COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW

PASRR Significant Change/Subsequent Review

Discharge, and Death information

Significant change- individual who previously did not meet PASRR criteria now does due to new diagnosis or validations.

Subsequent Review- Previously identified meeting PASRR criteria, who has not been discharged or received a lower level of Care

Use this form to indicate when an individual's mental or physical condition has changed in a manner that affects his/her need for specialized services, nursing facility level of care, or recommended services of lesser intensity. If any of the following events have occurred, please check the type of change, and contact the local Community Mental Health Center within twenty-one (21) days.

Residents Name_____ **Date of identified change:** ____/_____/____

Date of Birth___/___/___ **Social Security/ID #**_____

Facility_____ **Provider #**_____

Type of Change

☐ Resident with no history of Mental Illness, has been newly diagnosed.

☐ Resident has a Mental Illness, with a new onset of active symptoms.

☐ Resident has a Mental Illness, and a new Medical condition/diagnosis.

☐ Resident has a Mental Illness, and the medical condition for which they were admitted, has greatly improved.

☐ Resident has a Mental Illness, and the medical condition for which they were admitted, has greatly declined.

☐ Resident with no history of having an Intellectual Disability or Related Condition has been newly diagnosed.

☐ Resident has an Intellectual Disability or a Related Condition, and a new Medical condition/diagnosis.

☐ Resident has an Intellectual Disability or a Related Condition and now requires more intensive Services than a nursing facility setting can provide.

☐ Resident has an Intellectual Disability or a Related Condition, and the medical condition for which they were admitted has improved. They may now benefit from Specialized services.

☐ Resident has an Intellectual Disability, or a Related Condition, and the medical condition for which they were admitted, has greatly improved and they may no longer meet Nursing Facility Level of Care.

☐ Resident has an Intellectual Disability, or a Related Condition, receives specialized services, and whose medical condition has greatly declined and they are no longer able to benefit from specialized services.

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Prior to this change, did the Level I Screen indicate possible Mental Illness or Intellectual Disability diagnosis or support needs: ☐ Yes ☐ No

Describe the Significant Change and its effect on the Nursing Facility Resident:

_____
_____
_____

Was this individual recently readmitted to the Facility from the hospital? ☐ Yes ☐ No

Describe reason for hospitalization:

_____
_____

Is this individual transferring to another Nursing Facility? ☐ Yes ☐ No

Date of Transfer_____

Name of Receiving Facility_____

Location of Receiving Facility_____

Had the Individual been Discharged? ☐ Yes ☐ No

Date of Discharge: _____/_____/____

(Please check appropriate discharge location & document Kentucky Nursing Facility name, if applicable.)

1. ☐ NF Setting ☐Kentucky _____ ☐ Out of State_____
2. ☐ PC Setting 3.☐ Supports for Community Living Waiver
4. ☐ Group Home 5.☐ Foster Care Home
6. ☐ Psychiatric Support Facility _____
7. ☐ Other Community Setting (specify, if possible) _____

Is Individual Deceased? ☐ Yes ☐ No

Date of Death _____/_____/_____

_____Date:____/_____/_____

Signature of Facility Representative