

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG-TERM LIVING

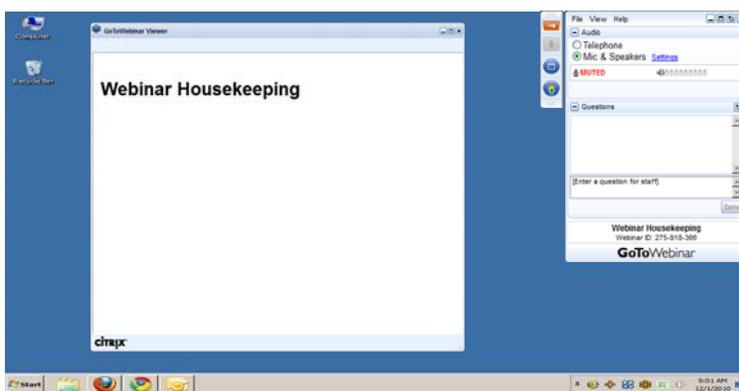
OBRA
Preadmission Screening
Resident Review Identification
Form
(Level I Tool)

November 2015

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GoToWebinar Housekeeping: What Attendees See

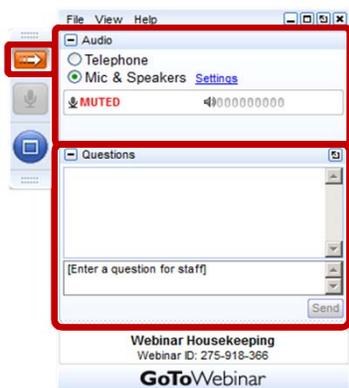


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GoToWebinar Housekeeping: Attendee Participation



Your Participation

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

Submit questions via the Questions panel.

During the presentation, we will unmute individuals to obtain your feedback on various topics.

Note: Today's presentation is being recorded and will be available on our website.

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Objectives of the Webinar

- Overview of the Federal (CMS) Requirements for PASRR
- What is required for NFs regarding PASRR
- NF eligibility
- PASRR Level I Tool Process
- Program Office Criteria
- Dual diagnoses
- Role of the Program Offices
- PASRR Level II Tool Process
- Important Websites
- Who to call for help

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▶ PASRR Background

- ▶ Is a requirement under Medicaid, pursuant to OBRA 1987 (Omnibus Budget Reconciliation Act) and 42 CFR § 483.100–483.138
- ▶ Applies to all individuals seeking admission to a Medicaid certified nursing facility (NF) regardless of payment source and ensures that individuals are placed in the least restrictive setting possible.
- ▶ Is part of the licensure for a Medicaid participating NF
- ▶ Provisions were addressed in PA Bulletin, Volume 18, Number 52 on December 24, 1988.

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▶ Background cont.

- ▶ Requires that a NF does not admit any new resident with **Mental Illness (MI), an Intellectual Disability (ID) or Related Condition (ORC)** unless the individual is determined through a PASRR evaluation to be appropriate for NF services (CFR § 483.106(a))
- ▶ **Failure to timely complete (prior to admission) the PASRR process will result in forfeiture of Medicaid Reimbursement to the NF during the period of non-compliance in accordance with Federal PASRR Regulations (CFR § 483.122(b))**

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▶ Preadmission Screening

Prior to Admission to a NF the following must be done:

- ▶ Preadmission Screening Identification (PASRR-ID) Level I tool
- ▶ Preadmission Screening Evaluation (PASRR-ID) Level II tool (if needed)
- ▶ Program Office Letter of Determination received if Level II has been done

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▶ PASRR-ID: Section I – Demo, Diagnosis, & Communication

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (PASRR-ID) LEVEL I FORM (Revised 1/1/2016)

This process applies to all nursing facility (NF) applicants, regardless of payer source. All current NF residents must have the appropriate form(s) on his/her record. The Preadmission Screening Resident Review Identification (PASRR-ID) Level I form and Level II evaluation, if necessary, must be completed prior to admission as per Federal PASRR Regulations 42 CFR § 483.106.

NOTE: FAILURE TO TIMELY COMPLETE THE PASRR PROCESS WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR § 483.122.

Section I – DEMOGRAPHICS

DATE THE FORM IS COMPLETED: _____ SOCIAL SECURITY NUMBER (9 digits): _____ - _____ - _____

APPLICANT/RESIDENT NAME - LAST, FIRST: _____

Communication

Does the applicant/resident require assistance with communication, such as an interpreter or other accommodation, to participate in or understand the PASRR evaluation process? NO YES

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PASRR-ID: Section II – NCD/Dementia

Section II – NEUROCOGNITIVE DISORDER (NCD)/DEMENTIA

For Neurocognitive Disorders (i.e. Alzheimer's disease, Traumatic Brain Injury, Huntington's, etc.), the primary clinical deficit is in cognitive function, and it represents a decline from a previously attained level of functioning. Neurocognitive disorders can affect memory, attention, learning, language, perception and social cognition. They interfere significantly with a person's everyday independence in Major Neurocognitive Disorder, but not so in Minor Neurocognitive Disorder.

1. Does the individual have a diagnosis of a Mild or Major NCD?
 - NO – Skip to Section III
 - YES
2. Has the psychiatrist/physician indicated the level of NCD?
 - NO
 - YES – indicate the level: Mild Major
3. Is there corroborative testing or other information available to verify the presence or progression of the NCD?
 - NO
 - YES – indicate what testing or other information:
 - NCD/Dementia Work up
 - Comprehensive Mental Status Exam
 - Other (Specify): _____

NOTE: A DIAGNOSIS OF MILD NCD WILL NOT AUTOMATICALLY EXCLUDE AN INDIVIDUAL FROM A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION.

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PASRR-ID: Section III - Serious Mental Illness

Section III – SERIOUS MENTAL ILLNESS (MI)

Examples of a MI may include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Psychotic Disorder, Personality Disorder, Panic or Other Severe Anxiety Disorder, Somatic Symptom Disorder, Bipolar Disorder, Depressive Disorder, or another mental disorder that may lead to chronic disability.

III-A – RELATED QUESTIONS

1. **Diagnosis**

Does the individual have a mental disorder or suspected mental disorder, other than Dementia, that may lead to a chronic disability?

 - NO
 - YES – List Diagnosis(es): _____
2. **Substance related disorder**
 - a. Does the individual have a diagnosis of a substance related disorder, documented by a physician, within the last two years?
 - NO
 - YES
 - b. List the substance(s): _____
 - c. Is the need for NF placement associated with this diagnosis?
 - NO
 - YES
 - UNKNOWN

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PASRR-ID: Section III-B 1

III-B – RECENT TREATMENTS/HISTORY: The treatment history for the mental disorder indicates that the individual has experienced at least one of the following:

NOTE: A "YES" TO ANY QUESTION IN SECTION III-B WILL REQUIRE THAT A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION BE COMPLETED.

1. Mental Health Services (check all that apply):

- a. Treatment in an acute psychiatric hospital at least once in the past 2 years:
 - NO
 - YES – Indicate name of hospital and date(s): _____
- b. Treatment in a partial psychiatric program (Day Treatment Program) at least once in the past 2 years:
 - NO
 - YES – Indicate name of program and date(s): _____
- c. Any admission to a state hospital:
 - NO
 - YES – Indicate name of hospital and date(s): _____
- d. One stay in a Long-Term Structured Residence (LTSR) in the past 2 years:

ALTSR is a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR. Admission may occur voluntarily.

 - NO
 - YES – Indicate name of LTSR and date(s): _____
- e. Electroconvulsive Therapy (ECT) for Serious Mental Illness within the past 2 years:
 - NO
 - YES – Date(s): _____
- f. Does the individual have a Mental Health Case Manager (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment (ACT))?
 - NO
 - YES

Indicate Name, Agency, and Telephone Number of Mental Health Case Manager: _____



PASRR-ID: Section III-B 2

2. Significant Life disruption due to Mental Illness

Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Serious Mental Illness within the past 2 years:

- a. Suicide attempt or ideation with a plan:
 - NO
 - YES – List Date(s) and Explain: _____
- b. Legal/law intervention:
 - NO
 - YES – Explain: _____
- c. Loss of housing/Life change(s):
 - NO
 - YES – Explain: _____
- d. Other:
 - NO
 - YES – Explain: _____

If questions in III-A (#1) and III-B are all "NO", skip to Section IV.



PASRR-ID: Section III-C-Level of Impairment

III-C – LEVEL OF IMPAIRMENT: The mental disorder has resulted in functional limitations in major life activities that are not appropriate for the individual's developmental stage. An individual typically has **at least one** of the following characteristics on a continuing or intermittent basis.

- 1. **Interpersonal functioning** - The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.
- 2. **Concentration, persistence and pace** - The individual 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, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.
- 3. **Adaptation to change** - The individual has serious difficulty 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.

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PASRR-ID: Mental Health Note

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A "YES" IN III-A #1 AND/OR A "YES" IN ANY OF SECTION III-B.

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PASRR-ID: Intellectual Disability – Section IV

Section IV– INTELLECTUAL DISABILITY (ID)

An individual is considered to have evidence of an intellectual disability if they have a diagnosis of ID and/or have received services from an ID agency in the past.

IV-A – Does the individual have current evidence of an ID or ID Diagnosis (mild, moderate, severe or profound)?

NO YES – List diagnosis(es) or evidence: _____

IV-B – Did this condition occur prior to age 18? NO YES CANNOT DETERMINE

IV-C – Is there a history of a severe, chronic disability that is attributable to a condition other than mental illness that could result in impairment of functioning in general intellectual and adaptive behavior?

NO – Skip to Section IV-D YES – Check below, all that applied prior to age 18:

- Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.
- Receptive and expressive language:** An individual is unable to effectively communicate with another person with out the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.
- Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
- Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
- Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.
- Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

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PASRR-ID: Section IV-D, E, F

IV-D – Has the individual ever been registered with their county for ID services and/or received services from an ID provider agency? NO YES UNKNOWN

If yes, indicate County name/agency _____

Name of Support Coordinator (if known) _____

IV-E – Was the individual referred for placement by an agency that serves individuals with ID/DD? NO YES

IV-F – Has the individual ever been a resident of a state facility including a state hospital, state operated ID center, or a state school?

NO

YES – Indicate the name of the facility and the date(s): _____

UNKNOWN

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PASRR-ID: Intellectual Disability Note

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID DIAGNOSIS AND HAS A "YES" OR "CANNOT DETERMINE" IN IV-B AND A "YES" IN IV-C WITH AT LEAST ONE FUNCTIONAL LIMITATION, OR
- THE INDIVIDUAL HAS A "YES" IN IV-D, OR E, OR F.

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PASRR-ID: Section V - Other Related Conditions

Section V— OTHER RELATED CONDITIONS (ORC)

ORC include physical, sensory or neurological disability(ies). Examples of an ORC may include but are not limited to: Arthritis, Juvenile Rheumatoid Arthritis, Cerebral Palsy, Autism, Epilepsy, Seizure Disorder, Tourette's Syndrome, Meningitis, Encephalitis, Hydrocephalus, Huntington's Chorea, Multiple Sclerosis, Muscular Dystrophy, Polio, Spina Bifida, Anoxic Brain Damage, Blindness and Deafness, Paraplegia or Quadriplegia, head injuries (e.g. gunshot wound) or other injuries (e.g. spinal injury), so long as the injuries were sustained **prior to age of 22**.

V-A – Does the individual have an ORC diagnosis that manifested **prior to age 22** and is expected to continue indefinitely?
 NO – Skip to Section VI
 YES – Specify the ORC Diagnosis(es): _____

V-B – Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC.

- Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.
- Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.
- Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
- Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
- Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.
- Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence is required more than half the time (during waking hours).

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PASRR-ID: Other Related Condition Note

NOTE: IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B, A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION.

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PASRR-ID: Section VI - Home & Community Services

Section VI – HOME AND COMMUNITY SERVICES

Was the individual/family informed about Home and Community Based Services that are available?

- NO YES

Is the individual/family interested in the individual going back home, back to the prior living arrangement, or exploring other community living options?

- NO YES

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PASRR-ID: Change in Exceptional Status

CHANGE IN EXCEPTIONAL STATUS

IF THE INDIVIDUAL'S CONDITION CHANGES OR HE/SHE WILL BE IN RESIDENCE FOR MORE THAN THE ALLOTTED DAYS:

- THE DEPARTMENT MUST BE NOTIFIED ON THE MA 408 WITHIN 48 HOURS FOR AN EVALUATION TO BE COMPLETED.
- THE LEVEL II EVALUATION MUST BE DONE ON OR BEFORE THE 40TH DAY FROM ADMISSION.
- DO NOT COMPLETE A NEW PASRR-ID (LEVEL I) FORM; JUST UPDATE THE CURRENT FORM WITH THE CHANGES AND INITIAL THE CHANGES. ENTER FULL SIGNATURE AND DATE BELOW TO INDICATE YOU MADE THE CHANGES.

SIGNATURE: _____ DATE: _____

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PASRR-ID: Section VIII – Screening Outcome

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

- Individual has negative screen for Serious Mental Illness, Intellectual Disability, or Other Related Condition; no further evaluation (Level II) is necessary.
- Individual has a positive screen for Serious Mental Illness, Intellectual Disability, and/or Other Related Condition; requires further evaluation (Level II).
- Individual has positive screen for further evaluation (Level II) but has a condition which meets the criteria for Exceptional Admission indicated in Section VII. NF must report Exceptional Admissions on the Target Resident Reporting Form (MA 408)

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PASRR-ID: Section IX– Individual Completing Form

SECTION IX – INDIVIDUAL COMPLETING FORM

By entering my name below, I certify the information provided is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

PRINT NAME:	SIGNATURE:	DATE:
FACILITY:		TELEPHONE NUMBER:

Affix Nursing Facility Field Operations stamp here:

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What happens if the Program Office criteria is met?

- ▶ If the Criteria on the PASRR–ID (Level I) form indicates a need for a PASRR Level II form to be completed, it must be completed prior to admission.
- ▶ The entity completing the PASRR–EV (Level II) must forward the evaluation and required information to the appropriate Program Office.

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▶ Dual Diagnoses

- ▶ If an individual meets the criteria for more than one Program Office the information will be forwarded by the first Program Office to the next Program Office.

- ▶ Do not have to wait for all letters before admission, you just need one to say “Yes” need for LTSS

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▶ Role of the Program Office

- ▶ To determine if the individual:
 - Meets the criteria for the Program Office
 - Eligibility for Long Term Services and Supports
 - Needs Specialized Services
- ▶ End result is a Program Office Letter of Determination

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Preadmission Screening Resident Review Evaluation Form (Level II Tool)

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PASRR-EV: Section I -Demographics

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW EVALUATION (PASRR-EV) LEVEL II FORM
PA-PASRR-EV (Revised 1/1/2016)

When a Pennsylvania Preadmission Screening Resident Review Evaluation (PA-PASRR-EV) Level II Form is completed the following documentation must be sent to the appropriate Department of Human Services (DHS) program office (Office of Mental Health and Substance Abuse Services, Office of Developmental Programs, Office of Long-Term Living): completed PA-PASRR-EV Level II Form, all supporting documentation (see list in Section VIII), the assessors' name, and telephone number.

DATE OF ASSESSMENT: _____

SECTION I - DEMOGRAPHICS

APPLICANT/RESIDENT'S NAME:	SOCIAL SECURITY NUMBER:	AGE:	BIRTH DATE:	COUNTY OF ORIGIN:
Is the applicant/resident enrolled in or applying for Medical Assistance (MA)? <input type="checkbox"/> Yes <input type="checkbox"/> No		MA NUMBER:		

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PASRR-EV: Section II - Documentation

SECTION II - DOCUMENTATION

II-A: MEDICATIONS

1. List all current medications the individual is taking related to his/her MI, ID, or ORC diagnosis(es):

MEDICATION	DOSE	FREQUENCY	SIDE EFFECTS

2. Does the individual have any allergies or adverse reactions to any medications? No Yes - List:

PASRR-EV: Section II-B Supports

II-B: SUPPORTS

List the medical and social supports the individual current receives (include activities of interest that show socialization with others):

II-C: REVIEW TYPE

Select type(s) of review: MI ID ORC

Please complete each section(s) for the review type(s) checked above. Once the appropriate section(s) noted above have been completed, complete Sections VI through IX.

PASRR-EV: Section III - Serious Mental Illness

SECTION III - MENTAL ILLNESS (MI)

III-A: DOCUMENTATION OF THE DIAGNOSIS

- Is the individual currently assaultive and/or self-abusive to the degree that he/she might endanger other residents of a nursing facility or might injure himself/herself without constant supervision by mental health personnel? Yes No
- For PASRR purposes, the Major Mental Disorders include the following. Please check "No" or "Yes" to indicate if a CURRENT Diagnosis exists, enter year (or approximate year) of onset, and attach documentation. Examples of acceptable documentation include a current psychiatric assessment with diagnosis or other professionally accepted diagnostic practices by a qualified physician or psychiatrist. (see CFR §483.134).

DIAGNOSIS	CURRENT?	ONSET YEAR	DIAGNOSIS	CURRENT?	ONSET YEAR
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No		Panic or other severe anxiety disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizoaffective disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Somatic Symptom disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Delusional disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Personality disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bipolar disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Depressive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychotic disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

- Does a review of the applicant/resident's case history and/or medical record substantiate that the mental disorder is responsible for the functional limitations in the last 3-6 months in the following areas? (See PASRR-ID for definitions).

Interpersonal functioning	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concentration, persistence, and pace	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptation to change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe:	

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PASRR-EV: Section III-A Treatment History

- Does a review of the applicant/resident's treatment history substantiate that the individual experienced at least one of the following in the past two years?
 - Psychiatric treatment more intensive than outpatient care: No Yes
If yes, describe: _____
 - An episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. (Supportive services include crisis intervention, intensive case management, and/or other social service agency intervention). No Yes
If yes, describe: _____
 - Suicide ideation with a plan or attempt as reported by the individual, other, or verified by a psychiatric consult: No Yes
If yes, describe: _____
 - Electroconvulsive Therapy - ECT (related to MI): No Yes
If yes, describe: _____
 - Mental Health Intensive Case Manager (ICM): No Yes
If yes, describe: _____

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PASRR-EV: Section III-B Supporting Information

III-B: SUPPORTING INFORMATION

1. The following information in the list below should be gathered to allow the Office of Mental Health to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

<input type="checkbox"/>	Complete medical history.
<input type="checkbox"/>	Review of all body systems.
<input type="checkbox"/>	Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; additional evaluations conducted by appropriate specialists.
<input type="checkbox"/>	A comprehensive drug history including current or immediate past use of medications that could mask symptom or mimic mental illness.
<input type="checkbox"/>	A psychosocial evaluation of the individual, including current living arrangements, medical, and support systems.
<input type="checkbox"/>	A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.
<input type="checkbox"/>	Functional assessment of the individual's ability to engage in activities of daily living. Include the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must also determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that nursing facility placement is required. The functional assessment must address the following areas: Self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, or both, self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.

2. Was a Saint Louis University Mental Status (SLUMS) exam performed as part of the Long-Term Services and Supports (LTSS) assessment?
 No - Please complete (see last page). Yes - Score: _____
3. Estimated level of intelligence of the individual during this evaluation: High Average Low Unknown

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PASRR-EV: Section III-C Recommend to the PO

III-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of a major mental disorder which meets the criteria of a "serious mental illness"?
 No Yes
2. Does the individual currently receive mental health or substance use disorder services in the community?
 No Yes - List what service(s): _____
3. Does the individual need specialized services in the nursing facility (See Section III-D)?
 No Yes - List what service(s): _____
4. Does the individual need health rehabilitative services provided by the nursing facility for his/her mental illness?
 No Yes - List what service(s): _____

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PASRR-EV: Section III-D Desire for SS

III-D: DESIRE FOR SPECIALIZED SERVICES

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:
Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.
An individual may choose whether to participate in recommended specialized services.

2. Explain available Specialized Services using the definitions below.

Specialized services for an individual that meets the clinical criteria for a serious mental illness include appropriate community-based mental health services such as:

- **Partial Psychiatric Hospitalization** – Services provided in a non-residential treatment setting which includes psychiatric, psychological, social and vocational elements under medical supervision. Designed for patients with moderate to severe mental illness who require less than 24-hour continuous care but require more intensive and comprehensive services than offered in outpatient. Services are provided on a planned and regularly scheduled basis for a minimum of 3 hours, but less than 24 hours in any one day.
- **Psychiatric Outpatient Clinic** – Psychiatric, psychologist, social, educational and other related services provided under medical supervision in a non-residential setting designed for the evaluation and treatment of patients with mental or emotional disorders.
- **Mobile Mental Health Treatment (MMHT)** – A service array for adults and older adults with a mental illness who encounter barriers to, or have been unsuccessful in, attending an outpatient clinic. The purpose of MMHT is to provide therapeutic treatment to reduce the need for intensive levels of service including crisis intervention or inpatient hospitalization. MMHT provides treatment which includes evaluation; individual, group, or family therapy; and medication visits in an individual's residence or approved community site.
- **Crisis intervention services** – Immediate, crisis oriented services designed to ameliorate or resolve precipitating stress. Provided to persons who exhibit acute problems of disturbed thought, behavior, mood, or social relationships
- **Targeted mental health case management (intensive case management (ICM) and resource coordination)** – ICM services are provided to assist adults with serious and persistent mental illness to gain access to needed resources such as medical, social, educational, and other services. Activities undertaken by staff providing ICM services include: linking with services, monitoring of service delivery, gaining access to services, assessment and service planning, problem resolution, informal support network building, use of community resources. Resource Coordination is provided to persons who do not need the intensity and frequency of contacts provided through ICM, but who do need assistance in accessing, coordinating and monitoring of, resources and services.
- **Peer Support Services** – Person-centered and recovery focused services for adults with serious and persistent mental illness. The services are provided by individuals who have been served in the public behavioral health system. The service is designed to promote empowerment, self-determination, understanding and coping skills through mentoring and service coordination supports that allow people with severe and persistent mental illness to achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disabilities. Peer Specialists may provide site-based and/or mobile peer support services, off-site in the community.
- **Outpatient D&A services, including Methadone Maintenance Clinic** – An organized, non-residential, drug-free treatment service providing psychotherapy in which the client resides outside the facility. Services are usually provided in regularly scheduled treatment sessions for, at most, 5 contact hours per week.

If the individual meets the clinical criteria for a serious mental illness and is admitted to a nursing facility, some mental health or substance use disorder services may need to continue to be provided to the individual. The provision of specialized services should be assured by the nursing facility and Office of Mental Health.

Specialized services for individuals with a serious mental illness are authorized by the Office of Mental Health. The services shall be based on the individual's needs.

3. Explain further and answer questions as needed.

- a. Do you understand what I have told you about specialized services? No - Try again Yes
- b. If recommended, do you want to receive any specialized services? No Yes



PASRR-EV: Section IV: Intellectual Disability

SECTION IV: INTELLECTUAL DISABILITY (ID)

IV-A: DOCUMENTATION OF THE DIAGNOSIS

1. Does the documentation indicate a diagnosis of an ID? No Yes
Documentation can include, but is not limited to, IQ and adaptive testing (preferably before the age of 18), psychological reports, psychiatric reports, school records, summaries from the county ID program or ID agency, and other relevant professional reports.
2. Does the documentation provide evidence of the following characteristics?
- a. Significantly sub-average intellectual functioning with an IQ of approximately 70 or below on standardized intelligence testing identified by a qualified psychologist? No Yes
- b. Onset prior to the age of 18 (consider all relevant and informed sources)? No Yes
- c. Deficits in adaptive behavior or functioning on formal assessment? No Yes
3. Indicate level of ID. Mild (50-69) Moderate (35-49) Severe (25-34) Profound (<25) Unspecified Not known (scores not available) None



PASRR-EV: Section IV-B: Supporting Information

IV-B: SUPPORTING INFORMATION

1. Does the individual have a Supports Coordinator? No Yes - List name of Supports Coordinator and Agency: _____

2. The following information in the list below should be gathered to allow the Office of Developmental Programs to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

<input type="checkbox"/>	Self-monitoring of health status.
<input type="checkbox"/>	Self-administering and scheduling of medical treatments.
<input type="checkbox"/>	Self-monitoring of nutritional status.
<input type="checkbox"/>	Self-help development such as toileting, dressing, grooming and eating.
<input type="checkbox"/>	Sensory-motor skills such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination and the extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity.
<input type="checkbox"/>	Communication skills including expressive and receptive language and the extent to which a communication system, amplification device and/or program of amplification could improve the individual's functional capacity.
<input type="checkbox"/>	Social skills including relationships, interpersonal, and recreation-leisure skills.
<input type="checkbox"/>	Academic and educational skills including functional learning skills.
<input type="checkbox"/>	Independent living skills involving meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to neighborhood, town, city, etc.), orientation skills for individuals with visual impairments, laundry, housekeeping, shopping, bed making, and care of clothing.
<input type="checkbox"/>	Vocational skills.
<input type="checkbox"/>	Affective skills including interests, ability to express emotion, making judgements, and independent decision-making.
<input type="checkbox"/>	Presence of maladaptive or inappropriate behaviors including their description, frequency, and intensity.

PASRR-EV: Section IV-C Recommend to the PO

IV-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of an intellectual disability which meets the criteria of an "intellectual disability"?

No Yes

2. Does the individual currently receive intellectual disability services in the community?

No Yes - List what service(s): _____

3. Does the individual need specialized services in the nursing facility (See Section IV-D)?

No Yes - List what service(s): _____

4. Does the individual need health rehabilitative services provided by the nursing facility for his/her intellectual disability?

No Yes - List what service(s): _____

PASRR-EV: Section V-B Supporting Documentation

V-B: SUPPORTING DOCUMENTATION

- Indicate areas where the individual has a **SUBSTANTIAL FUNCTIONAL LIMITATION** which has manifested prior to age 22.
 - Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.
 - Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.
 - Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
 - Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
 - Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.
 - Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

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PASRR-EV: Section V-B: Supporting Documentation

- The following information in the list below should be gathered to allow Office of Long-Term Living to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment:

<input type="checkbox"/>	Sensorimotor development (ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination)
<input type="checkbox"/>	Speech and language development (includes expressive and receptive language, disorders, i.e. Communication disorders).
<input type="checkbox"/>	Social development (includes interpersonal skills, recreation-leisure skills, and relationships with others).
<input type="checkbox"/>	Academic/educational development (grade level of school completed and/or functional learning skills).
<input type="checkbox"/>	Independent living development (includes meal preparation, budgeting and personal finances, survival skill, mobility skills [orientation to the neighborhood, town, etc.], laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills for individuals with visual impairments).
<input type="checkbox"/>	Vocational development (include present vocational skills).
<input type="checkbox"/>	Affective development (such as interests and skills involved with expressing emotions, making judgments, and making independent decisions).
<input type="checkbox"/>	IQ and adaptive function testing.
<input type="checkbox"/>	Psychological evaluation.
<input type="checkbox"/>	Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systemic observation (include frequency and intensity of behavior).
<input type="checkbox"/>	Extent to which prosthetic, orthotic-corrective or mechanical-supportive devices can improve the individual's functional capacity.
<input type="checkbox"/>	Extent to which non-oral communication systems can improve the individual's functional capacity.

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PASRR-EV: Section V-C Recommendation to the PO

V-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of a related condition which meets the criteria of an "other related condition"?
 No Yes
2. Does the individual currently receive services in the community for the other related condition?
 No Yes - List what service(s): _____
3. Does the individual need specialized services in the nursing facility (See Section V-D)?
 No Yes - List what service(s): _____
4. Does the individual need health rehabilitative services provided by the nursing facility for his/her other related condition?
 No Yes - List what service(s): _____

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PASRR-EV: Section V-D Desire for SS

V-D: DESIRE FOR SPECIALIZED SERVICES

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:
 Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.
 An individual may choose whether to participate in recommended specialized services.
2. Explain available Specialized Services using the definitions below.
 Specialized services for an individual that meets the clinical criteria for a related condition include appropriate community-based services which result in:
 - The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
 - The prevention or deceleration of regression or loss of current optimal functional status.
 Specialized services are authorized for applicants/residents with an "Other Related Condition" by the Office of Long-Term Living or its agent. For individuals with ORC, community specialized services primarily include:
 - **Service Coordination/Advocacy Services** – Development and maintenance of a specialized service plan, facilitating and monitoring the integration of specialized services with the provision of nursing facility and specialized rehabilitative services, and assisting or advocating for residents on issues pertaining to residing in nursing facilities.
 - **Peer Counseling/Support Groups** – Linking residents to "role models" or "mentors" who are persons with physical disabilities and who reside in community settings.
 - **Training** – In areas such as self-empowerment/self-advocacy, household management in community settings, community mobility, decision making, laws relating to disability, leadership, human sexuality, time management, self-defense/victim assistance, interpersonal relationships, certain academic/development activities, and certain vocational/development activities.
 - **Community Integration Activities** – Exposing residents to a wide variety of unstructured community experiences which they would encounter in the event that they must or choose to leave the nursing facilities or engage in activities away from the nursing facilities.
 - **Equipment/Assessments** – Purchase of equipment and related assessment for residents who plan, within the next two years, to relocate to community settings.
 - **Transportation** – Facilitation of travel necessary to participate in the above specialized services.
3. Explain further and answer questions as needed.
 - a. Do you understand what I have told you about specialized services? No - Try again. Yes
 - b. If recommended, do you want to receive any specialized services? No Yes

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PASRR-EV: Section VI - Signatures

SECTION VI: SIGNATURES

Obtain signature of either the individual or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services.

INDIVIDUAL'S SIGNATURE:	DATE:
WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

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PASRR-EV: Section VII – Notice of Referral

SECTION VII: NOTICE OF REFERRAL FOR FINAL DETERMINATION

You must now explain to the individual, legal representative, family member and/or significant other (if the individual agrees to family participation) that persons with a serious Mental Illness, Intellectual Disability, or an Other Related Condition may not always need nursing facility services, and should be in places more suited to their needs. Explain that this assessment is a way for making sure the individual is receiving the appropriate services to meet his/her needs and receiving the services in the setting that best fits his/her needs.

For Persons with Mental Illness: You have (your relative/friend/responsible party has) been given a diagnosis of a Major Mental Disorder. We must forward this form and the related information to the DHS Office of Mental Health to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

For Persons with Intellectual Disability: You have (your relative/friend/responsible party has) been given a diagnosis of an Intellectual Disability. We must forward this form and the related information to the DHS Office of Developmental Programs to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

For Persons with an Other Related Condition: You have (your relative/friend/responsible party has) been given a diagnosis of an Other Related Condition. We must forward this form and the related information to the DHS Office of Long-Term Living to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

Questions about the preparation of this form should be referred to the person completing this form.

PRINT NAME:	TITLE:	DATE:
SIGNATURE:	DATE:	TELEPHONE:

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PASRR-EV: Section VIII – Documentation for Program Office

SECTION VIII: DOCUMENTATION TO INCLUDE FOR PROGRAM OFFICE REVIEW

Send the below documentation to the Program Office in the order it is listed below:

MH	ID	ORC
<input type="checkbox"/> Program Office Transmittal Sheet – should be the 1st sheet in packet.	<input type="checkbox"/> Program Office Transmittal Sheet – should be the 1st sheet in packet.	<input type="checkbox"/> Program Office Transmittal Sheet – should be the 1st sheet in packet.
<input type="checkbox"/> MA 51 (NF Field Operations may not have this)	<input type="checkbox"/> MA 51 (NF Field Operations may not have this)	<input type="checkbox"/> MA 51 (NF Field Operations may not have this)
<input type="checkbox"/> Notification Sheet – Reminder – Include the FAX number for the hospital/NF.	<input type="checkbox"/> Notification Sheet – Reminder – Include the FAX number for the hospital/NF.	<input type="checkbox"/> Notification Sheet – Reminder – Include the FAX number for the hospital/NF.
<input type="checkbox"/> PASRR-ID and PASRR-EV – Reminder – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.	<input type="checkbox"/> PASRR-ID and PASRR-EV – Reminder – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.	<input type="checkbox"/> PASRR-ID and PASRR-EV – Reminder – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.
<input type="checkbox"/> Comprehensive History & Physical Exam	<input type="checkbox"/> Long-Term Services and Supports (LTSS) assessment	<input type="checkbox"/> Long-Term Services and Supports (LTSS) assessment
<input type="checkbox"/> Comprehensive Medication History (most current and immediate past)	<input type="checkbox"/> Admission Report – To include History, Diagnosis, Physical Exam	<input type="checkbox"/> Comprehensive History & Physical Exam
<input type="checkbox"/> Comprehensive Psychosocial Evaluation	<input type="checkbox"/> Nurses Notes – only the most recent (1 week prior to NF Admission)	<input type="checkbox"/> Nurses notes including what Specialized Service would be helpful
<input type="checkbox"/> Comprehensive Psychiatric Evaluation	<input type="checkbox"/> Current Medication record	<input type="checkbox"/> Course of Stay – any important issues during stay
<input type="checkbox"/> Long-Term Services and Supports (LTSS) assessment	<input type="checkbox"/> Course of Stay – any important issues during stay	<input type="checkbox"/> Psychological evaluation
<input type="checkbox"/> Last 3 days of the most current Physician's orders and progress notes at time of review, (if applicable).	<input type="checkbox"/> Psychological evaluation – include school records with an IQ score before age of 22 if possible.	<input type="checkbox"/> PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF)
<input type="checkbox"/> Last 3 days of the most current nurses' notes, (if applicable).	<input type="checkbox"/> PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF)	<input type="checkbox"/> D/C Plans
<input type="checkbox"/> Current medication record	<input type="checkbox"/> D/C Plans	<input type="checkbox"/> MDS – if individual is already in the NF
<input type="checkbox"/> CT/Neurology Consults if applicable	<input type="checkbox"/> MDS – if individual is already in the NF	
<input type="checkbox"/> MDS – if individual is already in the NF		

N



PASRR-EV: Section IX – Notification

SECTION IX: NOTIFICATION

Assessor should:

- Complete the notification information below for all assessments.
- Make a copy of the assessment packet for their records, and then,
- Forward the assessment packet to the appropriate program office or its designee for a final determination.

COPIES OF THE EVALUATION REPORT SHOULD BE SENT TO EACH OF THE FOLLOWING:

1. THE INDIVIDUAL BEING ASSESSED

NAME: _____ SOCIAL SECURITY NUMBER: _____ TELEPHONE NUMBER: _____

2. THE LEGAL REPRESENTATIVE - A PERSON DESIGNATED BY STATE LAW TO REPRESENT THE INDIVIDUAL, THIS INCLUDES A COURT-APPOINTED GUARDIAN OR AN INDIVIDUAL HAVING POWER OF ATTORNEY.

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

3. ADMITTING/TRANSFERRING NURSING FACILITY (NF) (if known)

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____ FAX NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

4. INDIVIDUAL'S ATTENDING PHYSICIAN

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____ FAX NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

5. LIST FULL NAME OF DISCHARGING HOSPITAL (if individual is seeking nursing facility admission directly from a hospital)

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____ FAX NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT PERSON AND TELEPHONE NUMBER: _____

November 2015 – Do you have a fax number for the Hospital/Nursing Facility on the Notification Sheet (this page)? No Yes



PASRR-EV: SLUMS Examination

SLUMS EXAMINATION

Instructions can be found at http://www.etdpspa.com/directories/SLUMS_instructions.pdf

NAME	AGE
TO THE NURSE/AGENT	DATE OF EXAMINATION

____/1

____/1

____/1

____/3

____/3

____/5

____/2

____/4

____/2

____/8

TOTAL SCORE:

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tea House Car
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a bicycle for \$95.
 1. How much did you spend?
 2. How much do you have left?
6. Please name as many animals as you can in one minute.
 1. 0-4 animals
 2. 5-9 animals
 3. 10-14 animals
 4. 15+ animals
7. What were the five objects I asked you to remember? 1 point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
 1. 97
 2. 44
 3. 432
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
 1. Hour markers ok.
 2. Time correct.
10. Please place an X in the triangle. Which of the above figures is largest?



11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

 1. What was the female's name?
 2. What work did she do?
 3. When did she go back to work?
 4. What state did she live in?

HIGH SCHOOL EDUCATION		NORMAL	LESS THAN HIGH SCHOOL EDUCATION	
27-30	21-26	1-20	21-26	1-19
1-20	21-26	1-19	21-26	1-19

NURSE'S SIGNATURE

DATE

TIME



pennsylvania

DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

November 2015

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Organization of the Program Offices

- ▶ MH – Office of Mental Health And Substance Abuse Services
 - Information is sent directly to the Central office
- ▶ ID – Office of Developmental Programs
 - Information initially is sent to the County of origin
 - County concurs or not with the AAA recommendation for LTSS
 - Then information is sent to Regional Offices for Letter of Determination
- ▶ ORC – Bureau of Participant Operations
 - Information is sent directly to the Central office

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▶ Important Websites

Order MA Forms:

<http://www.dhs.pa.gov/dhsassets/maforms/index.htm>

OBRA Information Website:

<http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/obratrainingInformation/index.htm>

Long Term Care Nursing Facility Providers website:

<http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm>

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▶ Questions?

- ▶ **Ruth Anne Barnard, B.S.N., R.N.**
MDS/OBRA Coordinator for Field Operations
 - rbarnard@pa.gov
 - 717-214-3736
- ▶ **Randy Nolen**
Division Director of Field Operations
 - rnolen@pa.gov
 - 717-772-2543
- ▶ **Program Offices** – see list found on the OBRA Website (see previous slide)
- ▶ **Field Operations Supervisors** – see list found on the OBRA Website (see previous slide)

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PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (PASRR-ID) LEVEL I FORM **(Revised 1/1/2016)**

This process applies to all nursing facility (NF) applicants, regardless of payer source. All current NF residents must have the appropriate form(s) on his/her record. The Preadmission Screening Resident Review Identification (PASRR-ID) Level I form and Level II evaluation, if necessary, must be completed **prior to** admission as per Federal PASRR Regulations 42 CFR § 483.106.

NOTE: FAILURE TO TIMELY COMPLETE THE PASRR PROCESS WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR § 483.122.

Section I – DEMOGRAPHICS

DATE THE FORM IS COMPLETED: _____ SOCIAL SECURITY NUMBER (9 digits): _____ – _____ – _____

APPLICANT/RESIDENT NAME - LAST, FIRST: _____

Communication

Does the applicant/resident require assistance with communication, such as an interpreter or other accommodation, to participate in or understand the PASRR evaluation process? NO YES

Section II – NEUROCOGNITIVE DISORDER (NCD)/DEMENCIA

For Neurocognitive Disorders (i.e. Alzheimer's disease, Traumatic Brain Injury, Huntington's, etc.), the primary clinical deficit is in cognitive function, and it represents a decline from a previously attained level of functioning. Neurocognitive disorders can affect memory, attention, learning, language, perception and social cognition. They interfere significantly with a person's everyday independence in Major Neurocognitive Disorder, but not so in Minor Neurocognitive Disorder.

1. Does the individual have a diagnosis of a Mild or Major NCD?

NO – Skip to Section III YES

2. Has the psychiatrist/physician indicated the level of NCD?

NO YES – indicate the level: Mild Major

3. Is there corroborative testing or other information available to verify the presence or progression of the NCD?

NO YES – indicate what testing or other information:

NCD/Dementia Work up Comprehensive Mental Status Exam

Other (Specify): _____

NOTE: A DIAGNOSIS OF MILD NCD WILL NOT AUTOMATICALLY EXCLUDE AN INDIVIDUAL FROM A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION.

Section III – SERIOUS MENTAL ILLNESS (MI)

Examples of a MI may include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Psychotic Disorder, Personality Disorder, Panic or Other Severe Anxiety Disorder, Somatic Symptom Disorder, Bipolar Disorder, Depressive Disorder, or another mental disorder that may lead to chronic disability.

III-A – RELATED QUESTIONS**1. Diagnosis**

Does the individual have a mental disorder or suspected mental disorder, other than Dementia, that may lead to a chronic disability?

NO YES – List Diagnosis(es): _____

2. Substance related disorder

a. Does the individual have a diagnosis of a substance related disorder, documented by a physician, within the last two years? NO YES

b. List the substance(s): _____

c. Is the need for NF placement associated with this diagnosis?

NO YES UNKNOWN

III-B – RECENT TREATMENTS/HISTORY: The treatment history for the mental disorder indicates that the individual has experienced **at least one** of the following:

NOTE: A “YES” TO ANY QUESTION IN SECTION III-B WILL REQUIRE THAT A LEVEL II ASSESSMENT/PROGRAM OFFICE EVALUATION BE COMPLETED.

1. Mental Health Services (check all that apply):

a. Treatment in an acute psychiatric hospital at least once in the past 2 years:

NO
 YES – Indicate name of hospital and date(s): _____

b. Treatment in a partial psychiatric program (Day Treatment Program) at least once in the past 2 years:

NO
 YES – Indicate name of program and date(s): _____

c. Any admission to a state hospital:

NO
 YES – Indicate name of hospital and date(s): _____

d. One stay in a Long-Term Structured Residence (LTSR) in the past 2 years:

A LTSR is a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR. Admission may occur voluntarily.

NO
 YES – Indicate name of LTSR and date(s): _____

e. Electroconvulsive Therapy (ECT) for Serious Mental Illness within the past 2 years:

NO YES – Date(s): _____

- f. Does the individual have a Mental Health Case Manager (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment (ACT))?
- NO YES

Indicate Name, Agency, and Telephone Number of Mental Health Case Manager:

2. Significant Life disruption due to Mental Illness

Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Serious Mental Illness within the past 2 years:

- a. Suicide attempt or ideation with a plan:

NO YES – List Date(s) and Explain: _____

- b. Legal/law intervention: NO YES – Explain: _____

- c. Loss of housing/Life change(s): NO YES – Explain: _____

- d. Other: NO YES – Explain: _____

If questions in III-A (#1) and III-B are all “NO”, skip to Section IV.

III-C – LEVEL OF IMPAIRMENT: The mental disorder has resulted in functional limitations in major life activities that are not appropriate for the individual’s developmental stage. An individual typically has **at least one** of the following characteristics on a continuing or intermittent basis.

- 1. Interpersonal functioning** - The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.
- 2. Concentration, persistence and pace** - The individual 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, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.
- 3. Adaptation to change** - The individual has serious difficulty 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.

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A “YES” IN III-A #1 AND/OR A “YES” IN ANY OF SECTION III-B.

Section IV– INTELLECTUAL DISABILITY (ID)

An individual is considered to have evidence of an intellectual disability if they have a diagnosis of ID and/or have received services from an ID agency in the past.

IV-A – Does the individual have current evidence of an ID or ID Diagnosis (mild, moderate, severe or profound)?

- NO YES – List diagnosis(es) or evidence: _____

IV-B – Did this condition occur **prior to age 18?** NO YES CANNOT DETERMINE

IV-C – Is there a history of a severe, chronic disability that is attributable to a condition other than mental illness that could result in impairment of functioning in general intellectual and adaptive behavior?

- NO – Skip to Section IV-D YES – Check below, all that applied **prior to age 18:**

- Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.
- Receptive and expressive language:** An individual is unable to effectively communicate with another person with out the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.
- Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
- Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
- Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.
- Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

IV-D – Has the individual ever been registered with their county for ID services and/or received services from an ID provider agency? NO YES UNKNOWN

If yes, indicate County name/agency _____

Name of Support Coordinator (if known) _____

IV-E – Was the individual referred for placement by an agency that serves individuals with ID/DD? NO YES

IV-F – Has the individual ever been a resident of a state facility including a state hospital, state operated ID center, or a state school?

- NO
- YES – Indicate the name of the facility and the date(s): _____
- UNKNOWN

NOTE: A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID DIAGNOSIS AND HAS A “YES” OR “CANNOT DETERMINE” IN IV-B AND A “YES” IN IV-C WITH AT LEAST ONE FUNCTIONAL LIMITATION, OR
- THE INDIVIDUAL HAS A “YES” IN IV-D, OR E, OR F.

Section V– OTHER RELATED CONDITIONS (ORC)

“ORC” include physical, sensory or neurological disability(ies). Examples of an ORC may include but are not limited to: Arthritis, Juvenile Rheumatoid Arthritis, Cerebral Palsy, Autism, Epilepsy, Seizure Disorder, Tourette’s Syndrome, Meningitis, Encephalitis, Hydrocephalus, Huntingdon’s Chorea, Multiple Sclerosis, Muscular Dystrophy, Polio, Spina Bifida, Anoxic Brain Damage, Blindness **and** Deafness, Paraplegia or Quadriplegia, head injuries (e.g. gunshot wound) or other injuries (e.g. spinal injury), so long as the injuries were sustained **prior to age of 22**.

V-A – Does the individual have an ORC diagnosis that manifested **prior to age 22** and is expected to continue indefinitely?

NO – Skip to Section VI

YES – Specify the ORC Diagnosis(es): _____

V-B – Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC:

Self-care: A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.

Receptive and expressive language: An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.

Learning: An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

Mobility: An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.

Self-direction: An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.

Capacity for independent living: An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

NOTE: IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B, A LEVEL II EVALUATION MUST BE COMPLETED BY THE AAA OR FIELD OPERATIONS AND FORWARDED TO THE PROGRAM OFFICE FOR FINAL DETERMINATION.

Section VI – HOME AND COMMUNITY SERVICES

Was the individual/family informed about Home and Community Based Services that are available?

NO

YES

Is the individual/family interested in the individual going back home, back to the prior living arrangement, or exploring other community living options?

NO

YES

Section VII – EXCEPTIONAL ADMISSION

Does the individual meet the criteria to have a Level II Assessment/Program Office Evaluation done by one of the Program Offices and is not dangerous to self and/or others meet the criteria for Exceptional Admission to a NF?

- NO – Skip to Section VIII YES

NOTE: IT IS THE RESPONSIBILITY OF THE NF TO VERIFY THAT ALL CRITERIA OF THE EXCEPTION ARE MET.

Mark the Exceptional Admission that applies:

VII-A – Individual Is an Exempted Hospital Discharge - Must meet all the following prior to NF Admission and have a known MI, ID, or ORC:

- Admission to NF directly from the Acute Hospital after receiving **inpatient medical care** (not observational stay/not inpatient psych or Behavioral Health Unit), **AND**
 - Requires NF services for the medical condition for which he/she received care in the hospital, (Specify the condition: _____), **AND**
 - The hospital physician shall document on the medical record (**which must be forwarded to the NF**) that the **individual will require less than 30 calendar days of NF service and the individual's symptoms or behaviors are stable.**
- NO YES – Physician's name: _____

VII-B – Individual Requires Respite Care - An individual with a serious MI, ID, or ORC, may be admitted for Respite Care for a period up to 14-days without further evaluation if he/she is certified by a referring or attending physician to require 24-hour nursing facility services and supervision.

- NO YES

VII-C – Individual Requires Emergency Placement - An individual with a serious MI, ID, or ORC, may be admitted for emergency placement for a period of up to 30-days without further evaluation if the Area Agency on Aging's (AAA) Protective Services has certified that such placement is needed.

- NO YES

VII-D – Individual is in a coma or functions at brain stem level - An individual with a serious MI, ID, ORC may be admitted without further evaluation if certified by the referring or attending physician to be in a coma or who functions at brain stem level. The condition must require intense 24-hour nursing facility services and supervision and is so extreme that the individual cannot focus upon, participate in, or benefit from specialized services.

- NO YES

CHANGE IN EXCEPTIONAL STATUS

IF THE INDIVIDUAL'S CONDITION CHANGES OR HE/SHE WILL BE IN RESIDENCE FOR MORE THAN THE ALLOTTED DAYS:

- **THE DEPARTMENT MUST BE NOTIFIED ON THE MA 408 WITHIN 48 HOURS FOR AN EVALUATION TO BE COMPLETED.**
- **THE LEVEL II EVALUATION MUST BE DONE ON OR BEFORE THE 40TH DAY FROM ADMISSION.**
- **DO NOT COMPLETE A NEW PASRR-ID (LEVEL I) FORM; JUST UPDATE THE CURRENT FORM WITH THE CHANGES AND INITIAL THE CHANGES. ENTER FULL SIGNATURE AND DATE BELOW TO INDICATE YOU MADE THE CHANGES.**

SIGNATURE: _____

DATE: _____

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

- Individual has negative screen for Serious Mental Illness, Intellectual Disability, or Other Related Condition; no further evaluation (Level II) is necessary.
- Individual has a positive screen for Serious Mental Illness, Intellectual Disability, and/or Other Related Condition; requires further evaluation (Level II).
- Individual has positive screen for further evaluation (Level II) but has a condition which meets the criteria for Exceptional Admission indicated in Section VII. NF must report Exceptional Admissions on the Target Resident Reporting Form (MA 408)

SECTION IX – INDIVIDUAL COMPLETING FORM

By entering my name below, I certify the information provided is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

PRINT NAME:	SIGNATURE:	DATE:
FACILITY:	TELEPHONE NUMBER:	

Affix Nursing Facility Field Operations stamp here:

SECTION III - MENTAL ILLNESS (MI)**III-A: DOCUMENTATION OF THE DIAGNOSIS**

1. Is the individual currently **assaultive and/or self-abusive** to the degree that he/she might endanger other residents of a nursing facility or might injure himself/herself without constant supervision by mental health personnel? Yes No
2. For **PASRR** purposes, the Major Mental Disorders include the following. Please check "No" or "Yes" to indicate if a **CURRENT Diagnosis** exists, enter year (or approximate year) of onset, and attach documentation. Examples of acceptable documentation include a current psychiatric assessment with diagnosis or other professionally accepted diagnostic practices by a qualified physician or psychiatrist, (see CFR §483.134).

DIAGNOSIS	CURRENT?	ONSET YEAR	DIAGNOSIS	CURRENT?	ONSET YEAR
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No		Panic or other severe anxiety disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizoaffective disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Somatic Symptom disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Delusional disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Personality disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bipolar disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Depressive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychotic disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Does a review of the applicant/resident's case history and/or medical record substantiate that the mental disorder is responsible for the functional limitations **in the last 3-6 months** in the following areas? (See PASRR-ID for definitions).

Interpersonal functioning	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concentration, persistence, and pace	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptation to change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe:	

4. Does a review of the applicant/resident's treatment history substantiate that the individual experienced **at least one** of the following **in the past two years**?

- a. Psychiatric treatment more intensive than outpatient care: No Yes

If yes, describe: _____

- b. An episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. (Supportive services include crisis intervention, intensive case management, and/or other social service agency intervention). No Yes

If yes, describe: _____

- c. Suicide ideation with a plan or attempt as reported by the individual, other, or verified by a psychiatric consult: No Yes

If yes, describe: _____

- d. Electroconvulsive Therapy - ECT (related to MI): No Yes

If yes, describe: _____

- e. Mental Health Intensive Case Manager (ICM): No Yes

If yes, describe: _____

III-B: SUPPORTING INFORMATION

1. The following information in the list below should be gathered to allow the Office of Mental Health to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

<input type="checkbox"/>	Complete medical history.
<input type="checkbox"/>	Review of all body systems.
<input type="checkbox"/>	Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; additional evaluations conducted by appropriate specialists.
<input type="checkbox"/>	A comprehensive drug history including current or immediate past use of medications that could mask symptom or mimic mental illness.
<input type="checkbox"/>	A psychosocial evaluation of the individual, including current living arrangements, medical, and support systems.
<input type="checkbox"/>	A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.
<input type="checkbox"/>	Functional assessment of the individual's ability to engage in activities of daily living. Include the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must also determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that nursing facility placement is required. The functional assessment must address the following areas: Self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, or both, self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.

2. Was a Saint Louis University Mental Status (SLUMS) exam performed as part of the Long-Term Services and Supports (LTSS) assessment?

No - Please complete (see last page). Yes - Score: _____

3. Estimated level of intelligence of the individual during this evaluation: High Average Low Unknown

III-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of a major mental disorder which meets the criteria of a "serious mental illness"?

No Yes

2. Does the individual currently receive mental health or substance use disorder services in the community?

No Yes - List what service(s): _____

3. Does the individual need specialized services in the nursing facility (See Section III-D)?

No Yes - List what service(s): _____

4. Does the individual need health rehabilitative services provided by the nursing facility for his/her mental illness?

No Yes - List what service(s): _____

III-D: DESIRE FOR SPECIALIZED SERVICES

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.

An individual may choose whether to participate in recommended specialized services.

2. Explain available Specialized Services using the definitions below.

Specialized services for an individual that meets the clinical criteria for a serious mental illness include appropriate community-based mental health services such as:

- **Partial Psychiatric Hospitalization** – Services provided in a non-residential treatment setting which includes psychiatric, psychological, social and vocational elements under medical supervision. Designed for patients with moderate to severe mental illness who require less than 24-hour continuous care but require more intensive and comprehensive services than offered in outpatient. Services are provided on a planned and regularly scheduled basis for a minimum of 3 hours, but less than 24 hours in any one day.
- **Psychiatric Outpatient Clinic** – Psychiatric, psychologist, social, educational and other related services provided under medical supervision in a non-residential setting designed for the evaluation and treatment of patients with mental or emotional disorders.
- **Mobile Mental Health Treatment (MMHT)** – A service array for adults and older adults with a mental illness who encounter barriers to, or have been unsuccessful in, attending an outpatient clinic. The purpose of MMHT is to provide therapeutic treatment to reduce the need for intensive levels of service including crisis intervention or inpatient hospitalization. MMHT provides treatment which includes evaluation; individual, group, or family therapy; and medication visits in an individual's residence or approved community site.
- **Crisis intervention services** – Immediate, crisis oriented services designed to ameliorate or resolve precipitating stress. Provided to persons who exhibit acute problems of disturbed thought, behavior, mood, or social relationships
- **Targeted mental health case management (intensive case management (ICM) and resource coordination)** – ICM services are provided to assist adults with serious and persistent mental illness to gain access to needed resources such as medical, social, educational, and other services. Activities undertaken by staff providing ICM services include: linking with services, monitoring of service delivery, gaining access to services, assessment and service planning, problem resolution, informal support network building, use of community resources. Resource Coordination is provided to persons who do not need the intensity and frequency of contacts provided through ICM, but who do need assistance in accessing, coordinating and monitoring of, resources and services.
- **Peer Support Services** – Person-centered and recovery focused services for adults with serious and persistent mental illness. The services are provided by individuals who have been served in the public behavioral health system. The service is designed to promote empowerment, self-determination, understanding and coping skills through mentoring and service coordination supports that allow people with severe and persistent mental illness to achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disabilities. Peer Specialists may provide site-based and/or mobile peer support services, off-site in the community.
- **Outpatient D&A services, including Methadone Maintenance Clinic** – An organized, non-residential, drug-free treatment service providing psychotherapy in which the client resides outside the facility. Services are usually provided in regularly scheduled treatment sessions for, at most, 5 contact hours per week.

If the individual meets the clinical criteria for a serious mental illness and is admitted to a nursing facility, some mental health or substance use disorder services may need to continue to be provided to the individual. The provision of specialized services should be assured by the nursing facility and Office of Mental Health.

Specialized services for individuals with a serious mental illness are authorized by the Office of Mental Health. The services shall be based on the individual's needs.

3. Explain further and answer questions as needed.

a. Do you understand what I have told you about specialized services? No - Try again Yes

b. If recommended, do you want to receive any specialized services? No Yes

SECTION IV: INTELLECTUAL DISABILITY (ID)**IV-A: DOCUMENTATION OF THE DIAGNOSIS**

1. Does the documentation indicate a diagnosis of an ID? No Yes
Documentation can include, but is not limited to, IQ and adaptive testing (preferably before the age of 18), psychological reports, psychiatric reports, school records, summaries from the county ID program or ID agency, and other relevant professional reports.
2. Does the documentation provide evidence of the following characteristics?
- a. Significantly sub-average intellectual functioning with an IQ of approximately 70 or below on standardized intelligence testing identified by a qualified psychologist? No Yes
- b. Onset prior to the age of 18 (consider all relevant and informed sources)? No Yes
- c. Deficits in adaptive behavior or functioning on formal assessment? No Yes
3. Indicate level of ID. Mild (50-69) Moderate (35-49) Severe (25-34) Profound (<25) Unspecified Not known (scores not available) None

IV-B: SUPPORTING INFORMATION

1. Does the individual have a Supports Coordinator? No Yes - List name of Supports Coordinator and Agency: _____
2. The following information in the list below should be gathered to allow the Office of Developmental Programs to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment.

<input type="checkbox"/>	Self-monitoring of health status.
<input type="checkbox"/>	Self-administering and scheduling of medical treatments.
<input type="checkbox"/>	Self-monitoring of nutritional status.
<input type="checkbox"/>	Self-help development such as toileting, dressing, grooming and eating.
<input type="checkbox"/>	Sensorimotor skills such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination and the extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity.
<input type="checkbox"/>	Communication skills including expressive and receptive language and the extent to which a communication system, amplification device and/or program of amplification could improve the individual's functional capacity.
<input type="checkbox"/>	Social skills including relationships, interpersonal, and recreation-leisure skills.
<input type="checkbox"/>	Academic and educational skills including functional learning skills.
<input type="checkbox"/>	Independent living skills involving meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to neighborhood, town, city, etc.), orientation skills for individuals with visual impairments, laundry, housekeeping, shopping, bed making, and care of clothing.
<input type="checkbox"/>	Vocational skills.
<input type="checkbox"/>	Affective skills including interests, ability to express emotion, making judgements, and independent decision-making.
<input type="checkbox"/>	Presence of maladaptive or inappropriate behaviors including their description, frequency, and intensity.

IV-C: RECOMMENDATION TO THE PROGRAM OFFICE

1. Does the individual have a diagnosis of an intellectual disability which meets the criteria of an "intellectual disability"?
 No Yes
2. Does the individual currently receive intellectual disability services in the community?
 No Yes - List what service(s): _____
3. Does the individual need specialized services in the nursing facility (See Section IV-D)?
 No Yes - List what service(s): _____
4. Does the individual need health rehabilitative services provided by the nursing facility for his/her intellectual disability?
 No Yes - List what service(s): _____

IV-D: DESIRE FOR SPECIALIZED SERVICES

1. Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:
Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.
An individual may choose whether to participate in recommended specialized services.
2. Explain available Specialized Services using the definitions below.
Specialized services for an individual that meets the clinical criteria for an intellectual disability include appropriate community-based intellectual/developmental disability services which result in:

- The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of current optimal functional status

Specialized services are authorized for applicants/residents with an "intellectual disability" by the Office of Developmental Programs or its agent. For individuals with ID, community specialized services primarily include:

- **Assistive Technology** – An item, piece of equipment, or product system that is used to increase, maintain, or improve an individual's functioning. Assistive technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device.
- **Behavioral Support** – This service includes functional assessment; development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, parents and caregivers. Services must be required to meet the current needs of the individual.
- **Companion Services** – Services are provided to individuals for the limited purposes of providing supervision and assistance focused on the health and safety of the adult individual with an intellectual disability. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety.
- **Home and Community Habilitation Services** – This is a direct service (face-to-face) provided to assist individuals in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. Through the provision of this service individuals will acquire, maintain, or improve skills necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life.
- **Licensed Day Habilitation** – This is a direct service (face-to-face) that consists of supervision, training, and supports in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development. The service also includes transportation that is an integral component of the service; for example, transportation to a community activity. The Licensed Day Habilitation provider is not, however, responsible for transportation to and from an individual's home.
- **Supports Coordination** – This is a service that involves the primary functions of locating, coordinating, and monitoring needed services and supports. Locating services and supports consists of assistance to the individual and his or her family in linking, arranging for, and obtaining services specified in an ISP, including needed medical, social, habilitation, education, or other needed community services.
- **Support (Medical Environment)** – This service may be used to provide support in general hospital or nursing home settings, when there is a documented need and the County Program Administrator or Director approves the support in a medical facility. The service is intended to supply the additional support that the hospital or nursing home is unable to provide due to the individual's unique behavioral or physical needs.
- **Transportation** – Transportation is a direct service that enables individuals to access services and activities specified in their approved Individual Support Plan.

3. Explain further and answer questions as needed.

- a. Do you understand what I have told you about specialized services? No - Try again Yes
- b. If recommended, do you want to receive any specialized services? No Yes

SECTION V: OTHER RELATED CONDITIONS (ORC)

"Other Related Conditions" include physical, sensory or neurological disabilities which manifested before age 22 are likely to continue indefinitely and result in substantial functional limitations in **three or more** of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living. It is important to note that a person can have an "Other Related Condition" **regardless of whether the ORC impairs their intellectual abilities.**

V-A: DOCUMENTATION OF THE DIAGNOSIS

1. Is there documentation to substantiate that the individual meets the following criteria for an ORC? No Yes

Documentation is to include, but not limited to, a psychological evaluation, physician's note which indicates that the diagnosis and three functional limitations **occurred prior to age 22**, or a statement to this effect from the individual or family.

2. Does the documentation provide evidence of the following characteristics?

- a. Has a physical, sensory, or neurological disability which is considered an "Other Related Condition".

No Yes - Specify condition/diagnosis(es): _____

- b. The condition manifested before age 22? No Yes

- c. The condition is expected to continue indefinitely. No Yes

V-B: SUPPORTING DOCUMENTATION

1. Indicate areas where the individual has a **SUBSTANTIAL FUNCTIONAL LIMITATION** which has manifested prior to age 22.

- Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.
- Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.
- Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
- Mobility:** An individual that is impaired in his/her use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
- Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.
- Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

2. The following information in the list below should be gathered to allow Office of Long-Term Living to evaluate functional level and needs of the individual. Check to indicate what supporting documentation has been included and attach it to the Level II assessment:

<input type="checkbox"/>	Sensorimotor development (ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination)
<input type="checkbox"/>	Speech and language development (includes expressive and receptive language, disorders, i.e. Communication disorders).
<input type="checkbox"/>	Social development (includes interpersonal skills, recreation-leisure skills, and relationships with others).
<input type="checkbox"/>	Academic/educational development (grade level of school completed and/or functional learning skills).
<input type="checkbox"/>	Independent living development (includes meal preparation, budgeting and personal finances, survival skill, mobility skills [orientation to the neighborhood, town, etc.], laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills for individuals with visual impairments).
<input type="checkbox"/>	Vocational development (include present vocational skills).
<input type="checkbox"/>	Affective development (such as interests and skills involved with expressing emotions, making judgments, and making independent decisions).
<input type="checkbox"/>	IQ and adaptive function testing.
<input type="checkbox"/>	Psychological evaluation.
<input type="checkbox"/>	Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systemic observation (include frequency and intensity of behavior).
<input type="checkbox"/>	Extent to which prosthetic, orthotic-corrective or mechanical-supportive devices can improve the individual's functional capacity.
<input type="checkbox"/>	Extent to which non-oral communication systems can improve the individual's functional capacity.

V-C: RECOMMENDATION TO THE PROGRAM OFFICE

- Does the individual have a diagnosis of a related condition which meets the criteria of an "other related condition"?
 No Yes
- Does the individual currently receive services in the community for the other related condition?
 No Yes - List what service(s): _____
- Does the individual need specialized services in the nursing facility (See Section V-D)?
 No Yes - List what service(s): _____
- Does the individual need health rehabilitative services provided by the nursing facility for his/her other related condition?
 No Yes - List what service(s): _____

V-D: DESIRE FOR SPECIALIZED SERVICES

- Explain to the individual, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:
 Federal regulations state that a person with a serious mental illness, intellectual disability, or an "Other Related Condition" must receive services and supports, related to their mental illness, intellectual disability or other related condition that are necessary to assist him/her in attaining the highest practicable physical, mental and psychosocial well-being. These specialized services are individualized and exceed the services and supports normally provided in a nursing facility.
 An individual may choose whether to participate in recommended specialized services.
- Explain available Specialized Services using the definitions below.
 Specialized services for an individual that meets the clinical criteria for a related condition include appropriate community-based services which result in:
 - The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
 - The prevention or deceleration of regression or loss of current optimal functional status.
 Specialized services are authorized for applicants/residents with an "Other Related Condition" by the Office of Long-Term Living or its agent. For individuals with ORC, community specialized services primarily include:
 - Service Coordination/Advocacy Services** – Development and maintenance of a specialized service plan, facilitating and monitoring the integration of specialized services with the provision of nursing facility and specialized rehabilitative services, and assisting or advocating for residents on issues pertaining to residing in nursing facilities.
 - Peer Counseling/Support Groups** – Linking residents to "role models" or "mentors" who are persons with physical disabilities and who reside in community settings.
 - Training** – In areas such as self-empowerment/self-advocacy, household management in community settings, community mobility, decision making, laws relating to disability, leadership, human sexuality, time management, self-defense/victim assistance, interpersonal relationships, certain academic/development activities, and certain vocational/development activities.
 - Community Integration Activities** – Exposing residents to a wide variety of unstructured community experiences which they would encounter in the event that they must or choose to leave the nursing facilities or engage in activities away from the nursing facilities.
 - Equipment/Assessments** – Purchase of equipment and related assessment for residents who plan, within the next two years, to relocate to community settings.
 - Transportation** – Facilitation of travel necessary to participate in the above specialized services.
- Explain further and answer questions as needed.
 - Do you understand what I have told you about specialized services? No - Try again Yes
 - If recommended, do you want to receive any specialized services? No Yes

SECTION VI: SIGNATURES

Obtain signature of either the individual or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services.

INDIVIDUAL'S SIGNATURE:	DATE:
WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

SECTION VII: NOTICE OF REFERRAL FOR FINAL DETERMINATION

You must now explain to the individual, legal representative, family member and/or significant other (if the individual agrees to family participation) that persons with a serious Mental Illness, Intellectual Disability, or an Other Related Condition may not always need nursing facility services, and should be in places more suited to their needs. Explain that this assessment is a way for making sure the individual is receiving the appropriate services to meet his/her needs and receiving the services in the setting that best fits his/her needs.

For Persons with Mental Illness: You have (your relative/friend/responsible party has) been given a diagnosis of a Major Mental Disorder. We must forward this form and the related information to the DHS Office of Mental Health to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

For Persons with Intellectual Disability: You have (your relative/friend/responsible party has) been given a diagnosis of an Intellectual Disability. We must forward this form and the related information to the DHS Office of Developmental Programs to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

For Persons with an Other Related Condition: You have (your relative/friend/responsible party has) been given a diagnosis of an Other Related Condition. We must forward this form and the related information to the DHS Office of Long-Term Living to obtain a final determination decision regarding your need for nursing facility care and specialized services. You will receive a letter conveying the Department's decision.

Questions about the preparation of this form should be referred to the person completing this form.

PRINT NAME:	TITLE:	DATE:
SIGNATURE:	DATE:	TELEPHONE:

SECTION VIII: DOCUMENTATION TO INCLUDE FOR PROGRAM OFFICE REVIEW

Send the below documentation to the Program Office in the order it is listed below:

MH		ID		ORC	
<input type="checkbox"/>	Program Office Transmittal Sheet – should be the 1st sheet in packet.	<input type="checkbox"/>	Program Office Transmittal Sheet – should be the 1st sheet in packet.	<input type="checkbox"/>	Program Office Transmittal Sheet – should be the 1st sheet in packet.
<input type="checkbox"/>	MA 51 (NF Field Operations may not have this)	<input type="checkbox"/>	MA 51 (NF Field Operations may not have this)	<input type="checkbox"/>	MA 51 (NF Field Operations may not have this)
<input type="checkbox"/>	Notification Sheet – <u>Reminder</u> – Include the FAX number for the hospital/NF.	<input type="checkbox"/>	Notification Sheet – <u>Reminder</u> – Include the FAX number for the hospital/NF.	<input type="checkbox"/>	Notification Sheet – <u>Reminder</u> – Include the FAX number for the hospital/NF.
<input type="checkbox"/>	PASRR-ID and PASRR-EV – <u>Reminder</u> – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.	<input type="checkbox"/>	PASRR-ID and PASRR-EV – <u>Reminder</u> – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.	<input type="checkbox"/>	PASRR-ID and PASRR-EV – <u>Reminder</u> – for the Notification (page 11, PASRR-EV) list home address, NOT hospital unless client is homeless.
<input type="checkbox"/>	Comprehensive History & Physical Exam	<input type="checkbox"/>	Long-Term Services and Supports (LTSS) assessment	<input type="checkbox"/>	Long-Term Services and Supports (LTSS) assessment
<input type="checkbox"/>	Comprehensive Medication History (most current and immediate past)	<input type="checkbox"/>	Admission Report – To include History, Diagnoses, Physical Exam	<input type="checkbox"/>	Comprehensive History & Physical Exam
<input type="checkbox"/>	Comprehensive Psychosocial Evaluation	<input type="checkbox"/>	Nurses Notes – only the most recent (1 week prior to NF Admission)	<input type="checkbox"/>	Nurses notes including what Specialized Service would be helpful
<input type="checkbox"/>	Comprehensive Psychiatric Evaluation	<input type="checkbox"/>	Current Medication record	<input type="checkbox"/>	Course of Stay – any important issues during stay
<input type="checkbox"/>	Long-Term Services and Supports (LTSS) assessment	<input type="checkbox"/>	Course of Stay – any important issues during stay	<input type="checkbox"/>	Psychological evaluation
<input type="checkbox"/>	Last 3 days of the most current Physician's orders and progress notes at time of review, (if applicable).	<input type="checkbox"/>	Psychological evaluation – include school records with an IQ score before age of 22 if possible.	<input type="checkbox"/>	PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF)
<input type="checkbox"/>	Last 3 days of the most current nurses' notes, (if applicable).	<input type="checkbox"/>	PT/OT/ST/SS/Physician Notes – only the most recent note (dates 1 week before anticipate admission to NF)	<input type="checkbox"/>	D/C Plans
<input type="checkbox"/>	Current medication record	<input type="checkbox"/>	D/C Plans	<input type="checkbox"/>	MDS – if individual is already in the NF
<input type="checkbox"/>	CT/Neurology Consults if applicable	<input type="checkbox"/>	MDS – if individual is already in the NF		
<input type="checkbox"/>	MDS – if individual is already in the NF				

SECTION IX: NOTIFICATION

Assessor should:

- Complete the notification information below for all assessments,
- Make a copy of the assessment packet for their records; and then,
- Forward the assessment packet to the appropriate program office or its designee for a final determination.

COPIES OF THE EVALUATION REPORT SHOULD BE SENT TO EACH OF THE FOLLOWING:**1. THE INDIVIDUAL BEING ASSESSED**

NAME:	SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER:
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2. THE LEGAL REPRESENTATIVE - A PERSON DESIGNATED BY STATE LAW TO REPRESENT THE INDIVIDUAL. THIS INCLUDES A COURT-APPOINTED GUARDIAN OR AN INDIVIDUAL HAVING POWER OF ATTORNEY.

NAME:	TELEPHONE NUMBER:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:

3. ADMITTING/RETAINING NURSING FACILITY (NF) (if known)

NAME:	TELEPHONE NUMBER:	
ADDRESS:	FAX NUMBER:	
CITY:	STATE:	ZIP CODE:
ATTENTION:		

4. INDIVIDUAL'S ATTENDING PHYSICIAN

NAME:	TELEPHONE NUMBER:	
ADDRESS:	FAX NUMBER:	
CITY:	STATE:	ZIP CODE:

5. LIST FULL NAME OF DISCHARGING HOSPITAL (if individual is seeking nursing facility admission directly from a hospital)

NAME:	TELEPHONE NUMBER:	
ADDRESS:	FAX NUMBER:	
CITY:	STATE:	ZIP CODE:
CONTACT PERSON AND TELEPHONE NUMBER:		

*** Do you have a fax number for the Hospital/Nursing Facility on the Notification Sheet (this page)? No Yes

SLUMS EXAMINATION

Instructions can be found at: http://www.elderguru.com/downloads/SLUMS_instructions.pdf

NAME:	AGE:
IS THE PATIENT ALERT?	LEVEL OF EDUCATION:

___ / 1
___ / 1
___ / 1
___ / 3
___ / 3
___ / 5
___ / 2
___ / 4
___ / 2
___ / 8
TOTAL SCORE:

- 1** 1. What day of the week is it?
- 1** 2. What is the year?
- 1** 3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.

Apple
Pen
Tie
House
Car
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
 - 1** How much did you spend?
 - 2** How much do you have left?
6. Please name as many animals as you can in one minute.

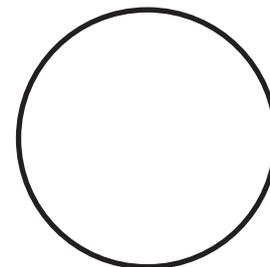
0 0-4 animals
1 5-9 animals
2 10-14 animals
3 15+ animals
7. What were the five objects I asked you to remember? 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.

- 0** 87
1 648
1 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

- 2** Hour markers ok.
2 Time correct.



- 1** 10. Please place an X in the triangle
- 1** Which of the above figures is largest?



11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

- 2** What was the female's name?
2 When did she go back to work?

2 What work did she do?
2 What state did she live in?

SCORING	
HIGH SCHOOL EDUCATION	LESS THAN HIGH SCHOOL EDUCATION
27 - 30	NORMAL
21 - 26	MILD NEUROCOGNITIVE DISORDER
1 - 20	DEMENTIA
	25 - 30 20 - 24 1 - 19

CLINICIAN'S SIGNATURE _____

DATE _____

TIME _____

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini- Mental Status Examination (MMSE) - A pilot study. Am J Geriatr Psych 14:900-10, 2006.