Community PASRR Submission

Name of Person Submitting Form:

Submitter's Credentials:

Submitter's Email Address:

Submitter's Phone Number:

Member Name:

Date of Birth:

MA Number or Temp ID:
(if Applicable)

Social Security Number:

Receiving Nursing Facility Name:

Receiving Facility NPI:

Confirm the following documentation is included (place X in the box):

Community PASRR Form	☐
History and Physical (H&P)	☐
Medication List	☐
Diagnosis List	☐

The completed Community PASRR form and supporting documentation can be submitted to Telligen via fax.

- Fax: 888-297-4276; Attention: LTC PASRR

Reason For PASRR 1 Submission

1. **Please provide the credentials of person submitting the level 1 screening**

☐ Qualified Mental Health Provider (LCSW, Psych RN, LPC, ect.)
☐ Other

Specify Credentials

2. **Reporting Status Change/Other reason for submitting level 1**

☐ 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☐ Existing Level 2 no longer represents individual's current condition or new diagnosis/diagnoses found after admission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)

3. **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.

4. **Is the individual enrolled in a State Medicaid program?**

☐ Yes
☐ No
☐ Unknown

5. **Does the individual's medical record have a primary diagnosis of neurocognitive Disorder (Dementia)?**

☐ Yes
☐ No

If Yes, please attach the documentation indicating the primary diagnosis of neurocognitive disorder (dementia) and at least 1 (one) assessment score(s). If No, please skip to question # 10.

☐ BIMS
☐ SLUMS
☐ MoCA

7. **BIMS Score**

8. **SLUMS Score**

9. **MoCA Score**

10. **Is the individual admitted to an inpatient psychiatric hospital or psychiatric unit?**

☐ Yes
☐ No

11. **Is this a SNF-SNF transfer?**

☐ Yes
☐ No

PASRR Condition Indicators – Mental Illness

12. **Does the individual have a known or suspected diagnosis of a major mental illness? If no, skip to question #22.**

☐ Yes
☐ No

Major Mental Illness

13. **Major Mental Illness Onset Date**

14. **Major Mental Illness Type**

☐ Suspected Diagnosis
☐ Known Diagnosis

15. **Major Mental Illness ICD Code**

16. **Major Mental Illness Diagnosis Description**

17. **Does the individual have any signs and/or symptoms of a major mental illness?**

☐ Yes
☐ No

18. **Describe other symptoms**

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

☐ Yes
☐ No

20. **Medications**

21. **Symptoms**

Section B: PASRR Condition Indicators – Intellectual or Developmental Disabilities, or Related Conditions

22. **Does the individual have a documented or suspected Diagnosis or Intellectual or Developmental Disability? If no, go to question #30.**

☐ Yes
☐ No

23. **Describe suspected diagnosis of intellectual or developmental disability and provide the I/DD Determination if available with the individual's documentation**

24. **Does the individual have a diagnosis of neurological condition such as Cerebral Palsy, Autism, etc.?**

☐ Yes
☐ No

25. **Describe neurological condition**

26. **Has the individual ever received services from, or been referred to, an agency serving persons with an intellectual or development disability?**

☐ Yes
☐ No

27. **Name of most recent Case Management Agency**

28. **Did the individual sustain a brain injury or receive a Seizure Disorder and/or Epilepsy Diagnosis prior to the age of 22?**

☐ Yes
☐ No

29. **Describe brain injury, Seizure Disorder and/or Epilepsy Diagnosis prior to age 22.**

Section C: Provisional Admissions

30. The individual admitting under an EHD (Exempted Hospital Discharge)

☐ Yes
☐ No

31. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital

☐ Yes
☐ No

32. The applicant requires nursing facility care for the condition for which they received care in the hospital

☐ Yes
☐ No

33. The attending physician has certified the applicant is likely to require less than thirty (30) days of nursing facility services

☐ Yes
☐ No

34. Emergency stay due to emergency evacuations or protective services placements not to exceed 7 days

☐ Yes
☐ No

35. Individual is enrolled on a Qualified HCBS (Home Community Based Services) Waiver needing a Respite stay up to 30 consecutive days to provide respite to an in-home caregiver

☐ Yes
☐ No

36. Please provide the name of the HCBS waiver the individual is enrolled in and describe reason for the respite stay

Impairment and Treatment History

37. 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 – 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 individual's normal living situation that required supportive services or legal intervention to maintain functioning due to mental health symptoms, housing changes or homelessness

38. How recent has there been limitations in Interpersonal Functioning

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

39. Severity of limitations in Interpersonal Functioning

- ☐ Mild
- ☐ Moderate
- ☐ Severe

40. How recent have there been limitations in Concentration/Task Related Symptoms

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

41. Severity of limitations in Concentration/Task Related Symptoms

- ☐ Mild
- ☐ Moderate
- ☐ Severe

42. How recent has their been limitations in Adaption to Change

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

43 Severity of limitations in Adaptation to Change

- ☐ Mild
- ☐ Moderate
- ☐ Severe

44. How recent has there been Significant Life Disruption

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

45. Severity of Significant Life Disruption

- ☐ Mild
- ☐ Moderate
- ☐ Severe

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

- ☐ Yes
- ☐ No

46. 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)

47. How recent have there been self-injurious or self-mutilation symptoms

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

48. How recent have there been suicide threats or ideation

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

49. How recent have there been a history of suicide attempts or gesture

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

50. How recent has there been physical violence

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

51. How recent have there been physical threats

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

52. How recent has there been severe appetite disturbance

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

53. How recent have there been hallucinations or delusions

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

54. How recent have there been serious losses of interest in things

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

55. How recent has there been excessive tearfulness

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

56. How recent has there been excessive irritability

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

57. Specify other major mental health symptoms

58. How recent has there been other mental health symptoms

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

59. Has the individual received any of the following mental health services

- ☐ Yes
- ☐ No

60. 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

61. How recent has there been inpatient psychiatric hospitalization

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

62. How recent has there been partial hospitalization/day treatment

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

63. How recent has there been residential treatment

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

64. How recent has there been outpatient mental health services including IOP (Intensive Outpatient Treatment Program)

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

65. Describe other mental health services

66. How recent has there been other mental health services

- ☐ Current or within past 30 days
- ☐ 2-6 months ago
- ☐ 7-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 2 years

67. Has a recent depression screening been completed? If yes, please provide the screening results in the individual's documentation

- ☐ Yes
- ☐ No

Select all recent depression screenings that have been completed

- ☐ PHQ-9
- ☐ GDS
- ☐ Other

PHQ-9 score

GDS Score

Describe other mental health screenings

Other mental health screening score

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

- ☐ Yes
- ☐ No

Date of Evaluation

Provider Name

Please Submit the following:

1.Most recent History and Physical or any medical documentation with a review of systems
2.List of current medications
3.Comprehensive list of diagnoses (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

Signature:

Contact Info: