ELECTRONIC LEVEL 1 PASRR FORM

Reason For PASRR 1 Submission

Please provide the Credentials of Person Submitting The Level 1 Screening *
- ○ Qualified Mental Health Provider(LCSW, Psych RN, LPC, etc.)
- ○ Other

Reporting status change/ Other reason for submitting level I *
- ○ Pre-admission
- ○ Admitted without PASRR
- ○ Resident initially admitted under exempted hospital discharge (EHD); needs longer NF stay
- ○ Resident initially admitted under other categorical/advance group determination reasons for convalescent care, emergency/protective services, acute delirium, or respite care; needs longer NF stay
- ○ Missing documentation
- ○ Existing Level 2 no longer represents individual's current condition or new diagnosis/diagnoses found after admission
- ○ MH diagnosis clarification – (EXAMPLE: Conflicting diagnosis)
- ○ Recent in-patient psychiatric hospitalization, or emergency department evaluation (without admission) including suicidal/homicidal ideation or increase in psychotic behavior – within the last 3 months
- ○ Discovery of possible I/DD condition not previously known
- ○ Transfer from NF to NF
- ○ Other reason for submitting Level 1

Does the individual's medical record have a primary diagnosis of neurocognitive Disorder (Dementia)? *
- ○ Yes
- ○ No

Where is the individual currently located? *
- ○ Hospital
- ○ Community (includes home, independent living, assisted living, group home, shelter, etc.)
- ○ Out of State
- ○ Other Nursing Facility
- ○ Nursing Facility where the individual currently resides

Is the individual enrolled in a State Medicaid program? *
- ○ Yes
- ○ No
- ○ Unknown

PASRR Condition indicators – Mental Illness

Score: 0

Does the individual have a known or suspected diagnosis of a major mental illness? *
- ○ Yes
- ○ No

Does the individual have any signs and/or symptoms of a major mental illness? *
- ○ Yes
- ○ No

Is the individual on antipsychotic, mood stabilizing, or antidepressant medication? *
- ○ Yes
- ○ No

PASRR Condition Indicators – Intellectual or Developmental Disabilities, or Related Conditions

Score: 0

Does the individual have a documented or suspected Diagnosis of Intellectual or Developmental Disability? *
- ○ Yes
- ○ No

Does the individual have a diagnosis of a neurological condition such as Cerebral Palsy, Autism, etc.? *
- ○ Yes
- ○ No

Has the individual ever received services from, or been referred to, an agency serving persons with an intellectual or development disability? *
- ○ Yes
- ○ No

Did the individual sustain a brain injury or receive a Seizure Disorder and/or Epilepsy Diagnosis prior to the age of 22? *
- ○ Yes
- ○ No

SAMPLE FOR DISCUSSION PURPOSES ONLY. NOT FOR SUBMISSION.

Impairment and Treatment History

Score: 0

Has the individual had any limitation in major life activities in any of the areas listed? *

- ○ Yes
- ○ No

Check limitations that apply *

- ☐ Interpersonal Functioning - significant difficulty interacting and/or communicating effectively with others, illogical comments, self-isolating or avoiding others (not due to medical condition)
- ☐ Concentration/Task Related Symptoms-significant difficulty completing age-appropriate tasks and/or concentrating, requires assistance with activities/tasks the individual should be capable of accomplishing, frequent or substantial errors
- ☐ Adaptation to Change- The individual has significant difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions or requires intervention by the mental health or judicial system
- ☐ Significant Life disruption - significant disruption to the members normal living situation that required supportive services or legal intervention to maintain functioning due to mental health symptoms, housing changes or homelessness

Additional mental health symptoms- Has the individual exhibited any of the following significant symptoms or behaviors (not due to a medical condition)? *

- ○ Yes
- ○ No

Check all mental health symptoms that apply *

- ☐ Self-injurious or self-mutilation
- ☐ Suicide threats or ideation
- ☐ History of suicide attempt or gesture
- ☐ Physical violence
- ☐ Physical threats
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious loss of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing

Has the individual received any of the following mental health services? *

- ○ Yes
- ○ No

Select all mental health services the individual has received *

- ☐ Inpatient psychiatric hospitalization
- ☐ Partial hospitalization/day treatment
- ☐ Residential treatment
- ☐ Outpatient mental health services including IOP (Intensive Outpatient Treatment Program)
- ☐ Other

Has a recent depression screening been completed? If yes, please provide the screening results in the individuals documentation *

- ○ Yes
- ○ No

Has the individual had a recent psychiatric/behavioral evaluation? If yes, please provide the evaluation in the individual's documentation if available *

- ○ Yes
- ○ No

Please submit all of the following:

1. The most recent History and Physical or any medical documentation with a review of systems from within the last 6 months. Include vitals if relevant to the individual's condition.
2. List of current medications.
3. Comprehensive list of diagnosis (ex: SNF face sheet or hospital list).
4. If applicable, please upload documentation related to any active court orders for involuntary mental health treatment and/or psychiatric medications.

As the PASRR Level 1 screener, I certify that I have attached the required documents. (Certify by entering your name) *

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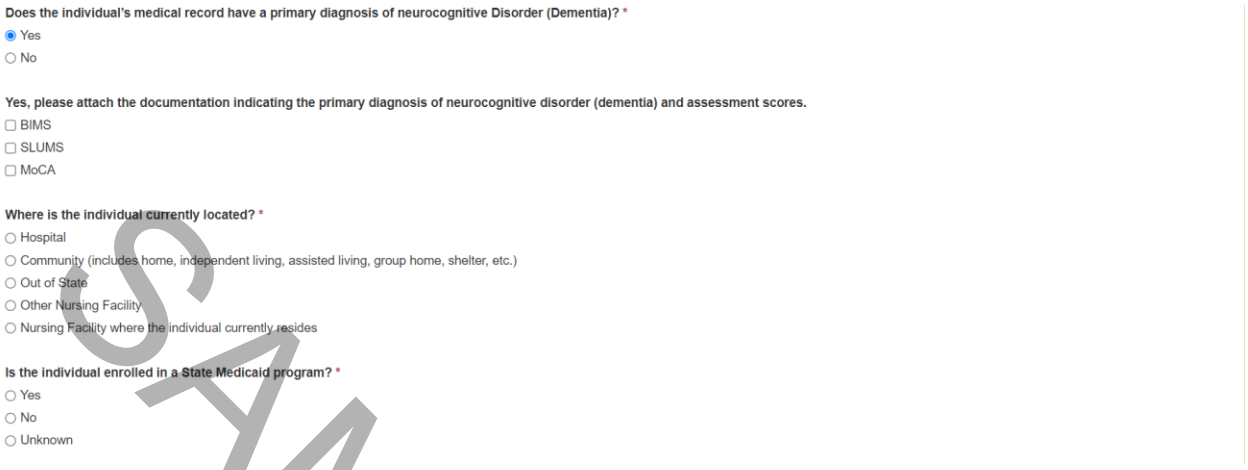
If you answer "yes" to Does the medical record have a primary diagnosis of a neurocognitive disorder (Dementia)?


Does the individual's medical record have a primary diagnosis of neurocognitive Disorder (Dementia)? *
- (●) Yes
- ( ) No

Yes, please attach the documentation indicating the primary diagnosis of neurocognitive disorder (dementia) and assessment scores.
- [ ] BIMS
- [ ] SLUMS
- [ ] MoCA

Where is the individual currently located? *
- ( ) Hospital
- ( ) Community (includes home, independent living, assisted living, group home, shelter, etc.)
- ( ) Out of State
- ( ) Other Nursing Facility
- ( ) Nursing Facility where the individual currently resides

Is the individual enrolled in a State Medicaid program? *
- ( ) Yes
- ( ) No
- ( ) Unknown

If you answer "yes," Does the patient have a major mental illness?


Major Mental Illness

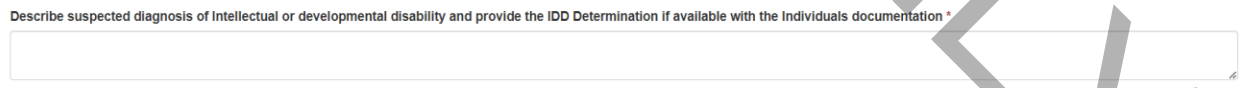
Major Mental Illness Onset Date	Major Mental Illness Type	Major Mental Illness ICD Code	Major Mental Illness Diagnosis Description
MM/DD/YYYY (approximate date or use 1/1/1900 if unknown)	( ) Suspected Diagnosis ( ) Known Diagnosis		

Is the individual on antipsychotic, mood stabilizing, or antidepressant medication?


Medications and Symptoms

Medications *	Symptoms	MI Diagnosis Code *	MI Diagnosis Name *	Action

Does the individual have a documented or suspected Diagnosis of Intellectual or Developmental Disability?


Describe suspected diagnosis of Intellectual or developmental disability and provide the IDD Determination if available with the Individuals documentation *

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Provisional or Exempt Hospital Discharges

Provisional Admissions

Score: 0

Is the individual admitting under an EHD (Exempted Hospital Discharge) *
- ○ Yes
- ○ No

The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital *
- ○ Yes
- ○ No

The applicant requires nursing facility care for the condition for which they received care in the hospital *
- ○ Yes
- ○ No

The attending physician has certified the applicant is likely to require less than thirty (30) days of nursing facility services *
- ○ Yes
- ○ No

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