



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

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**MEMORANDUM**

**TO:** Nursing Facility Providers (PT 12)

**FROM:** Lee A. Guice, Director  
Division of Policy and Operations

**DATE:** August 1, 2018

**RE:** PASRR Significant Change/Subsequent Review Discharge and Death Information  
Provider Letter # A - 257

The Departments for Medicaid Services (DMS) and Behavioral Health, Developmental and Intellectual Disabilities (BHDID) have revised the MAP 4095, PASRR Significant Change/Subsequent Review Discharge and Death form. Completion of the MAP 4095 is required 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. Please contact your local Community Mental Health Center within fourteen (14) calendar days of a significant change in the resident's status.

The mandatory implementation date for the revised MAP 4095 (July 2018) form is **August 15, 2018**.

The new MAP 4095 and Instructions on how to complete the form are available on the following websites:

<http://www.chfs.ky.gov/agencies/dms/dpo/bpb/Pages/nursing-facilities.aspx>

<http://dbhdid.ky.gov/kdbhdid/pasrr.aspx>

If you have questions, please contact the following Division of Policy and Operations staff:

- Vicki Barber, RN, Nurse Consultant Inspector at [Vicki.Barber@ky.gov](mailto:Vicki.Barber@ky.gov) or
- Jennifer Swingle, RN, Nurse Consultant Inspector at [Jennifer.Swingle@ky.gov](mailto:Jennifer.Swingle@ky.gov)

Division of Developmental and Intellectual Disabilities Staff:

- Jessica Beaubien, DDID Regional Liaison at [jessica.Beaubien@ky.gov](mailto:jessica.Beaubien@ky.gov) or 502-782-0249;
- Allison K. Paul, Mental Illness Evaluations at [allisonk.paul@ky.gov](mailto:allisonk.paul@ky.gov) or 502-782-5497 or
- Crystal Shadd, Community Supports Branch Manager at [crystal.shadd@ky.gov](mailto:crystal.shadd@ky.gov) or 502-782-8883



## 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.

**PASRR Significant Change/Subsequent Review  
 Discharge and Death Information**

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. If the patient meets this criteria and any of the following events have occurred, please check the type of change, and contact the local Community Mental Health Center within fourteen (14) calendar days.

**Section 1: General Information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Medicaid ID if Applicable: \_\_\_\_\_  
 Nursing Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Provider Number: \_\_\_\_\_ Phone: \_\_\_\_\_

**Section 2: Change in Diagnosis/Condition**

- The individual has a new mental health diagnosis that caused significant difficulty in at least 1 of these areas:  
**Interpersonal functioning** such as serious difficulty interacting with others, difficulty communicating with others, altercations, evictions, unstable employment, frequent isolation, avoids others, or fear of strangers.  
**Concentration, persistence and pace** such as serious difficulty in focusing and concentrating, requiring assistance with completing tasks, and the inability to complete simple tasks within an established time period without assistance.  
**Adaption to change** that shows serious difficulty adapting to changes involving work, school, family, or social interactions through agitation, self-harm, suicidal/homicidal ideation, physical violence or threats, appetite disturbances, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or intervention by mental health or judicial system.  
AND  
 Due to the diagnosis and related impairments, required intensive psychiatric treatment (more intensive than outpatient care) or experienced an episode of significant disruption to their normal living situation for which supportive services were required to maintain functioning.
  
- The individual has a new Intellectual Disability diagnosis with reason to believe that onset was prior to age 18 with deficits in both:  
**Intellectual functioning** such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience; and  
**Adaptive functioning** such as failure to meet developmental and sociocultural standards for personal independence and social responsibility and limited independent functioning in one or more activities of daily life such as – communication, social participation, and independent living; and across multiple environments, such as home, school, work, and community.
  
- The individual has a new Related Condition diagnosis such as cerebral palsy, Down Syndrome, fetal alcohol syndrome, seizure disorder, and traumatic brain injury with reason to believe that onset prior to age 22.  
AND  
 This diagnosis results in substantial functional limitations in 3 or more of the following areas of major life activities that requires treatment or services similar to those required by persons with an intellectual disability: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living.
  
- The PASRR SMI/ID/RC resident has a medical condition which has **greatly declined**.
  
- The PASRR SMI/ID/RC resident has a medical condition which has **greatly improved**.

If there is a box in section 2 checked, then describe the Significant Change and its effect on the Nursing Facility Resident:

**Section 3: Transfer/Discharge/Death**

The individual is transferring to another Nursing Facility. Date of Transfer \_\_\_\_\_  
Name of Receiving Facility \_\_\_\_\_  
Location of Receiving Facility \_\_\_\_\_

The individual has been discharged. Date of discharge \_\_\_\_\_  
Discharged to: \_\_\_\_\_  
(be specific to type of setting, i.e. Supports for Community Living Waiver, Group or Foster Care Home, Psychiatric Support Facility, out of state NF)

The individual is deceased. Date of Death \_\_\_\_\_

**Section 4: Designation**

Was any box in section 2 or 3 checked?

Yes. The NF must submit this form to their local CMHC for a PASRR Level II evaluation; or to notify them of a PASRR individuals transfer, discharge, or death.

No, there was a change to the individual's condition (as described below), however, this change did not meet the criteria to require a referral for a PASRR Level II evaluation.

**Section 5: Signatures**

**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		

**Original – Nursing facility record  
COPY TO CMHC**