Revised March 2007

MAP-409

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
NURSING FACILITY IDENTIFICATION SCREEN (LEVEL I)

Applicant Name – Last, First	Social Security Number		Date of Birth
______________________________	______________________		_________________
Applicant's Address	City	State	Zip Code
______________________________	______________	_____	_________________

***Section I criteria for Mental Illness ONLY**
(Not MR/DD)

I. An individual is considered to have mental illness (MI) if he/she meets all of the following requirements regarding diagnosis; level of impairment and duration of illness.

A. DIAGNOSIS:

The individual has a major mental disorder [as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DMS—III)] which includes: a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; other psychotic disorders; or another mental disorder that may lead to a chronic disability. This does not include a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. ____**Yes** ____**No**

B. LEVEL OF IMPAIRMENT:

The mental disorder resulted in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual's developmental stage. An individual typically has at least one (1) of the following characteristics on a continuing or intermittent basis (check the appropriate boxes):

☐ **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, inability to complete simple tasks with 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 in 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.

C. RECENT TREATMENT:

The treatment history indicates that the individual has experienced at least one of the following (check the appropriate box (es)):

☐ 1. Psychiatric treatment more intensive than outpatient psychiatric care more than once in the past two (2) years (e.g. partial hospitalization or inpatient hospitalization); **OR**

____

Name of inpatient facility, partial program, or other mental health treatment

☐ 2. Within the last two (2) years, due to the mental disorder, experienced 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.

D. Does the applicant meet all of the requirements of having a mental illness listed in Section I. A-C? ____**Yes**____**No**

***Section II criteria for MR/DD ONLY (Not Mental Illness)**

II. Mental Retardation and Related Conditions

An individual is considered to have mental retardation if he/she has a level of retardation (mild, moderate, severe, or profound) as described in the American Association of Mental Retardation Manual on Classification in Mental Retardation (1983).

A. The individual has significantly sub-average general intellectual functioning (I.Q. of approximately 70 or below) resulting in, or associated with, concurrent impairments in adaptive behavior and manifested during the development period, before the age of 18. ____**Yes**____**No**

B. Is there a history of mental retardation or developmental disability in the identified past? ____**Yes**____**No**

C. Is there any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a developmental disability? ____**Yes**____**No**

Please List: ____

____

D. Has the person been referred by an agency that serves persons with mental retardation or developmental disabilities and been deemed eligible for that agency services? ____**Yes**____**No**

Please List Agency: ____

E. "Persons with related conditions" means individuals who have a severe, chronic disability that meets **all** of the following conditions:

1. It is attributable to:

   a. Cerebral palsy or epilepsy; or

   b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three (3) or more of the following area of major life activities:

   a. Self care:

   b. Understanding and the use of language;

   c. Learning;

   d. Mobility;

   e. Self-direction; or

   f. Capacity for independent living.

Examples of diagnoses that may indicate that the individual has a related condition if all of the above criteria are met include:

Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, or Deafness/Blindness.

Does this applicant meet all of the conditions in Section E? ____Yes ____No

III. If responses to the applicable Section I and/or Section II were answered "Yes", do not admit the applicant to the nursing facility. The nursing facility staff shall refer the applicant to the Community Mental Health Center for a Level II PASRR. The Level II PASRR determination shall be completed prior to the nursing facility admitting the applicant.

IF RESPONSES TO THE APPLICABLE SECTION I AND/OR SECTION II WERE ANSWERED "NO" AND THERE IS NO FURTHER EVIDENCE TO INDICATE THE POSSIBILITY OF MENTAL ILLNESS, MENTAL RETARDATION, OR OTHER RELATED CONDITION, THE NURSING FACILITY MUST DECIDE WHETHER OR NOT TO ADMIT THE APPLICANT. ADMISSION TO THE FACILITY DOES NOT CONSTITUTE APPROVAL FOR TITLE XIX LEVEL OF CARE.

IV. Does the applicant meet the Criteria for Exceptional Admission to a Nursing Facility without a Level II PASRR. The applicant may be admitted if one of the following conditions exists (PLEASE NOTE TIME LIMITS):

A. <u>Person Is an Exempted Hospital Discharge</u>

Although identified as an individual with mental illness____, mental retardation ____, or other related condition____, an applicant who is not dangerous to self and/or others may be directly admitted for nursing facility services from an acute care hospital **for a period up to thirty (30) days** without a Level II PASRR if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization. An Exempted Hospital Discharge Physician Certification form shall be completed and in the resident's clinical record at the nursing facility. ____**Yes** ____**No**

B. <u>Person Requires Respite Care</u>

Although identified as an individual with mental illness ____, mental retardation ____, or other related condition ____, an applicant who is not dangerous to self or others may be admitted for Respite Care **for a period up to fourteen (14) days** without a Level II PASRR. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility.

____**Yes**____**No**

C. <u>Person Has a Diagnosis of Delirium</u>

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self and/or others may receive nursing facility services **for a period up to fourteen (14) days** without a Level II PASRR, if certified by the referring or attending physician to have a diagnosis of delirium. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility. ____**Yes** ____**No**

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ROUTING OF FORM

This form shall be completed by nursing facility personnel prior to admission of the applicant to the nursing facility.

If the individual wishes to apply for Medicaid, application shall be made to the local county DSI office in the usual manner.

The facility is required to call the PRO for the Medicaid level of care determination prior to admission, and a copy of the Level I and, if appropriate, Level II PASRR, shall be faxed to the PRO. Except for the pre-admission screening process, the procedure for approval of nursing facility applicants remains the same.

A COPY OF THIS FORM, AS WELL AS A COPY OF THE LEVEL II PASRR DETERMINATION, IF REQUIRED, SHALL BE PLACED IN EACH RESIDENT'S CLINICAL RECORD AT THE FACILITY.

If someone other than the person signing the form provided any of the above history, please list name and telephone number:

______________________________ ________________________
Name Telephone

______________________________ ________________________
Name Telephone

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate, and complete.

Signature Title Date Telephone Number

Facility Name _________________________Medicaid Provider Number ________________

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COPY TO: **Original – Community Mental Health Center**
Second – Medical Records