

Instructions for the Completion of the Pre-Admission Screening and Resident Review (PASRR) Level I Screen

Section I – Demographics and Clinical Assessment Status

- **Name of Applicant:** Provide legal name, including last name and first name.
- **Social Security Number:** Individuals full social security number.
- **Current Location Address:** Where the individual is when completing the PASRR Level I Screen.
- **County of Current Location:** County where individual is located when filling out the PASRR Level I Screen.
- **Date of Birth:** Self-explanatory.
- **Current Location Setting:** Where the individual is when the PASRR Level I Screen is filled out (hospital, community, home etc.). Check one.
- **Clinical Assessment/Authorization Status:** Check applicable clinical assessment status.

Section II - Mental Illness Screen

1. **Does the individual have a diagnosis or evidence of a major mental illness?**
Check box for “Yes” or “No”. If yes, specify diagnosis and include any current substance-related disorder diagnosis.
2. **Has the individual had a significant impairment in functioning related to a suspected or known diagnosis of mental illness?** (Review subcategories 2a. – 2c., check those applicable)
Check box for “Yes” if any of the three subcategories are checked.
3. **Within the last two years has the individual...** (Review subcategories 3a. and 3b., check those applicable)
Check box for “Yes” if either/both of the two subcategories are checked. If yes is checked, explain and provide dates.

Section II - Screening Outcome for MI Screen Questions 1 through 3

- Complete this section referring to Section II questions 1 through 3. Check one outcome only.
 - Check box for a **Positive Screen MI** if all questions 1 through 3 are answered “Yes”.
 - Check box for a **Negative Screen MI** with any combination of “NO” for questions 1 through 3.

Section III - Intellectual Disability/Developmental Disability/Related Conditions Screen (ID/DD/RC)

4. **The definition of an intellectual disability (ID) is a significantly decreased level of intellectual functioning measured by a standardized, reliable test of intellectual functioning and encompasses a wide range of conditions and levels of impairment with concurrent impairments in adaptive functioning. The ID must have manifested prior to the age of 18.**
Check box for “Yes” or “No” to indicate if the individual has a current diagnosis or a history of intellectual disability with an onset prior to age 18. If “Yes”, provide explanation.
5. **The definition of a related condition (RC) is severe, chronic developmental disability, but not forms of intellectual disabilities, that produce similar functional impairments and require similar treatment or services. RCs must have manifested prior to the age of 22.**
Check box for “Yes” or “No” to indicate if the individual has a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction, learning, understanding/use of language, capacity for independent

**Department of Human Services
Division of Aging Services
Office of Community Choice Options**

living (e.g., autism, seizure disorder, cerebral palsy, spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf or closed head injury). If “Yes”, provide explanation.

6. Does the individual receive services or previously received services paid through the Division of Developmental Disabilities (DDD)?

Check box for “Yes” or “No” to indicate if the individual is currently or known to have received services through DDD.

7. The question is seeking to know if a referral was made from an agency that serves individuals with ID/DD/RC.

Check box for “Yes” or “No”, and if “Yes”, identify from what agency the referral was made.

Section III - Screening Outcome for ID/DD/RC Screen Questions 4 through 7

- **Complete this section referring to Section III questions 4 through 7.** Check one outcome only.
 - Check the box for a **Positive Screen ID/DD/RC** if ANY responses to questions 4 through 7 are “Yes”.
 - Check the box for a **Negative Screen ID/DD/RC** if ALL responses to questions 4 through 7 are “No”.

Section IV - PASRR Level I Screening Outcomes and Referral, if Indicated

- **Step 1: Determine Screening Outcome for Sections II and III.** Check one box for each section. Indicate “Positive” or “Negative” Screening Outcome for MI and ID/DD/RC as applicable.
- **Step 2: Determine Final Level 1 Screening Outcome.** Check only one box to identify screening outcome for this step and follow the directions if the screen is positive, to forward the referral to the applicable agency(ies) - DMHAS and/or DDD.

ALL POSITIVE PASRR LEVEL I SCREENS ARE TO BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. NF ADMISSION IS CONTINGENT UPON RECEIPT OF LEVEL II DETERMINATION OUTCOME.

Section V- Mental Illness Primary Dementia Exclusion for Positive Level I Screens for Mental Illness

The Mental Illness Primary Dementia Exclusion applies to individuals who have a confirmed diagnosis of dementia and that the dementia diagnosis is documented as primary or more progressed than a co-occurring mental illness.

- Check box for “**Primary Dementia Exclusion requested**”, if applicable.
 - If checked, a referral to the DMHAS for the PASRR Level II evaluation and determination is required prior to NF admission.
 - Fax the completed Positive Level I Screen, the Notice of Referral for PASRR Level II Evaluation (LTC-29), and the completed PASRR Level II Psychiatric Evaluation form to the DMHAS as per instructions on form. The DMHAS will issue the PASRR Level II determination.

Section VI - Categorical Determinations for Level I Positive Screens

A Categorical Determination omits the need for a full Level II Evaluation in certain circumstances that are time-limited or where the need for NF is clear.

- Check box for the requested type of “**Categorical Determination**”, if applicable.
 - If requesting a categorical determination for the Positive PASRR Level I Screen, you must check the box beside the appropriate condition/circumstance, and contact DDD and/or DMHAS as applicable.
 - DMHAS has a categorical determination form that will need to be completed for a categorical determination. A link to this form is in this section on the PASRR Level I Screen.

**Department of Human Services
Division of Aging Services
Office of Community Choice Options**

Section VII - 30-Day Exempted Hospital Discharge for Level I Positive Screens

Hospital Exemption applies only to **initial NF admission**; it does not apply to resident review for change in condition, NF readmission or inter-facility transfer.

- The individual must meet the following criteria to be considered for a PASRR Level I 30 Day Exempted Hospital Discharge:
 - The individual has received inpatient non psychiatric care at an acute care hospital; **and**
 - The individual requires skilled nursing services for the condition which he or she received care in the hospital; **and**
 - The hospital physician certifies before the NF admission that the individual is likely to require less than 30 days skilled nursing facility care.
- This section **must be signed by the hospital physician** that is certifying the 30-Day Exempted Hospital Discharge, or it will not be processed.
- The PASRR Level I form is then faxed to DMHAS and/or DDD **and** OCCO prior to the individual being discharged to the NF.

Section VIII - PASRR Level I Screening Outcome and Certification of Screening Professional Completing the Level I Form

- **Outcome of Level I Screen:** Check box applicable to outcome.
- **Name of Provider/Agency/Program:** Fill in provider name, agency and/or program where the PASRR Level I Screen is being completed.
- **Title of Screening Professional:** Print title of Screener.
- **Screening Professional Phone Number:** Phone number where the Screener can be reached if additional information is needed.
- **Screening Professional Fax Number:** Where the reviewed PASRR is to be faxed, when applicable.
- **Name of Screening Professional:** Print name of Screener completing the form.
- **Signature of Screening Professional:** Signature of Screener completing the form.
- **Date:** Date form is completed and faxed to the OCCO Regional Office.

Important:

All Positive PASRR Level I Screens, including those certified by the physician as a 30-Day Exempted Hospital Discharge are to be faxed to OCCO, DMHAS and/or DDD as applicable, prior to the individual being discharged to the NF.

Section IX- Required Contact information for All Positive Level I Screens

This section must be completed for all Positive Level I Screens. If this section is left blank, the Level I Screen will not be processed. This section allows for the determination of the Level II Authority to be sent to the referring entity, consumer, Legal Representative, if applicable, and Family member if permission is received from the individual, and the attending physician.

Section X - Contact Information

This section contains the phone numbers for the local DMHAS, OCCO, DDD agencies/legal authorities. The fax numbers are also included to indicate where the completed Positive PASRR Level I Screens, as well as referrals for the Level II Evaluation and Determinations are to be sent.