PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW (PASRR)
EVALUATION LEVEL II FORM (Revised 9/1/2018)

When a Pennsylvania Preadmission Screening Resident Review (PASRR) Evaluation Level II form is completed, all supporting documents (see list in Section X) 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, or Office of Long-Term Living (ORC)).

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)? ☐ YES ☐ NO	MA NUMBER:

SECTION II - MEDICAL DOCUMENTATION

II-A: MEDICAL DIAGNOSIS(ES) AND ONSET

1. List all current diagnosis(es) related to his/her MI, ID/DD, or ORC and approximate date of onset (attach additional page(s) as necessary):

DIAGNOSIS	DATE OF ONSET	DIAGNOSIS	DATE OF ONSET

II-B: BEHAVIORS

Does the individual currently display any of the following symptoms or behaviors to the degree that he/she may injure him/herself or endanger other nursing facility residents if not constantly supervised by healthcare personnel?

Assaultive and/or self-abusive:	☐ NO ☐ YES	Depression:	☐ NO ☐ YES
Aggressive:	☐ NO ☐ YES	Anxiety:	☐ NO ☐ YES
Disruptive:	☐ NO ☐ YES	Feelings of loneliness:	☐ NO ☐ YES
Inappropriateness:	☐ NO ☐ YES	Feelings of worthlessness:	☐ NO ☐ YES

Explanation of any of the symptoms or behaviors above:

_____

_____

II-C: MEDICATIONS

1. List all current medications and the diagnosis(es) for taking the medication (attach additional page(s) as necessary):

MEDICATION	DIAGNOSIS	DOSE	FREQUENCY	SIDE EFFECTS

NAME _____ SSN (LAST 4 DIGITS) _____

2. Does the individual have any allergies or adverse reactions to any medications? ☐ NO ☐ YES - List below:

_____

_____

_____

II-D: NEUROLOGICAL

Check all that apply:

☐ Right-sided weakness	☐ Weakness in arms
☐ Left-sided weakness	☐ Weakness in legs
☐ Right-sided paralysis	☐ Weakness in hands
☐ Left-sided paralysis	☐ Weakness in feet
☐ Unsteady gait	☐ Alteration in response to pain/touch/temperature
☐ Shuffling gait	☐ Uncontrolled movements
☐ Excessively slow movements	☐ History of falls - Last fall date: _____

☐ Use of assistive device(s) - List type(s): _____

II-E: FUNCTIONAL STATUS

Is the individual able to:

1. Perform own ADLs? ☐ NO ☐ YES

   If not, list what individual is unable to do: _____

2. Perform own IADLs?

Treat own minor physical problems:	☐ NO ☐ YES	Prepare meals:	☐ NO ☐ YES
Schedule medical/mental health appointments:	☐ NO ☐ YES	Maintain an adequately balanced diet:	☐ NO ☐ YES
Keep scheduled medical/mental health appointments:	☐ NO ☐ YES	Manage personal finances:	☐ NO ☐ YES
Take medications as prescribed:	☐ NO ☐ YES	Use money appropriately:	☐ NO ☐ YES
Use transportation:	☐ NO ☐ YES	Dress appropriately for season:	☐ NO ☐ YES

   Explain the assistance required for each "NO" response:

   _____

   _____

3. Receptively and expressively communicate?

Turn head toward speaker:	☐ NO ☐ YES	Summarize topic/story logically:	☐ NO ☐ YES
Understand one-step instructions:	☐ NO ☐ YES	Point to an item on request:	☐ NO ☐ YES
Understand multi-step instructions:	☐ NO ☐ YES	Speak in at least 3-4 word sentences:	☐ NO ☐ YES
Shake head/nod appropriately in response to questions:	☐ NO ☐ YES	Communicate pain/discomfort:	☐ NO ☐ YES
Say at least ten words which can be understood:	☐ NO ☐ YES	Communicate basic wants:	☐ NO ☐ YES

   For "NO" response, what are deficits/problems:

   _____

   _____

II-F: SUPPORTS/SOCIALIZATION

1. Individual appropriately responds to others' initiations? ☐ NO ☐ YES
2. Individual appropriately initiates contact with others? ☐ NO ☐ YES
3. Individual has inappropriate responses/interactions? ☐ NO ☐ YES If yes, describe: _____
4. List the individual's current medical and social/family supports:

   _____

   _____

   _____

   _____

5. List activities that demonstrate the individual socializes with others:

SECTION III - REVIEW TYPE

Select type(s) of Program Office review:

- ☐ Mental Health (MH) - Section IV
- ☐ Intellectual Disabilities/Developmental Disabilities (ID/DD) - Section V
- ☐ Other Related Conditions (ORC) - Section VI

Complete each section(s) for the review type(s) checked above. Once the appropriate section(s) noted above have been completed, complete the remaining Sections VII through XI.

NAME _____ SSN (LAST 4 DIGITS) _____

SECTION IV - MENTAL HEALTH (MH)

IV-A: DOCUMENTATION OF THE DIAGNOSIS

1. For **PASRR** purposes, Serious Mental Illness includes the following. Provide a response for each diagnosis listed. When checking "YES" for a current diagnosis, enter the 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	☐ NO ☐ YES		Panic or other severe anxiety disorder	☐ NO ☐ YES	
Schizoaffective disorder	☐ NO ☐ YES		Somatic Symptom disorder	☐ NO ☐ YES	
Delusional disorder	☐ NO ☐ YES		Personality disorder	☐ NO ☐ YES	
Bipolar disorder	☐ NO ☐ YES		Depressive disorder	☐ NO ☐ YES	
Psychotic disorder	☐ NO ☐ YES		Other	☐ NO ☐ YES	

2. 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 Level I for definitions).

Interpersonal functioning	☐ NO ☐ YES
Concentration, persistence, and pace	☐ NO ☐ YES
Adaptation to change	☐ NO ☐ YES
Describe:	

3. 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 the Mental Health Condition): ☐ 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: _____

IV-B: SUPPORTING INFORMATION

1. The assessor submits the items below to the Office of Mental Health and Substance Abuse Services for an evaluation of the individual's functional level and to identify the needs of the individual. Check off each item that has been included in the submission and attach the documentation to the PASRR Level II Evaluation.

☐	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: _____ ☐ Refused Test

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

NAME _____ SSN (LAST 4 DIGITS) _____

SECTION V: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY (ID/DD)

V-A: DOCUMENTATION OF THE DIAGNOSIS

1. Does the documentation indicate a diagnosis of an ID/DD? ☐ 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/DD program or ID/DD agency, and other relevant professional reports.

   List the documentation that supports ID/DD diagnosis:

   _____

   _____

   No documentation exists, but family member, significant other, or legal representative state the following to indicate ID/DD diagnosis:

   _____

   _____

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/DD: ☐ Mild (50-69) ☐ Moderate (35-49) ☐ Severe (25-34) ☐ Profound (<25) ☐ Unspecified ☐ Not known (scores not available) ☐ None

V-B: SUPPORTING INFORMATION

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

   _____

2. The assessor submits the items below to the Office of Developmental Programs for an evaluation of the individual's functional level and to identify the needs of the individual. Check off each item that has been included in the submission and attach the documentation to the PASRR Level II Evaluation.

☐	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.

SECTION VI: 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.**

VI-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.

   List the documentation that supports ORC diagnosis:

   _____

   _____

NAME _____ SSN (LAST 4 DIGITS) _____

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

VI-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).

2. The assessor submits the items below to the Office of Long Term Living for an evaluation of the individual's functional level and to identify the needs of the individual. Check off each item that has been included in the submission and attach the documentation to the PASRR Level II Evaluation.

☐	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.

SECTION VII: FINDINGS & RECOMMENDATION

VII-A: EVALUATOR'S RECOMMENDATION

1. Does the individual have a suspected or confirmed serious mental illness, intellectual disability/developmental disability, or related condition which meets the criteria for further review by the respective program office? ☐ NO ☐ YES

2. Does the individual currently receive services in the community for the mental health condition, intellectual disability/developmental disability, or related condition? ☐ NO ☐ YES

   If yes, list what service(s): _____

3. Is individual seeking NF placement? ☐ NO ☐ YES

   If no, what placement setting is the individual seeking? _____

   If yes, what is the NF name? _____

4. Does the individual need health rehabilitative services (physical therapy, occupational therapy, speech therapy, restorative nursing) provided by the nursing facility for his/her mental illness, intellectual disability/developmental disability, or other related condition? ☐ NO ☐ YES

   If yes, list what service(s): _____

VII-B: 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/developmental disability, or an other related condition must be provided services and supports, related to their mental health condition, intellectual disability/developmental disability, or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental, and psychological 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.

Check the applicable program office box indicating that the individual, his/her representative, family member, or significant other has been informed of the services available.

☐ **a. Mental Health**

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 three 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 an 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 (RC))** – 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, and use of community resources. RC 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, five 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 county mental health office.

☐ **b. Intellectual Disability/Developmental Disability**

Specialized services for an individual that meets the clinical criteria for an intellectual disability/developmental 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/developmental disability" by the Office of Developmental Programs or its agent. For individuals with ID/DD, community specialized services may include but are not necessarily limited to the following:

- **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 on assessment; and the provision of training to individuals, staff, parents, and caregivers. Services must be required to meet the current needs of the individual.
- **Communication Specialist** – Supports participants with non-traditional communication needs by determining the participant's communication needs, educating the participant and his/her caregivers on the participant's communication needs and the best way to meet those needs in their daily lives.
- **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/developmental disability. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety.
- **Housing Transition and Tenancy Sustaining Services** – This service includes pre-tenancy and housing sustaining supports to assist participants in being successful tenants in private homes owned, rented, or leased by the participants.
- **In-Home and Community Support** – In-home and Community Support is a direct service provided in home and community settings to assist participants in acquiring, maintaining, and improving the skills necessary to live in the community, to live more independently, and to participate meaningfully in community life.
- **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.

☐ **c. Other Related Condition**

Specialized services for an individual that meets the clinical criteria for an other 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 may include but are not necessarily limited to the following:

- **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. Based on your evaluation, will specialized services be needed if the individual will be served in a nursing facility? ☐ NO ☐ YES

   If yes, what specialized service(s) are recommended?

   _____

   _____

4. If the individual will be served in a nursing facility, would he/she need any services of a lesser intensity than the previously mentioned specialized services? ☐ NO ☐ YES

   If yes, what service(s) are recommended?

   _____

   _____

5. Does the individual understand what you have said about specialized services? ☐ NO ☐ YES

6. If recommended, does the individual want to receive any specialized services? ☐ NO ☐ YES

   If yes, what service(s)?

   _____

   _____

SECTION VIII: 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 a Mental Health Condition: You have (your relative/friend/responsible party has) been identified as requiring further evaluation by the DHS Office of Mental Health and Substance Abuse Services (OMHSAS). This form and related information will be forwarded in order to obtain a final determination regarding the need and appropriateness for nursing facility care and specialized services. You will receive a letter from OMHSAS outlining their decision.

For Persons with Intellectual Disability/Developmental Disability: You have (your relative/friend/responsible party has) been identified as requiring further evaluation by the DHS Office of Developmental Programs (ODP). This form and related information will be forwarded in order to obtain a final determination regarding the need and appropriateness for nursing facility care and specialized services. You will receive a letter from ODP outlining their decision.

For Persons with an Other Related Condition: You have (your relative/friend/responsible party has) been identified as requiring further evaluation by the DHS Office of Long-Term Living (OLTL). This form and related information will be forwarded in order to obtain a final determination regarding the need and appropriateness for nursing facility care and specialized services. You will receive a letter from OLTL outlining their decision.

NAME _____ SSN (LAST 4 DIGITS) _____

SECTION IX: NAME AND CONTACT INFORMATION OF INDIVIDUAL COMPLETING THIS FORM

PRINT NAME:	TITLE:	DATE:
SIGNATURE:	DATE:	TELEPHONE:
AGENCY:		EMAIL:

Does the individual want a copy of this evaluation? ☐ NO ☐ YES

If yes, please give individual a copy of the PASRR Level II Evaluation form. If you have questions about this form, please contact the person completing this form, identified above.

SECTION X: 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 – This should be the 1st sheet in packet.	☐	Program Office Transmittal Sheet – This should be the 1st sheet in packet.	☐	Program Office Transmittal Sheet – This 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 Level I & Level II Reminder – for the Notification (page 10, PASRR Level II) list home address, NOT hospital unless client is homeless.	☐	PASRR Level I & Level II Reminder – for the Notification (page 10, PASRR Level II) list home address, NOT hospital unless client is homeless.	☐	PASRR Level I & Level II Reminder – for the Notification (page 10, PASRR Level II) 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 XI: NOTIFICATION SHEET

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:	**CONTACT TELEPHONE:**	**CONTACT EMAIL:**

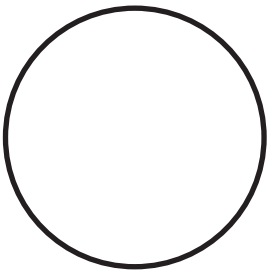
Have you listed the fax number for the Hospital/Nursing Facility on the Notification Sheet (this page) above? ☐ **No** ☐ **Yes**

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. **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.** 1 **How much did you spend?** 2 **How much do you have left?**
___ / 3		**6. Please name as many animals as you can in one minute.** 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.** 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.** 2 **Hour markers ok.** 2 **Time correct.**
___ / 2	1	**10. Please place an X in the triangle**
	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.** 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. 2 **What was the female's name?** 2 **What work did she do?** 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.