PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG-TERM LIVING

Preadmission Screening Resident Review Process for Pennsylvania

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Objectives for this Webinar

- Overview of the Federal (CMS) Requirements for PASRR and background
- What does Preadmission screening mean
- PASRR Level I Assessment
- What does meeting Program Office Criteria mean
- Role of the Program Office
- Important Websites
- Who to call for questions
- PASRR Level II Evaluation (for Aging Well and Nursing Facility (NF) Field Operations staff only)

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Items included in the Handouts

Handouts can be found on the same website as the PASRR Training and include the following items:

- PowerPoint Presentation slides
- MA bulletin for PASRR Level I form
- MA bulletin for PASRR Level II form
- PASRR Level I form (MA 376)
- PASRR Level II form (MA 367.2)

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PASRR Background

- Is a requirement under Medicaid, pursuant to OBRA 1987 (Omnibus Budget Reconciliation Act) and 42 CFR § 483.100-483.138
- Applies to all individuals seeking admission to a Medicaid certified nursing facility (NF) regardless of the individual's insurance and ensures that individuals are placed in the least restrictive setting possible.
- Is part of the licensure for a Medicaid participating NF
- Provisions were addressed in PA Bulletin, Volume 18, Number 52 on December 24, 1988.

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PASRR Reguires

- Requires that a NF does not admit any new resident with **Mental Illness (MI), an Intellectual Disability/Developmental Disability (ID/DD) or Related Condition (ORC)** unless the individual is determined through a PASRR evaluation to be appropriate for NF services (CFR § 483.106(a))
- **Failure to timely complete (prior to admission) the PASRR process will result in forfeiture of Medicaid Reimbursement to the NF during the period of non-compliance in accordance with Federal PASRR Regulations (CFR § 483.122(b))**

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Prior to entering Nursing Facility

Prior to Admission to a NF, the following must be done:

- Preadmission Screening Resident Review Identification – PASRR Level I
- Preadmission Screening Resident Review Evaluation – PASRR Level II (if needed)
- Program Office Letter of Determination received if PASRR Level II has been done

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Preadmission Screening Resident Review Identification Form

(PASRR Level I Form)

(MA 376)

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PASRR Level I: Section I – Demographics & Communication

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW (PASRR) IDENTIFICATION LEVEL I FORM

(Revised 9/1/2018)

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 (PASRR) Level I identification form and PASRR Level II evaluation form, 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 (all 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 process? ☐ NO ☐ YES

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PASRR Level I: Section II – Neurocognitive Disorder/Dementia

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 PASRR LEVEL II EVALUATION.

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PASRR Level I: Section III - Mental Health (MH)

Section III – MENTAL HEALTH (MH)

Serious Mental Illness diagnoses 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 health condition or suspected mental health condition, other than Dementia, that may lead to a chronic disability?
   ☐ NO ☐ YES
   List Mental Health 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

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PASRR Level I: Section III-B 1 Recent Treatments/History

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

A "YES" TO ANY QUESTION IN SECTION III-B WILL REQUIRE A PASRR LEVEL II 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 the Mental Health Condition 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: _____

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PASRR Level I: Section III-B 2 Significant Life Disruption

2. **Significant Life disruption due to a Mental Health Condition**

   Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Mental Health Condition 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: _____

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PASRR Level I: Section III-C Level of Impairment

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.

A CHECK IN ANY BOX IN SECTION III-C WILL REQUIRE A PASRR LEVEL II EVALUATION BE COMPLETED.

☐. 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.

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PASRR Level I: Mental Health Note

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE OMHSAS PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A "YES" IN ANY OF SECTION III-B AND/OR III-C AS A RESULT OF A CONFIRMED OR SUSPECTED MENTAL HEALTH CONDITION.

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PASRR Level I: Section IV - Intellectual Disability/Developmental Disability

Section IV– INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY (ID/DD)

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

IV-A – Does the individual have current evidence of an ID/DD or ID/DD 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 a mental health condition 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).

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PASRR Level I: Section IV-D, E, F

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

If yes, indicate county name/agency and state if different than Pennsylvania _____

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

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PASRR Level I: Intellectual/Developmental Disability Note

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE ODP PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- **THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID/DD 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.**

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PASRR Level I: Section V - Other Related Conditions

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).

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PASRR Level I: Other Related Condition Note

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE ORC PROGRAM OFFICE FOR FINAL DETERMINATION, IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B.

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PASRR Level I: Section VI - Home & Community Services

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

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PASRR Level I: Section VII -Exceptional Admission

Section VII – EXCEPTIONAL ADMISSION

Does the individual meet the criteria to have a PASRR Level II Evaluation done by one of the Program Offices, is not a danger to self and/or others, and meets 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 PRIOR TO ADMISSION.

Check the Exceptional Admission that applies:

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

- Admission to NF directly from the Acute Care Hospital after receiving **inpatient medical care, AND**
  NOTE: Exceptional Hospital Discharge cannot be an admission from any of the following: emergency room, observational hospital stay, rehabilitation unit/hospital, Long-Term Acute Care Hospital (LTACH), inpatient psych, behavioral health unit, or hospice facility.
- Requires NF services for the same medical condition for which he/she received care in the Acute Care Hospital, (Specify the condition: _____), **AND**
- The hospital physician shall document on the medical record **(which the NF must have prior to admission)** 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: _____

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PASRR Level I: VII-B, C, D Exceptional Admission cont.

☐ **VII-B – Individual Requires Respite Care -** An individual with a serious MI, ID/DD, 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 individual's 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/DD, or ORC, may be admitted for emergency placement for a period of up to 30-days without further evaluation if the Protective Services Agency and their physician 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/DD, 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

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PASRR Level I: VII - Change in Exceptional Status

FOR A 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 that a PASRR Level II Evaluation needs to be completed.
- The PASRR Level II Evaluation must be done on or before the 40th day from date of admission.
- Do not complete a new PASRR Level I form; just update the current form with the changes and initial the changes. Enter your full signature and date below to indicate you made the changes to this form.

SIGNATURE: _____ **DATE:** _____

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PASRR Level I: Section VIII – Screening Outcome

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

Check appropriate outcome:

☐ **Individual has negative screen for Serious Mental Illness, Intellectual Disability/Developmental Disability, or Other Related Condition; no further evaluation (Level II) is necessary.**

☐ **Individual has a positive screen for Serious Mental Illness, Intellectual Disability/Developmental Disability, and/or Other Related Condition; he/she requires a further PASRR Level II evaluation. You must notify the individual that a further evaluation needs to be done. Have the individual or his/her legal representative sign that they have been notified of the need to have a PASRR Level II evaluation done. Indicate by your signature here that you have given the notification (last page of this form) to the individual or his/her legal representative.**

Name of Individual or legal representative that has received the notification (page 9):

NAME: _____ (print) **SIGNATURE:** _____ (sign)

Name of individual who filled out the PASRR Level I and gave the notification to the individual/legal representative:

NAME: _____ (print) **SIGNATURE:** _____ (sign)

☐ **Individual has positive screen for a further PASRR Level II evaluation but has a condition which meets the criteria for an Exceptional Admission indicated in Section VII. NF must report Exceptional Admissions on the Target Resident Reporting Form (MA 408).**

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PASRR Level I: Section IX– Individual Completing Form

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:

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Notification of need to have PASRR Level II

NOTIFICATION OF THE NEED FOR A PASRR LEVEL II EVALUATION

All persons considering admission to a nursing facility for care must be screened with the Preadmission Screening Resident Review (PASRR) Level I to identify for any evidence of mental illness (MI), intellectual disability/developmental disability (ID/DD), or an other related condition (ORC). If you do have evidence or suspicion of MI, ID/DD, or ORC, you need to have a further PASRR Level II evaluation completed before you can be admitted to a nursing facility for care.

You have had the PASRR Level I screening process done and you are in need of a further PASRR Level II evaluation to make certain that a nursing facility is the most appropriate setting/placement for you and to identify the need for possible MI, ID/DD, or ORC services in the nursing facility's plan of care for you, if you choose to be admitted to a nursing facility.

You will have this evaluation done within the next several days to determine your needs.

The federal regulation for the above is the following:

§483.128 PASRR evaluation criteria (a) Level I: Identification of individuals with MI or ID. The state's PASRR program must identify all individuals who are suspected of having MI or ID as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The state's performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or ID and is being referred to the state mental health or intellectual disability authority for Level II screening.

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Meeting "Program Office (PO) criteria"?

When the PO Criteria is met on the PASRR Level I (meaning the greyed out Note section on the form applies to the individual for at least one of the POs):

- A PASRR Level II Evaluation must be completed either by Aging Well or Nursing Facility Field Operations, and
- A Program Letter of Determination must be received before you can admit an individual to a nursing facility

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Change in Condition after Admission to the NF

When the PO Criteria is met after admission (meaning there has been a change in condition after admission to the NF):

- A PASRR Level II Evaluation must be completed
  - Nursing Facility Field Operations will do the PASRR Level II Evaluation in the NF (MA 408 needs to be faxed to Field Operations), unless Aging Well will be doing an assessment for Medical Assistance (if this is the case, then Aging Well will do the PASRR Level II)
- A Program Letter of Determination is sent to the NF

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Role of the Program Office

- The Department of Human Services Program Offices review the PASRR Evaluation and the additional information sent to them to determine if the individual:
  - Meets the criteria for the Program Office
  - Needs the level of services of a nursing facility
  - Needs Specialized Services
- The Program Office Letter of Determination will indicate the above information.

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Important Websites

Pennsylvania PASRR Process Website:

http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/obratrainingInformation/index.htm

Out of State Process for PASRR

http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/obratrainingInformation/nfcareprocess/index.htm

Long Term Care Nursing Facility Providers website:

http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm

Order MA Forms:

http://www.dhs.pa.gov/dhsassets/maforms/index.htm

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Pennsylvania PASRR Process Website

- **PASRR Forms**
- Level I PASRR Identification Form (MA 376)
- Level II PASRR Evaluation Form (MA 376.2)
- **Resources for PASRR:**
- PASRR Clarifications, Questions and Answer Document
- **PASRR Bulletins**
  - MA376
  - MA376.2
- Handouts for Webinar Training
- PASRR Level I Tool Form Training Webinar
- Other PASRR Resources
- **Who to contact for help with the Pennsylvania PASRR process:**
- Field Operations Offices
- Program Office Contacts
- State PASRR Coordinator at 717-214-3736

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Questions?

- **Ruth Anne Barnard, B.S.N., R.N.**
  PASRR/MDS/Nursing Facility Field Operations Coordinator
  - rbarnard@pa.gov
  - 717-214-3736
- **Randy Nolen**
  Division Director for Nursing Facility Field Operations
  - rnolen@pa.gov
  - 717-772-2543
- **Program Offices** – see list found on the PASRR Website (see previous slide)
- **Field Operations Supervisors** – see list found on the PASRR Website (see previous slide)

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Preadmission Screening
Resident Review Evaluation Form
(PASRR Level II Form)
(MA 376.2)

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PASRR Level II: Section I -Demographics

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:

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PASRR Level II: Section II – Medical Documentation

II-A: Medical Diagnosis(es) and Onset

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

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PASRR Level II: Section II – Medical Documentation

II-B: Behaviors

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:

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PASRR Level II: Section II – Medical Documentation

II-C: Medications

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

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

_____

_____

_____

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PASRR Level II: Section II – Medical Documentation

II-D: Neurological

II-D: NEUROLOGICAL

Check all that apply:

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

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PASRR Level II: Section II – Medical Documentation

II-E: Functional Status

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:

_____

_____

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PASRR Level II: Section II – Medical Documentation

II-F: Supports/Socialization

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:

_____

_____

_____

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PASRR Level II: Section III – Review Type

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.

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PASRR Level II: Section IV - Mental Health (MH)

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:	

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PASRR Level II: Section IV-A Treatment History

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: _____

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PASRR Level II: Section IV–B Supporting Info

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

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PASRR Level II: Section V: Intellectual Disability/Developmental Disability

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 ☐ None (scores not available)

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PASRR Level II: Section V-B: Supporting Information

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.

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PASRR Level II: Section VI: Other Related Conditions

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:

   _____

   _____

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

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PASRR Level II: Section VI-B: Supporting Information

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 ca

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PASRR Level II: Section VII: Findings & Recommendation

VII-A: Evaluator's Recommendation

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): _____

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PASRR Level II: Section VII-B: Desire for Specialized Services

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.

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PASRR Level II: Section VII-B: Desire for Specialized Services

a. Mental Health

☐ **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 nursi
disorder services may need to continue to be provided to the individual. The provision of speci
facility and county mental health office.

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PASRR Level II: Section VII-B: Desire for Specialized Services

b. Intellectual Disability/Developmental Disability

☐ **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 serv al
Support Plan.

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PASRR Level II: Section VII-B: Desire for Specialized Services

c. Other Related Condition

☐ **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.

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PASRR Level II: Section VII-B: Desire for 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)?
   _____
   _____

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PASRR Level II: Section VIII: Notice of Referral for Final Determination

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.

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PASRR Level II: Section IX

Name and Contact Information of Individual Completing this Form

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.

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PASRR Level II: Section X

Documentation to include for Program Office Review

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
☐	CT/Neurology Consults if applicable	☐	MDS – if individual is already in the NF		
☐	MDS – if individual is already in the NF				

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PASRR Level II: Section XI – Notification Sheet

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

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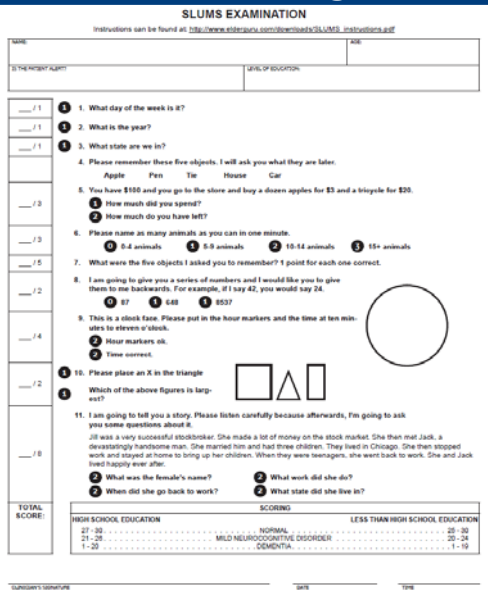
PASRR Level II: SLUMS Examination



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. What day of the week is it?

___ / 1 2. What is the year?

___ / 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

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DHS Program Offices – How do they receive the information

- MH – Office of Mental Health And Substance Abuse Services
  - Information is sent directly to the office
- ID/DD – Office of Developmental Programs
  - Information initially is sent to the County of origin
  - County concurs or not with Aging Well's/NF Field Operation's recommendation for Long-Term Services and Supports (LTSS)
  - Then information is sent to Regional Offices for Letter of Determination
- ORC – Office Of Long-Term Living – Bureau of Participant Operations
  - Information is sent directly to the office

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OFFICE OF LONG-TERM LIVING BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
August 1, 2018	September 1, 2018	01-18-03, 03-18-03, 07-18-03, 59-18-03

SUBJECT:
Revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level I Identification Form (MA 376)

Kevin Hancock
Deputy Secretary Office of Long-Term Living

PURPOSE:

The purpose of this bulletin is to issue a revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level I identification form (PASRR Level I). The revised PASRR Level I form replaces the PA-PASRR-ID (Bulletin 01-15-04, 03-15-04, 07-15-04, 55-15-04) dated January 1, 2016.

SCOPE:

This bulletin applies to all entities that perform preadmission screenings for individuals prior to entering a nursing facility enrolled in the Medical Assistance (MA) Program.

BACKGROUND:

In 1987, Congress enacted major nursing home reform legislation that affected all nursing facilities participating in the Medicare and MA Program as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). OBRA '87, among other things, required the implementation of a preadmission screening program, applicable to all persons seeking admission to an MA-certified nursing facility, regardless of payer source. The purpose of the preadmission screening is to determine whether an individual with a mental health condition, intellectual disability/developmental disability, or other related condition requires nursing facility services and, if the individual does, whether that individual meets certain program office criteria and requires specialized services for their condition. See 42 CFR §§ 483.100 - 483.138. An MA- certified nursing facility may not admit any new resident with a mental health condition, intellectual disability/developmental disability, or other related condition unless the Department of Human Services (department) has determined and notified the nursing facility in a letter that the individual requires nursing facility services and, if the individual does, whether that individual meets program office criteria and requires specialized services for the mental health condition, intellectual disability/developmental disability, or other related condition. Modifications to the PASRR Level I form were made based on recommended changes from the Centers for Medicare & Medicaid Services (CMS) and the department's program offices. There have been form changes which are summarized in this bulletin.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO: Ruth Anne Barnard
PA Dept. of Human Services
OLTL/Forum Place 6th Floor
Bureau of Quality and Provider Management
P.O. Box 8025
Harrisburg, PA 17105-8025
(717) 772-2570

Changes to the PASRR Level I form

Effective 09/01/2018

General Changes	There were general changes made to the form. In some sections, minor wording changes were made or clarifying language was added to assist individuals in completing the form. Medical terms were aligned with terms used by the department's Office of Mental Health and Substance Abuse Services (OMHSAS) in certain areas. In addition, in the gray text boxes at the end of Sections III, IV and V the specific program office and field office were added.
Page 3, Section III-C	After the first paragraph, added a gray text box to read "A check in any box in Section III-C will require a PASRR Level II evaluation be completed."
Page 3, Section III-C, gray text box after 3. Adaptation to change	Changed the gray text box to read "Note: A PASRR Level II evaluation must be completed by Aging Well or OLTL Field Operations (for a change in condition in a nursing facility) and forwarded to the OMHSAS program office for final determination if the individual has a "yes" in any of Section III-B and/or III-C as a result of a confirmed or suspected mental health condition". This change removes the requirement for a Level II evaluation if the individual has a "yes" in Section III-A #1.
Page 4, Section IV	Added clarifying language to include "developmental disability (DD)" in addition to intellectual disability language.
Page 4, Section IV-D	Added clarifying language to read "Has the individual ever been registered with their county for ID/DD services and/or received services from an ID/DD provider agency within Pennsylvania or in another state."
Page 4, Section IV, gray text box after IV-F	Changed the gray text box to read "Note: A PASRR Level II evaluation must be completed by Aging Well or OLTL Field Operations (for a change in condition in a nursing facility) and forwarded to the ODP Program Office for final determination if: the individual has evidence of an ID or an ID/DD 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.

Page 5, Section V, gray text box after V-B, Capacity for independent living	Changed the gray text box to read "Note: A PASRR Level II evaluation must be completed by Aging Well or OLTL Field Operations (for a change in condition in a nursing facility) and forwarded to the ORC Program Office for final determination, if the individual has an ORC diagnosis prior to the age of 22 and at least one box checked in V-B.
Page 6, Section VII, gray text box	Added clarifying language to read "Note: It is the responsibility of the NF to verify that all criteria of the exception are met prior to admission."
Page 6, Sections VII-A, VII-B, VII-C, and VII-D	Added a check box before each section to check the type of exceptional admission that applies.
Page 6, Section VII-A, first bullet point	At the end of the first bullet point, added a note to read "NOTE: Exceptional Hospital Discharge cannot be an admission from any of the following: emergency room, observational hospital stay, rehabilitation unit/hospital, Long-Term Acute Care Hospital (LTACH), inpatient psych, behavioral health unit, or hospice facility."
Page 6, Section VII-A, third bullet point	Added clarifying language to the bold text in parentheses to read "(which the NF must have prior to admission)."
Page 7, Section VIII, second check box	Added two sentences at the end to read "You must notify the individual that further evaluation needs to be done. Have the individual or his/her legal representative sign that they have been notified of the need to have a PASRR Level II evaluation done. Indicate by your signature here that you have given the notification (last page of this form) to the individual or his/her legal representative." Also, added signature requirements for the individual or legal representative who received the notification and for the individual who filled out the PASRR Level I and notification to individual/legal representative.
Page 8	Blank page added.

Page 9, Notification of the Need for a PASRR Level II Evaluation	This is a new page which notifies individuals or legal representatives that a PASRR Level I form was completed and it indicates the individual needs to have a PASRR Level II evaluation completed. This page should only be given to an individual who meets criteria to have a PASRR Level II evaluation completed. Note: When this page is given to the individual, the person who completed the PASRR Level I and gave this page to the individual /legal representative must ensure the signature requirements are satisfied under Section VIII, second bullet point.

PROCEDURES:

Beginning September 1, 2018, the revised PASRR Level I form must be completed, prior to or no later than the day of admission, for individuals seeking admission to an MA-certified nursing facility, regardless of the individual's payment source. If the applicant/resident is unable to answer the questions, another person who is knowledgeable about the applicant's/resident's medical condition and history (for example: family member, legal representative, or member of the health care team) may help to complete the form. Nursing facilities are responsible for assuring the accuracy of information reported on the PASRR Level I form. For a new resident entering the nursing facility, the nursing facility must make corrections to the PASRR Level I form on the resident's chart when new or missed information becomes available (for example, information provided by the family or doctor). Do not complete a new PASRR Level I for residents readmitted from a short-term acute care hospital stay that were in the nursing facility prior to the hospital stay. For these individuals, just update the PASRR Level I that was used in the nursing facility prior to the hospital stay. If the individual has a change in condition that affects program office criteria as found on the PASRR Level I form, a PASRR Level II evaluation form will need to be completed. Nursing facilities will communicate the need to have a PASRR Level II form done by notifying the department's Office of Long-Term Living, Division of Nursing Facility Field Operations Team via the MA 408 form. Nursing facilities are to advise applicants/residents regarding their rights to know how the PASRR process will be used, how to obtain a copy of this form, and the procedure to appeal the results of a decision by the departments program office.

If the applicant meets program office criteria and is not an Exceptional Admission, as defined on page 6 of the PASRR Level I form, the individual's PASRR Level I form, along with other required documents, must be forwarded to Aging Well, who will complete a PASRR Level II evaluation and will also determine the level of care the individual needs prior to an individual's admission to the nursing facility.

Failure to complete the PASRR Level I and, when applicable, the PASRR Level II prior to admission or on the day of admission will result in forfeiture of MA reimbursement to the nursing facility during the period of non-compliance in accordance with Federal PASRR Regulations at 42 CFR § 483.122.

Instructions for completing the revised PASRR Level I are included in the form and the instructional webinar can be found at: http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/obratraininginformation/index.htm.

The revised PASRR Level I form (MA 376 9/18) may be printed at the following website: http://www.dhs.pa.gov/dhsassets/maforms/index.htm.

The revised PASRR Level I form (MA 376 9/18) will be required for admissions on September 1, 2018 and thereafter. Previous versions of the PASRR Level I form are not acceptable for new admissions on September 1, 2018, and thereafter.

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OFFICE OF LONG-TERM LIVING BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
August 1, 2018	September 1, 2018	01-18-04, 03-18-04

SUBJECT:
Revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level II Evaluation Form (MA 376.2)

Kevin Hancock
Deputy Secretary, Office of Long-Term Living

PURPOSE:

The purpose of this bulletin is to issue a revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level II evaluation form. The revised PASRR Level II replaces the Pennsylvania PASRR evaluation (Bulletin 01-15-05, 03-15-05) dated January 1, 2016.

SCOPE:

This bulletin applies to all agencies that perform PASRR Level II evaluations for individuals either prior to or after the individual is a resident in a Medical Assistance (MA) enrolled nursing facility.

BACKGROUND:

In 1987, Congress enacted major nursing home reform legislation that affected all nursing facilities participating in the Medicare and MA Program as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). OBRA '87, among other things, required the implementation of a preadmission screening program, applicable to all persons seeking admission to an MA-certified nursing facility, regardless of payer source. The purpose of the preadmission screening is to determine whether an individual with a mental health condition, intellectual disability/developmental disability (ID/DD), or other related condition requires nursing facility services and, if the individual does, whether the individual meets certain program office criteria and requires specialized services for their condition. See 42 CFR §§ 483.100 - 483.138. An MA-certified nursing facility may not admit any new resident with a mental health condition, ID/DD, or other related condition unless the Department of Human Services (department) has determined and notified the nursing facility in a letter that the individual requires nursing facility services and, if the individual does, whether the individual meets program office criteria, and requires specialized services for a mental health condition, ID/DD, or other related condition.

The State must complete a PASRR Level II evaluation if the individual meets any of the program office criteria for a mental health condition, ID/DD, or other related condition on the PASRR Level I (MA 376) form. Modifications to the PASRR Level II form were made based on recommended changes from the Centers for Medicare & Medicaid Services (CMS) and the department's program offices. There have been form changes which are summarized in this bulletin.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO: Ruth Anne Barnard
PA Dept. of Human Services
OLTL/Forum Place 6th Floor
Bureau of Quality and Provider Management
P.O. Box 8025
Harrisburg, PA 17105-8025
(717) 772-2570

Changes to the PASRR Level II form

Effective 09/01/2018

General Changes	There were general changes made to the form. In some sections, minor wording changes were made or clarifying language was added to assist assessors in completing the form, some sections were moved and renumbered, and subsections that were deleted from a section were added to a different section. In addition, the SLUMS Examination is now on page 11 instead of page 10.
Page 1, First Paragraph under heading	Changed first paragraph under heading to read: "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))."
Page 1, Section II	Replaced Section II with new Section II titled "Medical Documentation". Under Section II, added the following subsections: II-A: Medical Diagnosis(es) and Onset; II-B: Behaviors; II-C: Medications; II-D: Neurological; II-E: Functional Status; II-F: Supports/Socialization.
Page 2, Section III	Moved "Section-III Mental Illness (MI)" to Section IV and added new "Section-III Review Type".
Page 4, Section IV	Old Section III is new Section IV. Under new Section IV, changed "Section III-Mental Illness (MI)" to "Section IV-Mental Health (MH)". Deleted the first question under subsection III-A, added clarifying language to the second question and labeled this subsection IV-A. Labeled subsection III-B to IV-B and under the second question added the check box option "Refused Test". Deleted subsections III-C and III-D.

Page 5, Section V	Moved “Section IV: Intellectual Disability (ID)” to Section V. Under new Section V, changed “Section IV: Intellectual Disability (ID)” to “Section V: Intellectual Disability/Developmental Disability (ID/DD)”. Labeled subsection IV-A to V-A and added additional fields to list supports for an ID/DD diagnosis. Labeled IV-B to V-B and added clarifying language to the second question. Deleted subsections IV-C and IV-D.
Pages 5 and 6, Section VI	Moved “Section V: Other Related Conditions (ORC)” to Section VI. Under new Section VI, labeled V-A to VI-A and added an additional field to the first question to list supports for an ORC diagnosis. Labeled V-B to VI-B and added clarifying language to the second question. Deleted subsections V-C and V-D.
Pages 6 - 8, Section VII	Moved “Section VII: Notice of Referral for Final Determination” to Section VIII and added new Section VII titled “Findings & Recommendation”. Under Section VII, added the following subsections: VII-A: Evaluator’s Recommendation and VII-B: Desire for Specialized Services.
Page 8, Section VIII	Replaced “Section VIII: Documentation to Include for Program Office Review” with new “Section VIII: Notice of Referral for Final Determination”. New Section VIII was old Section VII. Updated wording in paragraphs three through four. The fifth paragraph and signature text box for person who completed the form were deleted.
Page 9, Section IX	Moved “Section IX: Notification” to Section XI. Added new Section IX: “Name and Contact Information of Individual Completing this Form”.
Page 9, Section X	Added Section X: “Documentation to Include for Program Office Review”.
Page 10, Section XI	Old “Section IX: Notification” is new Section XI. Under new Section XI, changed “Section IX: Notification” to “Section XI: Notification Sheet”. Under number “5. List Full Name of Discharging Hospital” added a field for ”Contact Email”.

PROCEDURES:

Beginning September 1, 2018, the revised PASRR Level II form (MA 376.2) must be completed if the individual is identified as meeting program office criteria on the PASRR Level I form, has a change in condition, and is not an exceptional admission, as defined on page 6 of the PASRR Level I form. Aging Well or the department's Office of Long-Term Living, Division of Nursing Facility Field Operations, (if the individual is already in a nursing facility and there has been a change in condition) is responsible for completing the PASRR Level II form, including gathering the accompanying documentation, and for forwarding the information to the Office of Mental Health Substance Abuse Services (OMHSAS), Office of Developmental Programs (ODP), or Office of Long-Term Living (OLTL) program office. The program office will review the information to determine if the individual meets Nursing Facility Clinical Eligibility, program office criteria, and the need for Specialized Services as defined on pages 7 and 8 of the PASRR Level II form. The program office will issue its decision to all appropriate parties through a Program Office Letter of Determination.

Failure to complete the PASRR Level I and, when applicable, the PASRR Level II prior to admission or on the day of admission will result in forfeiture of MA reimbursement to the nursing facility during the period of non-compliance in accordance with Federal PASRR Regulations at 42 CFR § 483.122.

The revised PASRR Level II (MA 376.2 7/18) form may be downloaded or printed at the following website: http://www.dhs.pa.gov/dhsassets/maforms/index.htm.

If an individual meets the program office criteria on the PASRR Level I form completed on September 1, 2018 and thereafter, the revised PASRR Level II (MA 376.2 9/18) must be completed. Previous versions of the PASRR Level II form are not acceptable beginning September 1, 2018.

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW (PASRR) IDENTIFICATION LEVEL I FORM
(Revised 9/1/2018)

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 (PASRR) Level I identification form and PASRR Level II evaluation form, 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 (all 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 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 PASRR LEVEL II EVALUATION.

Section III – MENTAL HEALTH (MH)

Serious Mental Illness diagnoses 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 health condition or suspected mental health condition, other than Dementia, that may lead to a chronic disability?

☐ NO ☐ YES

List Mental Health 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:

A "YES" TO ANY QUESTION IN SECTION III-B WILL REQUIRE A PASRR LEVEL II 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 the Mental Health Condition 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 a Mental Health Condition

Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Mental Health Condition 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: _____

_____

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.

A CHECK IN ANY BOX IN SECTION III-C WILL REQUIRE A PASRR LEVEL II EVALUATION BE COMPLETED.

☐. **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 PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE OMHSAS PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A "YES" IN ANY OF SECTION III-B AND/OR III-C AS A RESULT OF A CONFIRMED OR SUSPECTED MENTAL HEALTH CONDITION.

Section IV– INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY (ID/DD)

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

IV-A – Does the individual have current evidence of an ID/DD or ID/DD 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 a mental health condition 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/DD services and/or received services from an ID/DD provider agency within Pennsylvania or in another state? ☐ NO ☐ YES ☐ UNKNOWN

If yes, indicate county name/agency and state if different than Pennsylvania _____

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 PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE ODP PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- **THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID/DD 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: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NURSING FACILITY) AND FORWARDED TO THE ORC PROGRAM OFFICE FOR FINAL DETERMINATION, IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B.

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 PASRR Level II Evaluation done by one of the Program Offices, is not a danger to self and/or others, and meets 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 PRIOR TO ADMISSION.

Check the Exceptional Admission that applies:

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

- Admission to NF directly from the Acute Care Hospital after receiving **inpatient medical care**, **AND**

  NOTE: Exceptional Hospital Discharge cannot be an admission from any of the following: emergency room, observational hospital stay, rehabilitation unit/hospital, Long-Term Acute Care Hospital (LTACH), inpatient psych, behavioral health unit, or hospice facility.

- Requires NF services for the same medical condition for which he/she received care in the Acute Care Hospital, (Specify the condition: _____), **AND**

- The hospital physician shall document on the medical record **(which the NF must have prior to admission)** 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/DD, 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 individual's 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/DD, or ORC, may be admitted for emergency placement for a period of up to 30-days without further evaluation if the Protective Services Agency and their physician 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/DD, 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

FOR A 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 that a PASRR Level II Evaluation needs to be completed.
- The PASRR Level II Evaluation must be done on or before the 40th day from date of admission.
- Do not complete a new PASRR Level I form; just update the current form with the changes and initial the changes. Enter your full signature and date below to indicate you made the changes to this form.

SIGNATURE: _____ **DATE:** _____

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

Check appropriate outcome:

☐ **Individual has <u>negative screen</u> for Serious Mental Illness, Intellectual Disability/Developmental Disability, or Other Related Condition; no further evaluation (Level II) is necessary.**

☐ **Individual has a <u>positive screen</u> for Serious Mental Illness, Intellectual Disability/Developmental Disability, and/or Other Related Condition; he/she requires a further PASRR Level II evaluation. You must notify the individual that a further evaluation needs to be done. Have the individual or his/her legal representative sign that they have been notified of the need to have a PASRR Level II evaluation done. Indicate by your signature here that you have given the notification (last page of this form) to the individual or his/her legal representative.**

Name of Individual or legal representative that has received the notification (page 9):

NAME: _____ (print) **SIGNATURE:** _____ (sign)

Name of individual who filled out the PASRR Level I and gave the notification to the individual/legal representative:

NAME: _____ (print) **SIGNATURE:** _____ (sign)

☐ **Individual has <u>positive screen</u> for a further PASRR Level II evaluation <u>but has a condition which meets the criteria for an Exceptional Admission</u> 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:

INTENTIALLY LEFT BLANK FOR TWO SIDED PRINTING.

NOTIFICATION OF THE NEED FOR A PASRR LEVEL II EVALUATION

All persons considering admission to a nursing facility for care must be screened with the Preadmission Screening Resident Review (PASRR) Level I to identify for any evidence of mental illness (MI), intellectual disability/developmental disability (ID/DD), or an other related condition (ORC). If you do have evidence or suspicion of MI, ID/DD, or ORC, you need to have a further PASRR Level II evaluation completed before you can be admitted to a nursing facility for care.

You have had the PASRR Level I screening process done and you are in need of a further PASRR Level II evaluation to make certain that a nursing facility is the most appropriate setting/placement for you and to identify the need for possible MI, ID/DD, or ORC services in the nursing facility's plan of care for you, if you choose to be admitted to a nursing facility.

You will have this evaluation done within the next several days to determine your needs.

The federal regulation for the above is the following:

§483.128 PASRR evaluation criteria (a) Level I: Identification of individuals with MI or ID. The state's PASRR program must identify all individuals who are suspected of having MI or ID as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The state's performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or ID and is being referred to the state mental health or intellectual disability authority for Level II screening.

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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:

   _____

   _____

   _____

   _____

NAME

SSN (LAST 4 DIGITS)

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:**

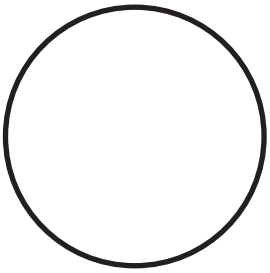
Have you listed the fax number for the Hospital/Nursing Facility on the Notification Sheet (this page) above? ☐ **No** ☐ **Yes**

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.