

MAP 4095 Significant Change/Subsequent Review Instruction Sheet

Use this form to indicate when an individual's mental or physical condition has changed in a manner that affects their need for nursing facility level of care, specialized services, or recommended services of lesser intensity.

Changes in condition that do not affect the level of care and need for services do not require submission of a significant change form.

If the patient meets this criteria and any of the changes listed on the form have occurred, then the type of change is checked and the nursing facility submits the form to the local Community Mental Health Center. All changes meeting this criteria are required to be submitted within fourteen (14) calendar days.

Section 1: The individual's information

This section is for general information concerning the individual.

Enter client's full first, middle and last name.

Enter client's date of birth, social security number and Medicaid ID if they have one.

Enter the Nursing Facility name and full address, provider number and phone number.

Section 2: Change in Diagnosis/Condition

Thoroughly go through each question in this section relating to type of change.

New Mental Health Diagnosis – mark this box if the individual has a new mental health diagnosis, or if new records/information have been found, that indicate a diagnosis that requires intensive treatment and causes significant difficulty that meets all the criteria outlined on the form.

New Intellectual Disability Diagnosis – mark this box if the individual has a new intellectual disability diagnosis, or if new records/information have been found that indicate a diagnosis that meets all the criteria outlined on the form.

New Related Condition Diagnosis – mark this box if the individual has a new related condition diagnosis, or if new records/information have been found that indicate a diagnosis that meets all the criteria outlined on the form.

Medical Decline – mark this box if the resident has a medical condition which has declined enough that it affects their need for nursing facility level of care, specialized services, or services of lesser intensity.

Medical Improvement – mark this box if the resident has a medical condition which has improved enough that it affects their need for nursing facility level of care, specialized services, or services of lesser intensity.

Description – If any change in section 2 is marked, then this question is required. Use the box to describe the significant change and its effect on the nursing facility resident. This is where you explain how/why the noted change effects the level of care, specialized services, or services of lesser intensity.

Section 3: Transfer/Discharge/Death

Thoroughly go through each question in this section relating to type of change.

Transfer – mark this box if the individual has transferred to another nursing facility. Include the date of transfer and the name and location of the nursing facility.

Discharge – mark this box if the individual has been discharged from the nursing facility. Include the date of discharge and where the individual was discharged to.

Death – mark this box if the individual is deceased. Include the date of death.

Section 4: Designation

Check “yes” if any box in section 2 or 3 is marked. Send a copy of this form to the local CMHC immediately, but no later than 14 calendar days from the date of the change.

Check “no” if there are no boxes checked but there has been a change for an individual who either:

1. Was previously identified as being a PASRR client, or
2. Has a new SMI, ID, or RC diagnosis who doesn’t meet the criteria on the form.

If “no” is checked, then detailed information about the change must be described in the space provided. Form should be maintained in the individual’s medical record, but should not be forwarded to the CMHC for any further evaluation.

Section 5: Signatures

Be sure to sign, list your title, date completed, and phone number. Also list the facility and its Medicaid provider number. Always keep the original of this form in the facility records. Send a copy to the CMHC to refer for PASRR process if Section 4 is marked yes.