Pre-Admission Screening Resident Review (PASRR) Level 1 Identification Screening

Please upload through the Provider Web Portal. If you are not an enrolled Nevada Medicaid provider, you may fax to (855) 709-6847.
Questions? Call: (800) 525-2395

DATE SUBMITTED:	**SCREENING TYPE:** ☐ Initial (PAS) ☐ Resident Review (RR) - Initial Date:	
RECIPIENT INFORMATION		
Name:	Recipient ID *(if Medicaid eligible)*:	Gender: ☐ Male ☐ Female
Home Address *(not a P.O. box)*:		Phone:
Date of Birth:	Social Security Number:	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	☐ Translator Required - Language:	
Known Diagnoses *(codes or descriptions)*:		
Other Insurance Name:	Other Insurance ID#:	
Where is the recipient currently located? ☐ Home ☐ Inpatient Acute Care ☐ ER/Observation ☐ Group Home/Assisted Living ☐ Nursing Facility ☐ Rehabilitation/Hospital ☐ Intermediate Care Facility (ICF) ☐ Other – Specify:		
On what date will the recipient be going into the Nursing Facility? *(Enter date if known.)*		
RESPONSIBLE PARTY INFORMATION *(required if recipient has indicators of MI, IID/RC)*		
Name:	Phone:	
Address*:*	Relationship to Recipient:	
ATTENDING PHYSICIAN INFORMATION *(required if recipient has indicators of MI, IID/RC)*		
Name:	Address:	
Phone:	Fax:	NPI:
REQUESTING FACILITY OR PROVIDER INFORMATION		
Name:	Address:	
Phone:	Fax:	NPI:
Contact Name:	Professional Title:	
The person completing this form attests that the individual (or appropriate family and/or guardian) has been informed that he/she is being considered for Nursing Facility placement.		
Name and Professional Title of Person Completing this Form:		
Date Completed:		
ADMITTING FACILITY INFORMATION *(if known)*		
Name:	Address:	
Phone:	Fax:	NPI:
Contact Name:		Contact Phone:

SECTION 1: MENTAL ILLNESS (MI) SCREENING

1A. Psychiatric Diagnosis *(Check each disorder that applies.)*

☐ Bipolar ☐ Delusional ☐ Major Depression ☐ Psychotic ☐ Schizoaffective ☐ Schizophrenia ☐ Severe Anxiety/Panic
☐ Somatoform ☐ Eating–specify: _____ ☐ Personality–*specify*:_____
☐ Mood Disorder - specify_____
☐ Paranoia: _____
☐ Other–*specify*: _____

1B. Current <u>Psychiatric</u> Medications Only	**Diagnosis/Purpose of Medication**
1. _____	_____
2. _____	_____
3. _____	_____

Recipient Name:_____ Date of Request:_____

2A. Psychiatric Treatment *(Identify treatment dates, excluding outpatient therapy services, within the last two years.)*

Inpatient Psychiatric Treatment (in psychiatric facility or hospital psychiatric unit)—*dates*: _____
Partial Hospital/Day Treatment (participated in structured group program)—*dates*: _____

2B. Intervention *(Identify treatment dates of services that were provided to prevent hospitalization within the last two years.)*

Supportive living due to MI—*dates*: _____

Housing intervention due to MI—*dates*: _____

Legal intervention due to MI including legal hold or L2K—*dates*:_____

Suicide attempt—*dates*: _____

Other—*specify*: _____

In Sections 3A and 3B, check the appropriate box to identify issues/limitations due to MI that arose frequently ("F"), occasionally ("O") or never ("N") in the last 6 months. If the issue or limitation has a medical basis (not related to MI), check the box in the "M" column.

3A. Interpersonal Functioning

Issue	*F*	*O*	*N*	*M*
Altercations	☐	☐	☐	☐
Evictions	☐	☐	☐	☐
Fear of strangers	☐	☐	☐	☐
Illogical comments	☐	☐	☐	☐
Suicidal talk	☐	☐	☐	☐
Social isolation/avoidance	☐	☐	☐	☐
Excessive irritability	☐	☐	☐	☐
Easily upset/anxious	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Serious communication difficulties	☐	☐	☐	☐
Other—*specify:*	☐	☐	☐	☐

3B. Concentration/Task Limitations

Limitation	*F*	*O*	*N*	*M*
Serious difficulty completing age related tasks	☐	☐	☐	☐
Serious loss of interest in things	☐	☐	☐	☐
Serious difficulty concentrating	☐	☐	☐	☐
Numerous errors in tasks that recipient should be physically capable of completing	☐	☐	☐	☐
Requires assistance with tasks that recipient should be physically capable of accomplishing	☐	☐	☐	☐
Other—*specify:*	☐	☐	☐	☐

Issues/Limitations Notes:

3C. Adaptation Problems *(Check the appropriate box to answer each question as related to recipient's MI (not medical) condition.)*

In the last 6 months, has the recipient had:	*Yes*	*No*
Mental health intervention due to increased symptoms?	☐	☐
Judicial intervention due to symptoms?	☐	☐
Increased symptoms due to adaptation difficulties?	☐	☐
Serious agitation/withdrawal due to adaptation difficulties?	☐	☐
Other significant adaptation problems? *(specify below)*	☐	☐

Adaptation Notes:

Recipient Name:_____ Date of Request:_____

SECTION 2: INTELLECTUAL DISABILITY (ID) AND RELATED CONDITIONS (RC) SCREENING

1A. Has recipient been diagnosed with ID? ☐ No ☐ Yes—*specify type/diagnosis:*_____

1B. Is ID suspected but undiagnosed? ☐ No ☐ Yes

1C. Does recipient have a history of receiving ID services? ☐ No ☐ Yes—*specify:*_____

2. Was the ID occurrence before age 18? ☐ No ☐ Yes—*specify age:* _____

2A. Check all related conditions that impair intellectual functioning or adaptive behavior:

☐ Blindness ☐ Cerebral Palsy ☐ Autism ☐ Seizure Disorder ☐ Deafness ☐ Closed head injury

☐ Other—*specify*: _____

2B. Check all substantial functional limitations (recipient must have three of the following limitations to meet IID/RC criteria):

☐ Self-care ☐ Self direction ☐ Mobility ☐ Capability of independent living ☐ Learning ☐ Understanding/Use of language

2C. Was the condition from item 2A manifested before age 22? ☐*No* ☐*Yes*—specify age: __

SECTION 3: DEMENTIA *Check all that apply.*

A. Is the recipient's primary diagnosis Alzheimer's disease? ☐ No ☐ Yes Dementia? ☐ No ☐ Yes

B. Does the recipient have any other organic disorders? ☐ No ☐ Yes-*specify:*_____

C. Is the recipient disoriented to: ☐ Time? ☐ Place? ☐ Situation?

Does the recipient display: ☐Severe ST memory deficit? ☐Pervasive, significant confusion? ☐Paranoid ideation?

D. Is there evidence of any of the following (which might be confused with dementia)? ☐ Frequent tearfulness ☐ Frequent anxiety ☐ Severe sleep disturbance ☐ Severe appetite disturbance

E. Can the requestor show dementia is the primary diagnosis?

☐ No ☐ Yes—*specify:* ☐ Dementia work-up ☐ Thorough mental status exam ☐ Medical/functional history prior to onset of dementia

☐ Other—*specify:* _____

SECTION 4: EXEMPTED HOSPITAL DISCHARGE (EHD) *A recipient meeting all criteria below does not require a PASRR Level II for 30 days. Admitting facility must submit PASRR Level I by 25th day to request PASRR Level II if it becomes apparent the stay will exceed 30 days. Check all that apply.*

☐ Recipient was directly admitted to a Nursing Facility after receiving acute inpatient care in a hospital

☐ Recipient requires Nursing Facility services for the condition for which the recipient received care in the hospital

☐ Attending physician has certified prior to NF admission that the recipient will require less than 30 days of NF services

Name of Certifying Physician: _____

(Attach physician certification to justify EHD and check the appropriate box in Section 7, "Attachments.")

SECTION 5: ---PASRR LEVEL II--- TIME LIMITED CATEGORICAL DETERMINATIONS *If a stay is anticipated to exceed the time limit, the admitting facility must submit a new PASRR Level I to request PASRR Level II at least 10 business days prior to the end of the time limit. The following categories indicate the individual requires NF services and does not require specialized services for the time specified.*

IIE. *Check all that apply:*

☐ **Convalescent care** needed from acute physical illness that required hospitalization. Does not meet all EHD criteria. *(Time Limit = 45 days)*

☐ **Emergency protective service** for MI or IID/RC recipient–placement in Nursing Facility not to exceed 7 days. *(Time Limit = 7 days)*

☐ **Delirium** precludes ability to accurately diagnose. Facility must obtain PASRR Level II as soon as delirium clears. *(Time Limit = 30 days)*

☐ **Respite** care is needed for in-home caregivers to whom the recipient with MI, IID/RC will return. *(Time Limit = 30 days)*

Recipient Name:_____ Date of Request:_____

SECTION 6: ---PASRR LEVEL II--- OTHER CATEGORICAL DETERMINATIONS *Check all that apply.*

☐ IIF. **Terminal Illness** where physician has certified life expectancy of less than 6 months

(Attach a physician certification of terminal illness and check the appropriate box in Section 7, "Attachments.")

☐ IIG. **Severe Physical Illness** limited to coma, ventilator dependence functioning at a brain stem level or a diagnosis of Parkinson's, Chronic Obstructive Pulmonary Disease, Huntington's disease, Amyotrophic lateral sclerosis or congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

SECTION 7: ATTACHMENTS *Check all that apply. Submit appropriate documentation with this form.*

SUPPORTING DOCUMENTATION CHECKLIST. Include all applicable documentation.

PRE-ADMISSION

☐ History & Physical or Physician Progress Note in Last 30 Days

☐ Diagnosis Specific Medication List

EXEMPTED HOSPITAL DISCHARGE

☐ Proof of Acute Inpatient Care

☐ Nursing Facility Level of Care

☐ Physician's Certification; Less than 30 Days of Care

CATEGORICAL

☐ Convalescent Care- Physician's Order

☐ Terminal Illness: Physician's Certification of Terminal Illness (CTI) (states that recipient's life expectancy is less than 6 months).

☐ Severe Physical Illness - Medical Provider Statement

☐ 7 Day Respite - Physician's Order

RESIDENT REVIEW

☐ History & Physical or Physician Progress Note in Last 30 Days

☐ Diagnosis Specific Medication List

☐ Copy of order for new diagnosis, medication, status change request reason (if applicable)

OTHER:

☐ Current Care Plan Skilled Therapy Notes

☐ Challenging Behavior Notes (if present)

☐ Activities of Daily Living documentation

☐ Urinary & Bowel Continence documentation

☐ Skin Assessment

☐ Recent Hospitalization Notes (if applicable)

☐ Psychological Evaluation (if applicable)

☐ Other Relevant Medical Records