**PASRR LEVEL II PSYCHIATRIC EVALUATION**

**NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES**

**PLEASE PRINT AND DO NOT USE ABBREVIATIONS**

**CLIENT’S NAME**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

LAST FIRST M.I.

**INSTRUCTIONS:**

1. **The Psychiatrist or Psychiatric Advanced Practice Nurse conducting the Evaluation shall not be directly involved in treating the client nor otherwise responsible for or involved in the person’s care.**
2. **All Sections, except for Section 1, must be completed by the Psychiatrist or Psychiatric Advanced Practice Nurse conducting the Evaluation. Every Section and all questions must be answered.**
3. **The Examiner may record an N/A to indicate Not Applicable or an N/K to indicate Not Known.**

1. **Note that a completed LTC-26 Level I Screen must be submitted with this form. DMHAS will terminate the review if either form is incomplete or not provided.**

**SECTION 1 Can be completed by person referring client for PASRR Level II Evaluation**

**REFERRING FACILITY INFO**: \_\_\_\_Psych. Hospital (involuntary unit) \_\_\_\_Psych. Hospital (voluntary unit) \_\_\_\_General hospital

\_\_\_Home \_\_\_Nursing Facility /Assisted Living \_\_\_ Other Residential Setting (RHCF, Group Home, Etc.) Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF FACILITY (Specify Facility Name/Complete Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring or Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT’S INFO:** DATE OF BIRTH: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ GENDER:  Male  Female \_\_\_\_\_\_\_\_ MARITIAL STATUS

RACE/ETHNICITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EDUCATION (none, Elem. School, High School, College Graduate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER (9 DIGITS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFO:**  Medicare  MEDICAID  Applied For Medicaid  Private Insurance  Self-Pay

Other (Identify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAID NUMBER (12 DIGITS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADMISSION INFO:** FACILITY ADMISSION DATE: \_\_\_\_\_\_/\_\_\_\_\_\_ /\_\_\_\_\_\_\_

RESIDENCE PRIOR TO ADMISSION:  Private Home/Apt.  Nursing Facility/Assisted Living  Residential community setting

Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY/Guardian: Does the client have family members and/or a guardian currently involved in his/her care?  NO  YES

If YES, specify Names, Relationships and describe family’s Level of involvement in the client’s care) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LEVEL II PYCHIATRIC EVAL. NEEDED** **FOR**:  Initial Nursing Facility Referral  Rehab.  Post 30 Day Rehab

Residential Review/Change in status Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**1 of 6 DMHAS 3/2/15**

**Client’s Name (Last, First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 2 PSYCHIATRIC EVALUATION (Must be completed by psychiatrist / psychiatric APN conducting Evaluation)**

**SOURCES OF INFORMATION FOR** **EVALUATION** (Check all that apply):  INTERVIEW  RECORD REVIEW  STAFF

**DESCRIBE COLLATEROL SOURCES (Family, Guardian, Treatment provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DOES THE INDIVIDUAL SPEAK ENGLISH?**  NO  YES If the CLIENT SPEAKS OTHER THAN ENGLISH, DESCRIBE HOW

EVAL. WAS CONDUCTED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DESCRIBE CLIENT’S PRESENTING BEHAVIORAL HEALTH PROBLEMS AND REASON FOR ANY RECENT HOSPITALIZATIONS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SUMMARIZE RELEVANT MENTAL HEALTH AND SUBSTANCE USE HISTORY** (including current/ recent psychiatric hospitalizations and the pre-admission behavioral health care received in last 6-12 months, if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PSYCHOSOCIAL/ HISTORY** (Describe pertinent life events and changes in the past 12-24 months, such as living situation, family and social supports, including supports needed to maintain community living):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMPLOYMENT AND VOCATIONAL HISTORY:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLIENT’S POSITIVE TRAITS AND STRENGTHS** (Describe the client’s experiences, abilities and interests as assets or resources in treatment planning) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client’s Name (Last, First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT PSYCHIATRIC MEDICATIONS** (Include indications, recent medication changes, and all PRNS needed in last 30 days)

***MEDICATION DOSAGE INDICATIONS***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PSYCHIATRIC OR COGNITIVE TESTING** (i.e., MINI MENTAL STATUS EXAM) PERFORMED:  NO  YES

IF YES, DESCRIBE TEST(S), DATE(S) COMPLETED, AND FINDINGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MENTAL STATUS EXAMINATION**

APPEARANCE AND ATTIRE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ATTITUDE AND BEHAVIORS: (Describe disruptive, assaultive, self-injurious, inappropriate sexual behavior, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SPEECH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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AFFECT AND MOOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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THOUGHT CONTENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PRESENCE OF SUICIDAL OR HOMICIDAL IDEATION/ BEHAVIOR (Give specifics, such as dates and details of any attempts, and current ideation):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERCEPTIONS, HALLUCINATIONS/DELUSIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SENSORIUM, MEMORY, AND ORIENTATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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INSIGHT AND JUDGEMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DIAGNOSES: MENTAL HEALTH, SUBSTANCE USE DISORDERS, DEVELOPMENTAL DISORDERS** (Provide ICD-9 OR DSM-5 CODES):

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**3 of 6 DMHAS 3/2/15**

**CLIENT’S NAME (First, Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 3 MEDICAL AND** **FUNCTIONING ASSESSMENT** (NOTE: Examiner may provide copy of client’s medical reports and progress notes to **supplement** parts of this section)

**CURRENT MEDICAL DIAGNOSES AND APPROX. YEARS OF EACH ILLNESS** (IF KNOWN):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNIFICANT RESULTS OF LABORATORY TESTS/SPECIAL NEUROLOGICAL DIAGNOSTIC STUDIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIST ALL CURRENT MEDICATIONS AND THEIR DOSAGES** (exclude psychotropic medications already listed above):

***NAME OF MEDICATIONS DOSAGE INDICATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RECENT MEDICAL/SURGICAL TREATMENT AND REHABILITATION SERVICES PROVIDED**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NEED FOR SPECIALIZED MEDICAL, NURSING AND/OR REHAB SERVICES:**  YES, SEE BELOW  NONE

BOWEL AND BLADDER CARE TRACH CARE CATH. CARE  TUBE FEEDING COLOSTOMY/ILEOSTOMY

SEIZURE PREC.  MODIFIED DIET DIABETIC MONITORING BLOOD TRANSFUSION  OXYGEN PROSTHETICS CARE

DECUBITI/WOUND CARE IV MEDS/FLUIDS  INHALATION THERAPY  INTAKE/OUTPUT

REHAB THERAPY (PT, OT)  SPEECH/LANGUAGE THERAPY PHARMACIST CONSULT.  LAB TEST MONITORING

INDICATE IF PRESENT:  ABNORMAL MOVEMENTS DYSPHAGIA VISION LOSS HEARING DEFICIT SPEECH PROBLEMS

DESCRIBE CLIENT’S GAIT AND NEED FOR WHEEL CHAIR/WALKER OR GERICHAIR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE OTHER CORRECTIVE AND ADAPTIVE EQUIPMENT OR INTERVENTIONS THAT WILL BE PROVIDED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLIENT’S SELF-MANAGEMENT OF MEDICATIONS OR OTHER NECESSARY MEDICAL TREATMENT**:

Unable to Perform/Refuses Needs supervision  Only needs occasional prompting or reminders Independent

DESCRIBE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT’S CAPABILITY TO PERFORM ADLS/IADLs** (Use the rating scale below to describe current functioning in each area):

1 – Unable to Perform at all 2 – Often needs assistance 3 – Needs occasional prompting/reminders 4 – Independent

|  |  |  |  |
| --- | --- | --- | --- |
| Activities of Daily Living | Rating | Instrumental Activities of Daily Living | Rating |
| DRESSING |  | HOUSEKEEPING |  |
| BATHING |  | MANAGING MONEY |  |
| TOILETING |  | SHOPPING |  |
| GROOMING |  | USING TRANSPORTATION |  |
| TRANSFERRING FROM BED/CHAIR |  | MEAL PREPARATION |  |
| EATING |  | USING TELEPHONE |  |

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**CLIENT’S NAME (Last, First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 4 SUMMARY OF PLACEMENT AND TREATMENT RECOMMENDATIONS**

**MOST APPROPRIATE/ LEAST RESTRICTIVE SETTING TO MANAGE THE INDIVIDUAL’S CURRENT MEDICAL AND BEHAVIORAL HEALTH CARE NEEDS:**

NURSING FACILITY  HOME OR INDEPENDENT LIVING

COMMUNITY SETTING (e.g., ASSISTED LIVING, SUPPORTED HOUSING, SUPERVISED GROUP HOME, RESIDENTIAL HEALTH CARE

FACILITY) SPECIFY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUMMARIZE THE RATIONALE FOR THE ABOVE RECOMMENDATION**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WOULD THIS INDIVIDUAL POSSIBLY BE APPROPRIATE FOR PLACEMENT IN AN ALTERNATIVE COMMUNITY SETTING (OTHER THAN A NURSING FACILITY)?**

NO  YES, DESCRIBE/EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IF THE INDIVIDUAL REQUIRES NURSING FACILITY PLACEMENT AT THIS TIME, WHAT BEHAVIORAL TREATMENT OR SUPPORT SERVICES ARE NEEDED TO MAINTAIN OR IMPROVE THE INDIVIDUAL’S RECOVERY?**

Person-centered Treatment/Service Plan  Behavioral management program

Psychotropic Medication Monitoring  Family Counseling

Structured socialization activities  Substance Use Counseling or treatment

Therapeutic group interventions  Attendance in Self Help Center or other recovery activities outside nursing facility

Supportive counseling  S-COPE Consultation

Individual therapy

☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE/ EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLIENT’S NAME (Last, First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 5. CERTIFICATION OF NEED FOR SPECIALIZED SERVICES FOR SERIOUS MENTAL ILLNESS**

|  |
| --- |
| **THIS SECTION MUST BE COMPLETED IN FULL**  **I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Name), having no direct treatment relationship with the client, do hereby certify that I have personally assessed this client, spoken with current caregivers, and have reviewed the available clinical records. I also certify that it is my professional opinion that the client:**  **NO  YES HAS AN ACTIVE PSYCHOSIS**  **NO  YES HAS A SERIOUS MENTAL ILLNESS**  **NO  YES HAS MENTAL HEALTH TREATMENT NEEDS THAT CAN BE MET IN A NURSING FACILITY**  **NO  YES NEEDS SPECIALIZED SERVICES (e.g., inpatient psychiatric hospitalization)** |

**Signature below also certifies the following: For current NF residents who no longer require NF services but require mental health services the individual or legally responsible person (legally responsible guardian) has been offered the choice of receiving services in an appropriate alternative setting. This person has been informed of all alternatives offered under the NJ State Medicaid Plan for the resident. This person has been informed of all alternatives covered under the NJ State Medicaid Plan for the resident. Furthermore, this person has been told of 1) the effect on eligibility for Medicaid services under the State Plan, 2) the effects on readmission to the facility, and 3) has been referred to the DMHAS for assistance in finding mental health (behavioral health) services and/or specialized services.**

**SIGNATURE OF EXAMINER DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**NAME / TITLE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPECIALTY AND AFFILIATION:**

**FAX THIS EVALUATION TO THE DMHAS PASRR COORDINATOR AT (609) 341-2307**

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