Preadmission Screening and Resident Review (PASRR) Level I Screening Document

The federal Omnibus Reconciliation Act (Public Law 100-203) and 42 CFR 483.100 - 138 requires that each resident, regardless of payment source, applying for admission to, or residing in, a Medicaid-certified Nursing Facility be screened for mental illness and intellectual disability. Federal law prohibits payment for Nursing Facility services until the PASRR screening has been completed.

Questions? MI - DHCS Tel: (916) 650-6945 Fax: (916) 440-5492 ID/DD/RC - DDS Tel: (916) 654-2300 Fax: (916) 652-3256

1. Date Started ______

2. Screening Type: Initial Preadmission Screening (PAS) ◯ Resident Review (RR) (Status Change) ◯ Admission Date for RR ______

Section I - Resident Identification

3. Last Name | First Name | Middle Initial

4. Date of Birth MM DD YYYY

5.a. Medi-Cal BIC #

5.b. Medicare HIC #

5.c. Social Security Number

6. ☐ No Identification

7. What type of bed is the resident currently residing in?

a. General Acute Care Hospital ◯
c. Psychiatric Health Facility (PHF) ◯
e. Rehabilitation/Hospital ◯
h. Group Home/Assisted Living ◯
b. Skilled Nursing Facility ◯
d. Acute Psychiatric Hospital/Unit ◯
f. STP/IMD ◯
g. ICF/ID ◯
i. Other - specify ◯ ______

8. **Physical** diagnosis at time of transfer/admission to Nursing Facility

Enter "None" if no physical diagnosis

Section II - Facility Completing Level I

9. Name of facility **(no initials)** completing the Level I prior to admission/transfer to the NF (PAS) or the NF where the resident currently resides (RR). **This is the location where the Level II evaluation will occur when applicable.**

Facility Name: ______ Name of Person Completing Form: ______

Address: ______ Phone: ______ Fax: ______

City: ______ Zip code: ______ E-mail address: ______

10.a. Yes ◯ No ◯ Unknown ◯ Has the resident been out of a Nursing Facility for more than 90 days, whether in an acute hospital or community setting?

10.b. Yes ◯ No ◯ Unknown ◯ Has the resident experienced a change in his or her medical condition that may indicate a change in his or her MI/MR status?

10.c. Enter the proposed transfer date to the NF or enter the date the resident was admitted to the NF where currently located

Transfer Date ______ or Date Admitted ______

Section III - Mental Illness (MI) Screen

11. **Diagnoses - Does the resident have, or is suspected of having, a mental illness?**

Yes - Select applicable boxes ◯ No ◯

☐ Schizophrenia
☐ Schizo-affective Disorder (SAD)
☐ Panic or Other Severe Anxiety Disorder
☐ Depression
☐ Delusional (Paranoid Disorder)
☐ Bipolar
☐ Mood Disorder
☐ Psychotic Disorder NOS
☐ Other - specify ______

Indications of MI

12. **Recent Treatment/History** - The treatment history for a mental disorder indicates that the resident has experienced at least one of the following within the last two years.

a. Yes ◯ No ◯ Hospitalization for psychiatric treatment
b. Yes ◯ No ◯ Intensive Case Management
c. Yes ◯ No ◯ Received County Mental Health Services
d. Yes ◯ No ◯ Significant disruption
e. Yes ◯ No ◯ Suicide Ideation with Plan (verified by psychiatric consult)
f. Yes ◯ No ◯ Suicide Attempt - Date ______

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13. Yes ◯ No ◯ **Functional Limitations in Major Life Activities**
The disorder results in functional limitations in major life activities within the past three to six months that would be appropriate for the resident's developmental stage.

14. Yes ◯ No ◯ **Interpersonal Functioning**
The resident has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and/or social isolation.

15. Yes ◯ No ◯ **Concentration, Persistence, and Pace**
The resident 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 within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

16. Yes ◯ No ◯ **Adaptation to Change**
The resident 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.

Section IV - Intellectual or Developmental Disability (ID)/(DD) or Related Condition (RC) Screen

17. Yes ◯ No/Unknown ◯ Does the resident have an ID/DD/RC diagnosis?
Specify type/diagnosis ____________________

18. Yes ◯ No/Unknown ◯ Does the resident have a history of a substantial disability prior to the age of 22?

19. Yes ◯ No/Unknown ◯ Is the resident a consumer of Regional Center services?

Section V - Major and Mild Neurocognitive Disorders Screen
(formerly Dementia / Related Disorder Determination)

20. Yes ◯ No/Unknown ◯ Is there documented evidence that a major or mild Neurocognitive Disorder is due to Alzheimer's?

21. Yes ◯ No/Unknown ◯ Is there documented evidence that a major or mild Neurocognitive Disorder is due to Traumatic Brain Injury, Vascular Disease, or Stroke/CVA?

22. Yes ◯ No/Unknown ◯ Is there documented evidence that a major or mild Neurocognitive Disorder is due to any other causes than those listed in questions 21 and 22?
If Yes, specify ____________________

23. How can requestor show that the Neurocognitive Disorder is the diagnosis?
   a. ☐ Neuropsychological Evaluation
   b. ☐ Medical/functional history prior to onset of Neurocognitive Disorder
   c. ☐ Other - Specify ____________________

24. Describe the resident's current cognitive function level. Briefly describe why you think the resident could or could not benefit from specialized mental health services.

Section VI - Provisional Admission

25.a. Yes ◯ No ◯ Does the resident have delirium?
Pending further assessment of delirium when an accurate diagnosis cannot be made until delirium clears.

25.b. Yes ◯ No ◯ Has the delirium exceeded 7 days?

26.a. Yes ◯ No ◯ Does the resident require protective services?
Pending further assessment in emergency situations requiring protective services, with placement in a nursing facility.

26.b. Yes ◯ No ◯ Has the protective services exceeded 7 days?

27.a. Yes ◯ No ◯ Is the resident being admitted to provide temporary respite for the in-home caregiver? *(CA Health & Safety Code, Section 1418.1)*
Brief respite care for in-home caregivers, with placement for the resident in a NF.

27.b. Yes ◯ No ◯ Has the respite care exceeded 15 days?

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Section VII - 30 Day Exempted Hospital Discharge

When the resident is admitted to the nursing facility from an ICF/ID, Acute Psychiatric Hospital/Unit or from a Psychiatric Health Facility (PHF), a Level II evaluation is required and the **30-day exempted hospital discharge is not applicable**?

28.a. Yes ◯ No ◯ Has the resident been admitted from a hospital after receiving acute inpatient care and requires NF convalescent or rehabilitation services related to the condition for which they received care in the hospital?

28.b. Yes ◯ No ◯ Will the resident's stay at your facility likely to require less than 30 days of NF services?

29.a. Yes ◯ No ◯ Has the attending physician certified before/upon admission to the NF that the resident is likely to require less than 30 days of NF services?

29.b. Enter Physician's Name

29.c. ☐ I acknowledge that the information entered in 29.a. and 29.b. (if applicable) is true

29.d. Date new Level I Due (Day 31 after admission)

Section VIII - Resident Information

30. Gender
Male ◯ Female ◯ Other ◯

31. Marital Status
Single ◯ Married ◯ Widowed ◯ Other ◯

32. Date of Last Complete Physical Examination
MM DD YYYY

33. Primary Language Spoken

34. Language Interpreter Needed?
Yes ◯ No ◯

35. Hearing Impaired?
Yes ◯ No ◯

36. Hearing Interpreter Needed?
Yes ◯ No ◯

37. Interpreter Type

38. Type of Insurance (check all that apply)

☐ Medi-Cal ☐ Medicare ☐ Managed Care ☐ Private Insurance ☐ Private Pay
☐ Medi-Cal Pending ☐ Medicare Pending ☐ HMO ☐ No Insurance ☐ Unknown

Section IX - Community Placement

39. Yes ◯ No ◯ **Have community placement alternatives been considered?**

If No, Select all applicable boxes

☐ Community resources unavailable
☐ Due to, or change in medical, mental, and physical functioning capability
☐ Caregiver unavailable
☐ Resident, conservator, or family choice
☐ Other

Section X - Conservatorship (Court Appointed) Power of Attorney (medical/fiduciary) is not a conservatorship

40. Yes ◯ No ◯ **Does the resident have a Conservator?** If Yes, provide the name, address, and phone number of the Conservator.

Name

Phone

Address

Fax

City

State

Zip Code

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Section XI - Advanced Categoricals

41. Yes ◯ No ◯ **Terminal Illness**

The resident has a terminal Illness as defined for hospice purposes in §418.3, CFR, Title 42, Part 483. The attending physician certified the resident's life expectancy is less than six months.

42. If 41 is Yes, briefly describe why you think the resident could or could not benefit from specialized mental health services.

43. Yes ◯ No ◯ **Severe Physical Condition**

The resident has a severe physical illness such as coma, ventilator dependence, functioning at a brain stem level, or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure which results in a level of impairment so severe that the resident could not be expected to benefit from specialized services.

44. If 43 is Yes, briefly describe why you think the resident could not be expected to benefit from specialized mental health services due to the severity of their physical condition.