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

NURSING FACILITY IDENTIFICATION SCREEN (LEVEL I PASRR)

Section 1: The Individual's Admission Information

First Name: **MI :** **Last Name:**

Type of Dwelling: _____ **How long at this address:** _____
Who were they there with: _____
Mailing Address: (if different from above): _____
Street City State Zip
Phone: ( ) -
Date of Birth: / / Social Security #: - - Medicaid ID if Applicable:

Typical living situation over the past year:
☐ **Lives Alone** ☐ **At Home with Family** ☐ **Home w/paid support** ☐ **Homeless/Shelter**
☐ **Hospital** ☐ **Nursing Facility** ☐ **Assisted Living Facility** ☐ **Waiver Services in the community**
☐ **Other:** _____

Will be admitted from:
Reason NF Admission Sought: **Expected Length of Stay:**
Admitting Nursing Facility: **Expected Date of Admission: / /**
Region: _____ **Address:** _____
City: **State:** **Zip:** **Phone: ( ) -**
Does this individual have a legally appointed Guardian, POA, or a Chosen Healthcare Advocate: ☐ **Yes** ☐ **No**
Name: _____ **Designation** _____
Contact information for Guardian _____
Who is providing this information to the Nursing Facility:
What is their relationship to the person being admitted:

Section 2: Mental Illness

2a: Diagnosis

1. Does the individual have any of the following Major Mental Illnesses (MMI), or Disorders?

If not diagnosed, leave blank

☐ **Schizophrenia**
☐ **Schizoaffective Disorder**
☐ **Major Depressive Disorder**
☐ **Psychotic/Delusional Disorder**
☐ **Bipolar Disorder (manic depression)**
☐ **Paranoid Disorder**

2. Does the individual have any of the following Disorder types:

If not, leave blank

☐ **Personality Disorder**
☐ **Anxiety Disorder**
☐ **Panic Disorder**
☐ **Depression**

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list Dementia here)

☐ **Yes** ☐ **No**

If yes, list diagnosis(es) below: (Example: Hoarding, Impulse Control, Obsessive Compulsive Disorder).

_____
_____
_____
_____

2b. Symptoms

Has the individual had significant impairment in functioning related to a suspected or known diagnosis of mental illness?

☐ **Yes** ☐ **No** ☐ **Unknown**

(Check all that Apply)

INTERPERSONAL FUNCTIONING

- ☐ **Serious Difficulty Interacting with Others**
- ☐ **Difficulty Communicating with Other**
- ☐ **Altercations**
- ☐ **Evictions**
- ☐ **Unstable Employment**
- ☐ **Frequently Isolated**
- ☐ **Avoids Others**
- ☐ **Fear of Strangers**
- ☐ **Other:_____**

CONCENTRATION, PERSISTENCE, PACE

- ☐ **Serious Difficulty in Focusing and Concentrating**
- ☐ **Requires Minimal Assistance Completing Tasks**
- ☐ **Requires Moderate Assistance Completing Tasks**
- ☐ **Requires Total Assistance Completing Tasks**
- ☐ **Unable to Complete simple tasks within an established time period without assistance**

ADAPTATION TO CHANGE

Shows serious difficulty adapting to changes involving: Work, School, Family, or Social Interactions by:

- ☐ **Agitation**
- ☐ **Self-Injurious**
- ☐ **Self-Mutilation**
- ☐ **Suicidal/Homicidal Ideation**
- ☐ **Physical Violence or Threats**
- ☐ **Appetite Disturbance**
- ☐ **Delusions**
- ☐ **Hallucinations**
- ☐ **Serious Loss of Interest**
- ☐ **Tearfulness**
- ☐ **Irritability**
- ☐ **Intervention by Mental Health or Judicial System**
- ☐ **Other:_____**

1. Has the individual received any of the following mental health services?

☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, please provide date of service:

- ☐ **Inpatient psychiatric Hospitalization** **Date:_____**
- ☐ **Partial hospitalization/ Day Treatment** **Date:_____**
- ☐ **Residential treatment** **Date:_____**
- ☐ **Other: _____** **Date:_____**

2. Has the individual experienced significant life disruption because of mental health symptoms?

☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes:

- ☐ **Legal intervention due to Mental health symptoms.** **Date:_____**
- ☐ **Housing change because of mental illness.** **Date:_____**
- ☐ **Suicide attempt or ideation** **Date:_____**
- ☐ **Has been homeless in the past but not currently** **Date:_____**
- ☐ **Other:_____** **Date:_____**

2c. History- Is this a long term problem, or has it come on, or escalated quickly?

Have medical causes been ruled out: ☐ **Yes** ☐ **No** ☐ **Unknown**

What is the primary diagnosis, what does the person think the primary diagnosis is?

Comments:

2d. Dementia- **Clear evidence of a progressive decline in memory and learning, with no indication of a Neurodegenerative, or Cerebrovascular Disease.**

1. Has the individual had a recent psychiatric/behavioral evaluation?

☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, give date: _____

2. Does the individual have a primary diagnosis of Dementia or Alzheimer's disease?

☐ **Yes** ☐ **No** ☐ **Unknown**

3. Does the individual have a diagnosis of Dementia, but it is NOT primary?

☐ **Yes** ☐ **No** ☐ **Unknown**

4. Is corroborative testing or other information available to verify the presence or progression of the Dementia?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, check all that apply:

a. ☐ **Dementia work up, which would include:**
- ☐ **Lab work**
- ☐ **Brain Scan**
- ☐ **Diagnostic Testing**
- ☐ **Other Procedures to Validate Diagnosis: Explain**_____

b. ☐ **Comprehensive Mental Status Exam**_____

c. ☐ **Other (Specify)** _____

2e. Delirium- **A rapid disturbance in Attention, Awareness, and Cognition, that could fluctuate throughout the day, and may be the consequence of another condition.**

Is the Individual being admitted with a Physician documented diagnosis of Delirium

☐ **Yes** ☐ **No**

If yes, note the causative factor below:

☐ **1. Substance Intoxication Delirium**

☐ **2. Medication Induced Delirium**

☐ **3. Substance Withdraw Delirium**

☐ **4. Delirium due to another Medical Condition**

☐ **5. Delirium Due to Multiple etiologies**

2f. Psychotropic Medications

Has the individual been prescribed psychotropic medications?

☐ **Yes** ☐ **No**

If yes, list the Medication, Dose/Frequency, and the Diagnosis/Reason it was prescribed.

When needed attached additional pages to capture complete medication information.

Medication	Dose/Frequency	Reason/Condition

Comments:

2g. Supports - What formal or informal supports or services has this individual received in the past, or is currently receiving for conditions of Mental Illness, Intellectual Disability, or a Related Condition Such as: In-patient Psych, Outreach, CMHC Services, First Steps, I/DD Services, IEP during School Years, Community Supports, previous Nursing Facility placement etc.

Section 3 Neurodevelopmental Disorders- (Intellectual/Developmental Disability and Related Conditions)

3a. Intellectual Disability (ID): - A disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains, that has resulted in clinical designations of Mild, Moderate, Severe, or Profound levels of Intellectual disability. Diagnostic Criteria ID/RC - DSM 5

1. Deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both Clinical assessment and individualized standardized intelligence testing.

Describe areas of concern, level of functioning, and its effect on the individual.

(**example: Impaired judgment resulting in exploitation**)

_____
_____
_____
_____

Has criteria been met?

☐ **Yes** ☐ **No** ☐ **Unable to determine**

2. **Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal Independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life such as communication, social participation, and independent living, across multiple environments, such as home, school, work and community.**

Describe areas of concern with level of social skills, interpersonal interaction, how is it perceived by others, effect on the Individual:

(example: A non-verbal *person* using a communication board may be ignored by others, leading to feelings of isolation)

_____
_____
_____
_____

Onset/discovery of intellectual and adaptive deficits during the developmental period (before age 18)

Has criteria been met:

☐ **Yes** ☐ **No** ☐ **Unable to determine**

IQ Score ____ Date of Determination_____

3b. Related Conditions

Individuals who have a severe, chronic disability that

(a) is attributable to, (1) cerebral palsy or epilepsy or (2) any other condition, other than mental illness, found

(b) to be closely related to intellectual disability because **this condition results in impairment of general intellectual functioning or adaptive behavior similar to those of an intellectual disability and requires treatment or services similar to those required by persons with an Intellectual Disability**, (b) is manifested before the person reaches the age of 22, (c) is likely to continue indefinitely (d) results in substantial functional limitations in three or more of the following areas of major life activities:

(1) self-care;
(2) understanding and use of language;
(3) learning;
(4) mobility;
(5) self-direction;
(6) capacity for independent living.

Qualifying Diagnosis or Condition _____

Age of Onset _____

Describe level of deficit for each affected activity:

_____

_____

_____

_____

_____

_____

_____

Has criteria been met?

☐ **Yes** ☐ **No** ☐ **Unable to determine**

Has a Co-existing or Dual Diagnosis been identified, or treated in the past? (any combination of Mental Illness,or Intellectual Disability/Related Condition)

☐ **Yes** ☐ **No** ☐ **Unable to determine**

In addition to the services and supports listed on page 4, have additional referrals for needed supports or services been identified by any other agency or provider supporting Person's with Intellectual Disabilities or a Related Condition?

☐ **Yes** ☐ **No** ☐ **Unable to determine**

Please provide details regarding dates of referral and needed supports:

Section 4: Substance Use Disorder-

The diagnosis of a substance use disorder may not lead to a referral. Substance use disorders occur in a broad range of severity, from mild to severe (DSM-5).

1. **Does the individual have a substance related Disorder?**

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, list diagnosis(es) below):

_____

_____

_____

If yes, is a Nursing Facility level of care need associated with the diagnosis?

☐ **Yes** ☐ **No** ☐ **Unknown**

2. **Is there reason to believe the individual has used illegal drugs or is taking multiple habit forming prescription medications and/or exceeding prescribed dosages?**

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, list drug(s) below:

_____

_____

_____

_____

_____

3. **When did the most recent substance use occur?**

☐ **<7 days** ☐ **>7-14 days** ☐ **>14-28 days**

☐ **> 28 days to 2 months** ☐ **2-3 Months**

☐ **Unknown**

4. **Is there reason to believe the individual has frequent binge drinking of any alcoholic beverage, has required medical intervention when drinking alcohol, has had episodes of lost time or blackouts, or has encountered law enforcement due to, or as a result of alcohol?**

☐ **Yes** ☐ **No** ☐ **Unknown**

Section 5: Level II Referral Designation

☐ **1.** If all responses regarding mental illness, intellectual disability, or other related Condition were marked "No", the facility may choose to admit the individual.

☐ **2**. If any responses in Section 2 or 3, were marked yes, the nursing facility will refer the applicant to the Community Mental Health Center for a Level II PASRR evaluation prior to admission, unless they meet admission criteria in section 6.

☐ **3**. If any responses in Section 2 or 3 were marked unknown, unsure, or unable to determine, or if any responses to Section 4 were marked yes, the nursing facility will consult with the Community Mental Health Center, who will determine if an evaluation is needed prior to the nursing facility admitting the individual.

Section 6: Exempted or Delayed Level II Referrals

☐ **Person Is an Exempted Hospital Discharge**

Although identified as an individual with mental illness, intellectual disability, 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 maintained in the resident's clinical record at the nursing facility.

☐ **Person Requires Respite Care**

Although identified as an individual with mental illness, intellectual disability, 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 maintained in the resident's clinical record at the nursing facility.

☐ **Person Has a Diagnosis of Delirium**

An individual suspected of having Delirium may be admitted without the Level II evaluation, and receive nursing facility services **for a period of fourteen (14) days,** pending a definitive diagnosis by the referring or attending physician once the condition clears. A Provisional Admission Form shall be completed and maintained in the resident's clinical record at the nursing facility.

Section 7: Routing of Form

This form shall be completed by Nursing Facility personnel prior to admitting the individual to the Nursing Facility. If the individual wishes to apply for Medicaid, applications shall be made at the local DCBS office, by phone at 855-306-8959, or at benefind.ky.gov.

The Facility is required to contact the Peer Review Organization (PRO), for the Medicaid level of care determination prior to admission, and a copy of the Level I, and if appropriate the Level II PASRR Evaluations, shall be faxed to the PRO.

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 additional information was provided by someone other than the person identified on page 1, please list their name, relationship to the individual, and telephone number below.

Name **Telephone Number**

Name **Telephone Number**

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.

To the best of my knowledge, and ability, the information contained in this document was obtained from interviewing the individual/family, direct observation, previous medical records, and/or other medical professionals, and is an accurate reflection of the collected data.

Signature_____ **Title** _____ **Date** _____ **Phone**_____

Facility Name_____ **Medicaid Provider Number** _____

Original – Nursing Facility record Copy – CMHC if Level II referral is requested