Name _____ SS# (last 4 digits): _____

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW (PASRR) IDENTIFICATION LEVEL I FORM (Revised 3/1/2024)

This process applies to all nursing facility (NF) applicants, regardless of payer source. All current NF residents must have the appropriate form(s) on their 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 NCD (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. NCD can affect memory, attention, learning, language, perception and social cognition. They interfere significantly with a person's everyday independence in Major NCD, but not so in Minor NCD.

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

   ☐ NO – Skip to Section III ☐ YES

   Date of Diagnosis (if known): _____

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.

Name _____ SS# (last 4 digits): _____

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?

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 receive community MH services or supports that may need to be continued if admitted to the NF?

☐ NO ☐ YES

g. 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))? ***Note:** This does NOT include psychiatrist, therapist or other mental health practitioners that provide mental health treatment.

☐ 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 THE OFFICE OF LONG-TERM LIVING (OLTL) FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NF) AND FORWARDED TO THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (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.

Name _____ SS# (last 4 digits): _____

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 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 their 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 for ID including a state operated ICF/ID or center?

☐ 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 NF) AND FORWARDED TO THE OFFICE OF DEVELOPMENTAL PROGRAMS (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.**

Name _____ SS# (last 4 digits): _____

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 their 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 NF) 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

Name _____ SS# (last 4 digits): _____

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 below?

☐ 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 Mental Illness (MI), ID/DD, or ORC:

- Admission to NF directly from the Acute Care Hospital after receiving **acute 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 the individual 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 they are 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 7-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 THE INDIVIDUAL WILL BE IN THE NF FOR MORE THAN THE ALLOTTED DAYS:

- OLTL Field Operations must be notified on the MA 408 within 48 hours that a PASRR Level II Evaluation needs to be completed within the timeframes as noted below:
  - If VII-A is a "YES", the PASRR Level II must be done on or before the 40th day from the date of admission.
  - If VII-B is a "YES", the PASRR Level II must be done on or before the 24th day from the date of admission.
  - If VII-C is a "YES", the PASRR Level II must be done on or before the 17th day from the date of admission.
  - If VII-D is a "YES", the PASRR Level II must be done when the individual comes out of the Coma.
- 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 OF PERSON NOTIFYING FIELD OPERATIONS **DATE OF NOTIFICATION**

Name _____ SS# (last 4 digits): _____

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

Check appropriate outcome:

☐ **Individual has negative screen for Serious MI, ID/DD, or ORC; no further evaluation (Level II) is necessary.**

☐ **Individual has a positive screen for Serious MI, ID/DD, and/or ORC; the individual will require a further PASRR Level II evaluation. You must notify the individual that a further evaluation needs to be done. Have the individual or their 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 their legal representative.**

Name of Individual or legal representative that has received the notification (page 8):

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 PASRR Positive 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:

Name _____ SS# (last 4 digits): _____

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 another 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 need.

Federal PASRR Regulation:

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-C?toc=1