

PENNSYLVANIA PREADMISSION SCREENING RESIDENT

REVIEW IDENTIFICATION (PASRR-ID) LEVEL I FORM (Revised 1/1/2016)

This process applies to all nursing facility (NF) applicants, regardless of payer source. All current NF residents must have the appropriate form(s) on his/her record. The Preadmission Screening Resident Review Identification (PASRR-ID) Level I form and Level II evaluation, if necessary, must be completed **prior to** admission as per Federal PASRR Regulations 42 CFR § 483.106.

NOTE: FAILURE TO TIMELY COMPLETE THE PASRR PROCESS WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR § 483.122.

Section I – DEMOGRAPHICS

DATE THE FORM IS COMPLETED: _____ SOCIAL SECURITY NUMBER (9 digits): _____ – _____ – _____

APPLICANT/RESIDENT NAME - LAST, FIRST: _____

Communication

Does the applicant/resident require assistance with communication, such as an interpreter or other accommodation, to participate in or understand the PASRR evaluation process? NO YES

Section II – NEUROCOGNITIVE DISORDER (NCD)/DEMENTIA

For Neurocognitive Disorders (i.e. Alzheimer's disease, Traumatic Brain Injury, Huntington's, etc.), the primary clinical deficit is in cognitive function, and it represents a decline from a previously attained level of functioning. Neurocognitive disorders can affect memory, attention, learning, language, perception and social cognition. They interfere significantly with a person's everyday independence in Major Neurocognitive Disorder, but not so in Minor Neurocognitive Disorder.

1. Does the individual have a diagnosis of a Mild or Major NCD?

NO – Skip to Section III YES

2. Has the psychiatrist/physician indicated the level of NCD?

NO YES – indicate the level: Mild Major

3. Is there corroborative testing or other information available to verify the presence or progression of the NCD?

NO YES – indicate what testing or other information: _____

NCD/Dementia Work up Comprehensive Mental Status Exam

Other (Specify): _____

NOTE: A DIAGNOSIS OF MILD NCD WILL NOT AUTOMATICALLY EXCLUDE AN INDIVIDUAL FROM A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION.

Section III – SERIOUS MENTAL ILLNESS (MI)

Examples of a MI may include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Psychotic Disorder, Personality Disorder, Panic or Other Severe Anxiety Disorder, Somatic Symptom Disorder, Bipolar Disorder, Depressive Disorder, or another mental disorder that may lead to chronic disability.

III-A – RELATED QUESTIONS**1. Diagnosis**

Does the individual have a mental disorder or suspected mental disorder, other than Dementia, that may lead to a chronic disability?

- NO YES – List Diagnosis(es): _____

2. Substance related disorder

a. Does the individual have a diagnosis of a substance related disorder, documented by a physician, within the last two years? NO YES

b. List the substance(s): _____

c. Is the need for NF placement associated with this diagnosis?

- NO YES UNKNOWN

III-B – RECENT TREATMENTS/HISTORY: The treatment history for the mental disorder indicates that the individual has experienced **at least one** of the following:

NOTE: A “YES” TO ANY QUESTION IN SECTION III-B WILL REQUIRE THAT A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION BE COMPLETED.

1. Mental Health Services (check all that apply):

a. Treatment in an acute psychiatric hospital at least once in the past 2 years:

- NO
 YES – Indicate name of hospital and date(s): _____

b. Treatment in a partial psychiatric program (Day Treatment Program) at least once in the past 2 years:

- NO
 YES – Indicate name of program and date(s): _____

c. Any admission to a state hospital:

- NO
 YES – Indicate name of hospital and date(s): _____

d. One stay in a Long-Term Structured Residence (LTSR) in the past 2 years:

A LTSR is a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR. Admission may occur voluntarily.

- NO
 YES – Indicate name of LTSR and date(s): _____

e. Electroconvulsive Therapy (ECT) for Serious Mental Illness within the past 2 years:

- NO YES – Date(s): _____

- f. Does the individual have a Mental Health Case Manager (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment (ACT))?
- NO YES

Indicate Name, Agency, and Telephone Number of Mental Health Case Manager:

2. Significant Life disruption due to Mental Illness

Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Serious Mental Illness within the past 2 years:

- a. Suicide attempt or ideation with a plan:

NO YES – List Date(s) and Explain: _____

- b. Legal/law intervention: NO YES – Explain: _____

- c. Loss of housing/Life change(s): NO YES – Explain: _____

- d. Other: NO YES – Explain: _____

If questions in III-A (#1) and III-B are all “NO”, skip to Section IV.

III-C – LEVEL OF IMPAIRMENT: The mental disorder has resulted in functional limitations in major life activities that are not appropriate for the individual’s developmental stage. An individual typically has **at least one** of the following characteristics on a continuing or intermittent basis.

- 1. Interpersonal functioning** - The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.
- 2. 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, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.
- 3. Adaptation to change** - The individual has serious difficulty 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.

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A “YES” IN III-A #1 AND/OR A “YES” IN ANY OF SECTION III-B.

Section IV– INTELLECTUAL DISABILITY (ID)

An individual is considered to have evidence of an intellectual disability if they have a diagnosis of ID and/or have received services from an ID agency in the past.

IV-A – Does the individual have current evidence of an ID or ID Diagnosis (mild, moderate, severe or profound)?

NO – Skip to **IV-C** YES – List diagnosis(es) or evidence: _____

IV-B – Did this condition occur **prior to age 18?** NO YES CANNOT DETERMINE

IV-C – Is there a history of a severe, chronic disability that is attributable to a condition other than mental illness that could result in impairment of functioning in general intellectual and adaptive behavior?

NO – Skip to Section IV-D YES – Check below, all that applied **prior to age 18:**

- 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 with out 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).

IV-D – Has the individual ever been registered with their county for ID services and/or received services from an ID provider agency? NO YES UNKNOWN

If yes, indicate County name/agency _____

Name of Support Coordinator (if known) _____

IV-E – Was the individual referred for placement by an agency that serves individuals with ID/DD? NO YES

IV-F – Has the individual ever been a resident of a state facility including a state hospital, state operated ID center, or a state school?

NO

YES – Indicate the name of the facility and the date(s): _____

UNKNOWN

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID DIAGNOSIS AND HAS A “YES” OR “CANNOT DETERMINE” IN IV-B AND A “YES” IN IV-C WITH AT LEAST ONE FUNCTIONAL LIMITATION, OR
- THE INDIVIDUAL HAS A “YES” IN IV-D, OR E, OR F.

Section V– OTHER RELATED CONDITIONS (ORC)

“ORC” include physical, sensory or neurological disability(ies). Examples of an ORC may include but are not limited to: Arthritis, Juvenile Rheumatoid Arthritis, Cerebral Palsy, Autism, Epilepsy, Seizure Disorder, Tourette’s Syndrome, Meningitis, Encephalitis, Hydrocephalus, Huntingdon’s Chorea, Multiple Sclerosis, Muscular Dystrophy, Polio, Spina Bifida, Anoxic Brain Damage, Blindness **and** Deafness, Paraplegia or Quadriplegia, head injuries (e.g. gunshot wound) or other injuries (e.g. spinal injury), so long as the injuries were sustained **prior to age of 22**.

V-A – Does the individual have an ORC diagnosis that manifested **prior to age 22** and is expected to continue indefinitely?

NO – Skip to Section VI

YES – Specify the ORC Diagnosis(es): _____

V-B – Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC:

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).

NOTE: IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B, A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION.

Section VI – HOME AND COMMUNITY SERVICES

Was the individual/family informed about Home and Community Based Services that are available?

NO

YES

Is the individual/family interested in the individual going back home, back to the prior living arrangement, or exploring other community living options?

NO

YES

Section VII – EXCEPTIONAL ADMISSION

Does the individual meet the criteria to have a Level II Assessment/Program Office Evaluation done by one of the Program Offices and is not dangerous to self and/or others meet the criteria for Exceptional Admission to a NF?

- NO – Skip to Section VIII YES

NOTE: IT IS THE RESPONSIBILITY OF THE NF TO VERIFY THAT ALL CRITERIA OF THE EXCEPTION ARE MET.

Mark the Exceptional Admission that applies:

VII-A – Individual Is an Exempted Hospital Discharge - Must meet all the following prior to NF Admission and have a known MI, ID, or ORC:

- Admission to NF directly from the Acute Hospital after receiving **inpatient medical care** (not observational stay/not inpatient psych or Behavioral Health Unit), **AND**
 - Requires NF services for the medical condition for which he/she received care in the hospital, (Specify the condition: _____), **AND**
 - The hospital physician shall document on the medical record (**which must be forwarded to the NF**) that the **individual will require less than 30 calendar days of NF service and the individual's symptoms or behaviors are stable.**
- NO YES – Physician's name: _____

VII-B – Individual Requires Respite Care - An individual with a serious MI, ID, or ORC, may be admitted for Respite Care for a period up to 14-days without further evaluation if he/she is certified by a referring or attending physician to require 24-hour nursing facility services and supervision.

- NO YES

VII-C – Individual Requires Emergency Placement - An individual with a serious MI, ID, or ORC, may be admitted for emergency placement for a period of up to 30-days without further evaluation if the Area Agency on Aging's (AAA) Protective Services has certified that such placement is needed.

- NO YES

VII-D – Individual is in a coma or functions at brain stem level - An individual with a serious MI, ID, ORC may be admitted without further evaluation if certified by the referring or attending physician to be in a coma or who functions at brain stem level. The condition must require intense 24-hour nursing facility services and supervision and is so extreme that the individual cannot focus upon, participate in, or benefit from specialized services.

- NO YES

CHANGE IN EXCEPTIONAL STATUS

IF THE INDIVIDUAL'S CONDITION CHANGES OR HE/SHE WILL BE IN RESIDENCE FOR MORE THAN THE ALLOTTED DAYS:

- **THE DEPARTMENT MUST BE NOTIFIED ON THE MA 408 WITHIN 48 HOURS FOR AN EVALUATION TO BE COMPLETED.**
- **THE LEVEL II EVALUATION MUST BE DONE ON OR BEFORE THE 40TH DAY FROM ADMISSION.**
- **DO NOT COMPLETE A NEW PASRR-ID (LEVEL I) FORM; JUST UPDATE THE CURRENT FORM WITH THE CHANGES AND INITIAL THE CHANGES. ENTER FULL SIGNATURE AND DATE BELOW TO INDICATE YOU MADE THE CHANGES.**

SIGNATURE: _____

DATE: _____

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

- Individual has negative screen for Serious Mental Illness, Intellectual Disability, or Other Related Condition; no further evaluation (Level II) is necessary.
- Individual has a positive screen for Serious Mental Illness, Intellectual Disability, and/or Other Related Condition; requires further evaluation (Level II).
- Individual has positive screen for further evaluation (Level II) but has a condition which meets the criteria for Exceptional Admission indicated in Section VII. NF must report Exceptional Admissions on the Target Resident Reporting Form (MA 408)

SECTION IX – INDIVIDUAL COMPLETING FORM

By entering my name below, I certify the information provided is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

PRINT NAME:	SIGNATURE:	DATE:
FACILITY:	TELEPHONE NUMBER:	

Affix Nursing Facility Field Operations stamp here: