

**Please complete each section(s) for the review type(s) checked above. Once the appropriate section(s) noted above have been completed, complete Sections VI through IX.**

NAME _____ SSN (LAST 4 DIGITS) _____

## SECTION III - MENTAL ILLNESS (MI)

### III-A: DOCUMENTATION OF THE DIAGNOSIS

1. Is the individual currently **assaultive and/or self-abusive** to the degree that he/she might endanger other residents of a nursing facility or might injure himself/herself without constant supervision by mental health personnel? ☐ Yes ☐ No

2. For **PASRR** purposes, the Major Mental Disorders include the following. Please check "No" or "Yes" to indicate if a **CURRENT Diagnosis** exists, enter year (or approximate year) of onset, and attach documentation. Examples of acceptable documentation include a current psychiatric assessment with diagnosis or other professionally accepted diagnostic practices by a qualified physician or psychiatrist, (see CFR §483.134).

| DIAGNOSIS | CURRENT? | ONSET YEAR | DIAGNOSIS | CURRENT? | ONSET YEAR |
|---|---|---|---|---|---|
| Schizophrenia | ☐ Yes ☐ No | | Panic or other severe anxiety disorder | ☐ Yes ☐ No | |
| Schizoaffective disorder | ☐ Yes ☐ No | | Somatic Symptom disorder | ☐ Yes ☐ No | |
| Delusional disorder | ☐ Yes ☐ No | | Personality disorder | ☐ Yes ☐ No | |
| Bipolar disorder | ☐ Yes ☐ No | | Depressive disorder | ☐ Yes ☐ No | |
| Psychotic disorder | ☐ Yes ☐ No | | Other | ☐ Yes ☐ No | |

3. Does a review of the applicant/resident's case history and/or medical record substantiate that the mental disorder is responsible for the functional limitations **in the last 3-6 months** in the following areas? (See PASRR-ID for definitions).

| | |
|---|---|
| Interpersonal functioning | ☐ Yes ☐ No |
| Concentration, persistence, and pace | ☐ Yes ☐ No |
| Adaptation to change | ☐ Yes ☐ No |
| Describe: | |

4. Does a review of the applicant/resident's treatment history substantiate that the individual experienced **at least one** of the following **in the past two years**?

   a. Psychiatric treatment more intensive than outpatient care: ☐ No ☐ Yes

   If yes, describe: _____

   b. 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. (Supportive services include crisis intervention, intensive case management, and/or other social service agency intervention). ☐ No ☐ Yes

   If yes, describe: _____

   c. Suicide ideation with a plan or attempt as reported by the individual, other, or verified by a psychiatric consult: ☐ No ☐ Yes

   If yes, describe: _____

   d. Electroconvulsive Therapy - ECT (related to MI): ☐ No ☐ Yes

   If yes, describe: _____

   e. Mental Health Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment (ACT): ☐ No ☐ Yes

   If yes, describe: _____

### III-B: SUPPORTING INFORMATION

1. The following information in the list below should be gathered to allow the Office of Mental Health to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

| | |
|---|---|
| ☐ | Complete medical history. |
| ☐ | Review of all body systems. |
| ☐ | Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; additional evaluations conducted by appropriate specialists. |
| ☐ | A comprehensive drug history including current or immediate past use of medications that could mask symptom or mimic mental illness. |
| ☐ | A psychosocial evaluation of the individual, including current living arrangements, medical, and support systems. |
| ☐ | A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations. |
| ☐ | Functional assessment of the individual's ability to engage in activities of daily living. Include the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must also determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that nursing facility placement is required. The functional assessment must address the following areas: Self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, or both, self-monitoring of nutritional status, handling money, dressing appropriately, and grooming. |

2. Was a Saint Louis University Mental Status (SLUMS) exam performed as part of the Long-Term Services and Supports (LTSS) assessment?

   ☐ No - Please complete (see last page). ☐ Yes - Score: _____

3. Estimated level of intelligence of the individual during this evaluation: ☐ High ☐ Average ☐ Low ☐ Unknown

NAME _____ SSN (LAST 4 DIGITS) _____

**III-C: RECOMMENDATION TO THE PROGRAM OFFICE**

1. Does the individual have a diagnosis of a major mental disorder which meets the criteria of a "serious mental illness"?

   ☐ No ☐ Yes

2. Does the individual currently receive mental health or substance use disorder services in the community?

   ☐ No ☐ Yes - List what service(s): _____

3. Does the individual need specialized services in the nursing facility (See Section III-D)?

   ☐ No ☐ Yes - List what service(s): _____

4. Does the individual need health rehabilitative services provided by the nursing facility for his/her mental illness?

   ☐ No ☐ Yes - List what service(s): _____

**III-D: DESIRE FOR SPECIALIZED SERVICES**

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.

   An individual may choose whether to participate in recommended specialized services.

2. Explain available Specialized Services using the definitions below.

   Specialized services for an individual that meets the clinical criteria for a serious mental illness include appropriate community-based mental health services such as:

   - **Partial Psychiatric Hospitalization** – Services provided in a non-residential treatment setting which includes psychiatric, psychological, social and vocational elements under medical supervision. Designed for patients with moderate to severe mental illness who require less than 24-hour continuous care but require more intensive and comprehensive services than offered in outpatient. Services are provided on a planned and regularly scheduled basis for a minimum of 3 hours, but less than 24 hours in any one day.
   - **Psychiatric Outpatient Clinic** – Psychiatric, psychologist, social, educational and other related services provided under medical supervision in a non-residential setting designed for the evaluation and treatment of patients with mental or emotional disorders.
   - **Mobile Mental Health Treatment (MMHT)** – A service array for adults and older adults with a mental illness who encounter barriers to, or have been unsuccessful in, attending an outpatient clinic. The purpose of MMHT is to provide therapeutic treatment to reduce the need for intensive levels of service including crisis intervention or inpatient hospitalization. MMHT provides treatment which includes evaluation; individual, group, or family therapy; and medication visits in an individual's residence or approved community site.
   - **Crisis intervention services** – Immediate, crisis oriented services designed to ameliorate or resolve precipitating stress. Provided to persons who exhibit acute problems of disturbed thought, behavior, mood, or social relationships
   - **Targeted mental health case management (intensive case management (ICM) and resource coordination)** – ICM services are provided to assist adults with serious and persistent mental illness to gain access to needed resources such as medical, social, educational, and other services. Activities undertaken by staff providing ICM services include: linking with services, monitoring of service delivery, gaining access to services, assessment and service planning, problem resolution, informal support network building, use of community resources. Resource Coordination is provided to persons who do not need the intensity and frequency of contacts provided through ICM, but who do need assistance in accessing, coordinating and monitoring of, resources and services.
   - **Peer Support Services** – Person-centered and recovery focused services for adults with serious and persistent mental illness. The services are provided by individuals who have been served in the public behavioral health system. The service is designed to promote empowerment, self-determination, understanding and coping skills through mentoring and service coordination supports that allow people with severe and persistent mental illness to achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disabilities. Peer Specialists may provide site-based and/or mobile peer support services, off-site in the community.
   - **Outpatient D&A services, including Methadone Maintenance Clinic** – An organized, non-residential, drug-free treatment service providing psychotherapy in which the client resides outside the facility. Services are usually provided in regularly scheduled treatment sessions for, at most, 5 contact hours per week.

   If the individual meets the clinical criteria for a serious mental illness and is admitted to a nursing facility, some mental health or substance use disorder services may need to continue to be provided to the individual. The provision of specialized services should be assured by the nursing facility and Office of Mental Health.

   Specialized services for individuals with a serious mental illness are authorized by the Office of Mental Health. The services shall be based on the individual's needs.

3. Explain further and answer questions as needed.

   a. Do you understand what I have told you about specialized services? ☐ No - Try again ☐ Yes

   b. If recommended, do you want to receive any specialized services? ☐ No ☐ Yes

NAME _____ SSN (LAST 4 DIGITS) _____

## SECTION IV: INTELLECTUAL DISABILITY (ID)

### IV-A: DOCUMENTATION OF THE DIAGNOSIS

1. Does the documentation indicate a diagnosis of an ID? ☐ No ☐ Yes

   Documentation can include, but is not limited to, IQ and adaptive testing (preferably before the age of 18), psychological reports, psychiatric reports, school records, summaries from the county ID program or ID agency, and other relevant professional reports.

2. Does the documentation provide evidence of the following characteristics?

   a. Significantly sub-average intellectual functioning with an IQ of approximately 70 or below on standardized intelligence testing identified by a qualified psychologist? ☐ No ☐ Yes

   b. Onset prior to the age of 18 (consider all relevant and informed sources)? ☐ No ☐ Yes

   c. Deficits in adaptive behavior or functioning on formal assessment? ☐ No ☐ Yes

3. Indicate level of ID. ☐ Mild (50-69) ☐ Moderate (35-49) ☐ Severe (25-34) ☐ Profound (<25) ☐ Unspecified ☐ Not known (scores not available) ☐ None

### IV-B: SUPPORTING INFORMATION

1. Does the individual have a Supports Coordinator? ☐ No ☐ Yes - List name of Supports Coordinator and Agency:

   _____

2. The following information in the list below should be gathered to allow the Office of Developmental Programs to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

| | |
|---|---|
| ☐ | Self-monitoring of health status. |
| ☐ | Self-administering and scheduling of medical treatments. |
| ☐ | Self-monitoring of nutritional status. |
| ☐ | Self-help development such as toileting, dressing, grooming and eating. |
| ☐ | Sensorimotor skills such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination and the extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity. |
| ☐ | Communication skills including expressive and receptive language and the extent to which a communication system, amplification device and/or program of amplification could improve the individual's functional capacity. |
| ☐ | Social skills including relationships, interpersonal, and recreation-leisure skills. |
| ☐ | Academic and educational skills including functional learning skills. |
| ☐ | Independent living skills involving meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to neighborhood, town, city, etc.), orientation skills for individuals with visual impairments, laundry, housekeeping, shopping, bed making, and care of clothing. |
| ☐ | Vocational skills. |
| ☐ | Affective skills including interests, ability to express emotion, making judgements, and independent decision-making. |
| ☐ | Presence of maladaptive or inappropriate behaviors including their description, frequency, and intensity. |

### IV-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of an intellectual disability which meets the criteria of an "intellectual disability"?

   ☐ No ☐ Yes

2. Does the individual currently receive intellectual disability services in the community?

   ☐ No ☐ Yes - List what service(s): _____

3. Does the individual need specialized services in the nursing facility (See Section IV-D)?

   ☐ No ☐ Yes - List what service(s): _____

4. Does the individual need health rehabilitative services provided by the nursing facility for his/her intellectual disability?

   ☐ No ☐ Yes - List what service(s): _____

### IV-D: DESIRE FOR SPECIALIZED SERVICES

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.

   An individual may choose whether to participate in recommended specialized services.

2. Explain available Specialized Services using the definitions below.

   Specialized services for an individual that meets the clinical criteria for an intellectual disability include appropriate community-based intellectual/developmental disability services which result in:

- The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of current optimal functional status

Specialized services are authorized for applicants/residents with an "intellectual disability" by the Office of Developmental Programs or its agent. For individuals with ID, community specialized services primarily include:

- **Assistive Technology** – An item, piece of equipment, or product system that is used to increase, maintain, or improve an individual's functioning. Assistive technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device.
- **Behavioral Support** – This service includes functional assessment; development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, parents and caregivers. Services must be required to meet the current needs of the individual.
- **Companion Services** – Services are provided to individuals for the limited purposes of providing supervision and assistance focused on the health and safety of the adult individual with an intellectual disability. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety.
- **Home and Community Habilitation Services** – This is a direct service (face-to-face) provided to assist individuals in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. Through the provision of this service individuals will acquire, maintain, or improve skills necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life.
- **Licensed Day Habilitation** – This is a direct service (face-to-face) that consists of supervision, training, and supports in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development. The service also includes transportation that is an integral component of the service; for example, transportation to a community activity. The Licensed Day Habilitation provider is not, however, responsible for transportation to and from an individual's home.
- **Supports Coordination** – This is a service that involves the primary functions of locating, coordinating, and monitoring needed services and supports. Locating services and supports consists of assistance to the individual and his or her family in linking, arranging for, and obtaining services specified in an ISP, including needed medical, social, habilitation, education, or other needed community services.
- **Support (Medical Environment)** – This service may be used to provide support in general hospital or nursing home settings, when there is a documented need and the County Program Administrator or Director approves the support in a medical facility. The service is intended to supply the additional support that the hospital or nursing home is unable to provide due to the individual's unique behavioral or physical needs.
- **Transportation** – Transportation is a direct service that enables individuals to access services and activities specified in their approved Individual Support Plan.

3. Explain further and answer questions as needed.

   a. Do you understand what I have told you about specialized services? ☐ No - Try again ☐ Yes

   b. If recommended, do you want to receive any specialized services? ☐ No ☐ Yes

## SECTION V: OTHER RELATED CONDITIONS (ORC)

"Other Related Conditions" include physical, sensory or neurological disabilities which manifested before age 22 are likely to continue indefinitely and result in substantial functional limitations in **three or more** of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living. It is important to note that a person can have an "Other Related Condition" **regardless of whether the ORC impairs their intellectual abilities.**

### V-A: DOCUMENTATION OF THE DIAGNOSIS

1. Is there documentation to substantiate that the individual meets the following criteria for an ORC? ☐ No ☐ Yes

   Documentation is to include, but not limited to, a psychological evaluation, physician's note which indicates that the diagnosis and three functional limitations **occurred prior to age 22**, or a statement to this effect from the individual or family.

2. Does the documentation provide evidence of the following characteristics?

   a. Has a physical, sensory, or neurological disability which is considered an "Other Related Condition".

   ☐ No ☐ Yes - Specify condition/diagnosis(es): _____

   b. The condition manifested before age 22? ☐ No ☐ Yes

   c. The condition is expected to continue indefinitely. ☐ No ☐ Yes

### V-B: SUPPORTING DOCUMENTATION

1. Indicate areas where the individual has a **SUBSTANTIAL FUNCTIONAL LIMITATION** which has manifested prior to age 22.

   ☐ **Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.

   ☐ **Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.

   ☐ **Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

   ☐ **Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.

   ☐ **Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.

   ☐ **Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

NAME _____ SSN (LAST 4 DIGITS) _____

2. The following information in the list below should be gathered to allow Office of Long-Term Living to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment:

| | |
|---|---|
| ☐ | Sensorimotor development (ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination) |
| ☐ | Speech and language development (includes expressive and receptive language, disorders, i.e. Communication disorders). |
| ☐ | Social development (includes interpersonal skills, recreation-leisure skills, and relationships with others). |
| ☐ | Academic/educational development (grade level of school completed and/or functional learning skills). |
| ☐ | Independent living development (includes meal preparation, budgeting and personal finances, survival skill, mobility skills [orientation to the neighborhood, town, etc.], laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills for individuals with visual impairments). |
| ☐ | Vocational development (include present vocational skills). |
| ☐ | Affective development (such as interests and skills involved with expressing emotions, making judgments, and making independent decisions). |
| ☐ | IQ and adaptive function testing. |
| ☐ | Psychological evaluation. |
| ☐ | Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systemic observation (include frequency and intensity of behavior). |
| ☐ | Extent to which prosthetic, orthotic-corrective or mechanical-supportive devices can improve the individual's functional capacity. |
| ☐ | Extent to which non-oral communication systems can improve the individual's functional capacity. |

**V-C: RECOMMENDATION TO THE PROGRAM OFFICE**

1. Does the individual have a diagnosis of a related condition which meets the criteria of an "other related condition"?

   ☐ No ☐ Yes

2. Does the individual currently receive services in the community for the other related condition?

   ☐ No ☐ Yes - List what service(s): _____

3. Does the individual need specialized services in the nursing facility (See Section V-D)?

   ☐ No ☐ Yes - List what service(s): _____

4. Does the individual need health rehabilitative services provided by the nursing facility for his/her other related condition?

   ☐ No ☐ Yes - List what service(s): _____

**V-D: DESIRE FOR SPECIALIZED SERVICES**

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.

   An individual may choose whether to participate in recommended specialized services.

2. Explain available Specialized Services using the definitions below.

   Specialized services for an individual that meets the clinical criteria for a related condition include appropriate community-based services which result in:

   - The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
   - The prevention or deceleration of regression or loss of current optimal functional status.

   Specialized services are authorized for applicants/residents with an "Other Related Condition" by the Office of Long-Term Living or its agent. For individuals with ORC, community specialized services primarily include:

   - **Service Coordination/Advocacy Services** – Development and maintenance of a specialized service plan, facilitating and monitoring the integration of specialized services with the provision of nursing facility and specialized rehabilitative services, and assisting or advocating for residents on issues pertaining to residing in nursing facilities.
   - **Peer Counseling/Support Groups** – Linking residents to "role models" or "mentors" who are persons with physical disabilities and who reside in community settings.
   - **Training** – In areas such as self-empowerment/self-advocacy, household management in community settings, community mobility, decision making, laws relating to disability, leadership, human sexuality, time management, self-defense/victim assistance, interpersonal relationships, certain academic/development activities, and certain vocational/development activities.
   - **Community Integration Activities** – Exposing residents to a wide variety of unstructured community experiences which they would encounter in the event that they must or choose to leave the nursing facilities or engage in activities away from the nursing facilities.
   - **Equipment/Assessments** – Purchase of equipment and related assessment for residents who plan, within the next two years, to relocate to community settings.
   - **Transportation** – Facilitation of travel necessary to participate in the above specialized services.

3. Explain further and answer questions as needed.

   a. Do you understand what I have told you about specialized services? ☐ No - Try again ☐ Yes

   b. If recommended, do you want to receive any specialized services? ☐ No ☐ Yes

NAME

SSN (LAST 4 DIGITS)

## SECTION VI: SIGNATURES

Obtain signature of either the individual or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services.

| INDIVIDUAL'S SIGNATURE: | DATE: |
|---|---|
| WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE: | DATE: |
| REPRESENTATIVE'S SIGNATURE: | DATE: |

## SECTION VII: NOTICE OF REFERRAL FOR FINAL DETERMINATION

You must now explain to the individual, legal representative, family member and/or significant other (if the individual agrees to family participation) that persons with a serious Mental Illness, Intellectual Disability, or an Other Related Condition may not always need nursing facility services, and should be in places more suited to their needs. Explain that this assessment is a way for making sure the individual is receiving the appropriate services to meet his/her needs and receiving the services in the setting that best fits his/her needs.

**For Persons with Mental Illness:** You have (your relative/friend/responsible party has) been given a diagnosis of a Major Mental Disorder. We must forward this form and the related information to the DHS Office of Mental Health to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

**For Persons with Intellectual Disability:** You have (your relative/friend/responsible party has) been given a diagnosis of an Intellectual Disability. We must forward this form and the related information to the DHS Office of Developmental Programs to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

**For Persons with an Other Related Condition:** You have (your relative/friend/responsible party has) been given a diagnosis of an Other Related Condition. We must forward this form and the related information to the DHS Office of Long-Term Living to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

Questions about the preparation of this form should be referred to the person completing this form.

| PRINT NAME: | TITLE: | | DATE: |
|---|---|---|---|
| SIGNATURE: | DATE: | TELEPHONE: | |

NAME _____ SSN (LAST 4 DIGITS) _____

## SECTION VIII: DOCUMENTATION TO INCLUDE FOR PROGRAM OFFICE REVIEW

Send the below documentation to the Program Office in the order it is listed below:

| MH | | ID | | ORC | |
|---|---|---|---|---|---|
| ☐ | Program Office Transmittal Sheet – should be the 1st sheet in packet. | ☐ | Program Office Transmittal Sheet – should be the 1st sheet in packet. | ☐ | Program Office Transmittal Sheet – should be the 1st sheet in packet. |
| ☐ | MA 51 (NF Field Operations may not have this) | ☐ | MA 51 (NF Field Operations may not have this) | ☐ | MA 51 (NF Field Operations may not have this) |
| ☐ | Notification Sheet – Reminder – Include the FAX number for the hospital/NF. | ☐ | Notification Sheet – Reminder – Include the FAX number for the hospital/NF. | ☐ | Notification Sheet – Reminder – Include the FAX number for the hospital/NF. |
| ☐ | PASRR-ID and PASRR-EV – Reminder – for the Notification (page 9, PASRR-EV) list home address, NOT hospital unless client is homeless. | ☐ | PASRR-ID and PASRR-EV – Reminder – for the Notification (page 9, PASRR-EV) list home address, NOT hospital unless client is homeless. | ☐ | PASRR-ID and PASRR-EV – Reminder – for the Notification (page 9, PASRR-EV) list home address, NOT hospital unless client is homeless. |
| ☐ | Comprehensive History & Physical Exam | ☐ | Long-Term Services and Supports (LTSS) assessment | ☐ | Long-Term Services and Supports (LTSS) assessment |
| ☐ | Comprehensive Medication History (most current and immediate past) | ☐ | Admission Report – To include History, Diagnoses, Physical Exam | ☐ | Comprehensive History & Physical Exam |
| ☐ | Comprehensive Psychosocial Evaluation | ☐ | Nurses Notes – only the most recent (1 week prior to NF Admission) | ☐ | Nurses notes including what Specialized Service would be helpful |
| ☐ | Comprehensive Psychiatric Evaluation | ☐ | Current Medication record | ☐ | Course of Stay – any important issues during stay |
| ☐ | Long-Term Services and Supports (LTSS) assessment | ☐ | Course of Stay – any important issues during stay | ☐ | Psychological evaluation |
| ☐ | Last 3 days of the most current Physician's orders and progress notes at time of review, (if applicable). | ☐ | Psychological evaluation – include school records with an IQ score before age of 18 if possible. | ☐ | PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF) |
| ☐ | Last 3 days of the most current nurses' notes, (if applicable). | ☐ | PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF) | ☐ | D/C Plans |
| ☐ | Current medication record | ☐ | D/C Plans | ☐ | MDS – if individual is already in the NF |
| ☐ | CT/Neurology Consults if applicable | ☐ | MDS – if individual is already in the NF | | |
| ☐ | MDS – if individual is already in the NF | | | | |

NAME

SSN (LAST 4 DIGITS)

## SECTION IX: NOTIFICATION

Assessor should:

- Complete the notification information below for all assessments,
- Make a copy of the assessment packet for their records; and then,
- Forward the assessment packet to the appropriate program office or its designee for a final determination.

| COPIES OF THE EVALUATION REPORT SHOULD BE SENT TO EACH OF THE FOLLOWING: | | |
|---|---|---|
| **1. THE INDIVIDUAL BEING ASSESSED** | | |
| NAME: | SOCIAL SECURITY NUMBER: | TELEPHONE NUMBER: |
| **2. THE LEGAL REPRESENTATIVE - A PERSON DESIGNATED BY STATE LAW TO REPRESENT THE INDIVIDUAL. THIS INCLUDES A COURT-APPOINTED GUARDIAN OR AN INDIVIDUAL HAVING POWER OF ATTORNEY.** | | |
| NAME: | | TELEPHONE NUMBER: |
| ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| **3. ADMITTING/RETAINING NURSING FACILITY (NF) (if known)** | | |
| NAME: | | TELEPHONE NUMBER: |
| ADDRESS: | | FAX NUMBER: |
| CITY: | STATE: | ZIP CODE: |
| ATTENTION: | | |
| **4. INDIVIDUAL'S ATTENDING PHYSICIAN** | | |
| NAME: | | TELEPHONE NUMBER: |
| ADDRESS: | | FAX NUMBER: |
| CITY: | STATE: | ZIP CODE: |
| **5. LIST FULL NAME OF DISCHARGING HOSPITAL (if individual is seeking nursing facility admission directly from a hospital)** | | |
| NAME: | | TELEPHONE NUMBER: |
| ADDRESS: | | FAX NUMBER: |
| CITY: | STATE: | ZIP CODE: |
| CONTACT PERSON AND TELEPHONE NUMBER: | | |

*** **Do you have a fax number for the Hospital/Nursing Facility on the Notification Sheet (this page)?** ☐ **No** ☐ **Yes**

# SLUMS EXAMINATION

Instructions can be found at: http://www.elderguru.com/downloads/SLUMS_instructions.pdf

| NAME: | AGE: |
|---|---|
| IS THE PATIENT ALERT? | LEVEL OF EDUCATION: |

| | |
|---|---|
| ___ / 1 | (1) **1. What day of the week is it?** |
| ___ / 1 | (1) **2. What is the year?** |
| ___ / 1 | (1) **3. What state are we in?** |
| | **4. Please remember these five objects. I will ask you what they are later.**<br>**Apple Pen Tie House Car** |
| ___ / 3 | **5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.**<br>(1) **How much did you spend?**<br>(2) **How much do you have left?** |
| ___ / 3 | **6. Please name as many animals as you can in one minute.**<br>(0) **0-4 animals** (1) **5-9 animals** (2) **10-14 animals** (3) **15+ animals** |
| ___ / 5 | **7. What were the five objects I asked you to remember? 1 point for each one correct.** |
| ___ / 2 | **8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.**<br>(0) **87** (1) **648** (1) **8537** |
| ___ / 4 | **9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.**<br>(2) **Hour markers ok.**<br>(2) **Time correct.** |
| ___ / 2 | (1) **10. Please place an X in the triangle**<br>(1) **Which of the above figures is largest?** |
| ___ / 8 | **11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.**<br>Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.<br>(2) **What was the female's name?** (2) **What work did she do?**<br>(2) **When did she go back to work?** (2) **What state did she live in?** |
| **TOTAL SCORE:** | |

**SCORING**

| HIGH SCHOOL EDUCATION | | LESS THAN HIGH SCHOOL EDUCATION |
|---|---|---|
| 27 - 30 | NORMAL | 25 - 30 |
| 21 - 26 | MILD NEUROCOGNITIVE DISORDER | 20 - 24 |
| 1 - 20 | DEMENTIA | 1 - 19 |

CLINICIAN'S SIGNATURE _____ DATE _____ TIME _____

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini- Mental Status Examination (MMSE) - A pilot study. Am J Geriatr Psych 14:900-10, 2006.