

# PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (LEVEL I) FORM PA-PASRR-ID (Revised March 1, 2014)

The information collected on this form is required by Federal Statute (P.L.100-203) since January 1, 1989. This process applies to all applicants, regardless of payer source. Current nursing facility (NF) residents must have a PASRR-ID form on their current medical record.

## Section I - Demographics and Diagnosis

Date the form is completed: \_\_\_\_\_

Applicant/resident name - Last, First: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_ Target diagnosis: \_\_\_\_\_

## Communication

Does the applicant/resident require assistance with communication, such as an interpreter or other accommodation, to participate in or understand the PASRR evaluation process?

Yes  No

## Section II - Serious Mental Illness (MI)

An individual is considered to have a serious MI if he/she meets all of the following requirements regarding diagnoses, level of impairment, and duration of illness. Examples of a MI may include: schizophrenia, schizoaffective disorder, delusional disorder, psychotic disorder, personality disorder, panic or other severe anxiety disorder, somatic symptom disorder, bipolar disorder, depressive disorder, or another mental disorder that may lead to chronic disability.

### Section II-A - Diagnoses:

1. Does the individual have a mental disorder, other than Dementia, that may lead to a chronic Disability?

Yes  No

**Note:** For this purpose, a diagnosis of dementia (including Alzheimer's disease and other organic brain diseases) will not automatically exclude an individual from PASRR evaluation. If the mental documentation clearly states the level of impairment or behavior/confusion is due primarily to the dementia, the individual can be excluded from further evaluation.

2. Does the individual have a substance related disorder?

Yes  No - If Section II-A 1 and 2 are "No", Skip to II-D

**Section II-B - Level of impairment:** The mental disorder resulted in functional limitations in major life activities within the past three to six months that were not appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis.

- 1. Interpersonal functioning** - The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.
- 2. Concentration, persistence and pace** - The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings, or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.
- 3. Adaptation to change** - The individual has serious difficulty adapting to typical changes in circumstances associated with work, school, family, or social interaction; manifests agitation, exacerbated signs and symptoms associated with the illness; or withdrawal from the situation; or requires intervention by the mental health or judicial system.

**Section II-C - Recent treatments/history:** The treatment history for the mental disorder indicates that the individual has experienced at least one of the following within the last two years:

1. **Inpatient treatment:** More than once (e.g. partial hospitalization, inpatient hospitalization, long-term structured rehab or state hospital):

Indicate name of inpatient facility and date: \_\_\_\_\_

2. **Suicide history:** Check the appropriate box(es):

Suicide ideation with plan (verified by psychiatric consult)  Suicide attempt - date: \_\_\_\_\_

3. **Electroconvulsive therapy - ECT (related to MI):**

Yes - date: \_\_\_\_\_

4. **Mental illness intensive case manager (ICM):**

MI-ICM - Indicate name and telephone number: \_\_\_\_\_

5. **Supportive services due to a mental disorder:**

Experienced an episode of significant disruption to the normal living situation or had intervention by law enforcement.

**Section II-D:** Does the applicant/resident meet all of the requirements of having a serious MI listed in **Sections II-A through II-C** above? (II-A = yes OR if II-A1 and II-A2=yes; AND at least one marked in II-B; AND at least one marked in II-C. **Note:** II-C 1 must have occurred more than one time).

Yes  No

# PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (LEVEL I) FORM

## Section III - Intellectual Disability (ID)

An individual is considered to have evidence of an intellectual disability if they have a diagnosis of ID, a condition that is associated with ID, evidence of function that might be consistent with an ID, and/or have received services from an ID agency in the past.

**Section III-A:** Does the individual have a diagnosis of ID (mild, moderate, severe or profound) currently or in the past?

Yes  No

**Section III-B:** Is there a history of a severe, chronic disability that is attributable to a condition other than mental illness that could result in impairment of functioning in general intellectual and adaptive behavior?

Yes - indicate the condition: \_\_\_\_\_  No

**Section III-C:** Is there any current evidence indicating that the individual may have an ID?

Yes  No

**Section III-D:** Did the onset of the condition occur before the age of 22?

Yes  No  Cannot determine

**Section III-E:** Has the individual ever been registered with their county for ID services and/or received services from an ID provider agency?

Yes  No

If yes, indicate county name/agency \_\_\_\_\_

and Supports Coordinator (if known) \_\_\_\_\_ .

**Section III-F:** Has the individual ever been a resident of a state facility including a state hospital, state operated ID center, or a state school?

Yes - indicate the name of the facility and dates: \_\_\_\_\_  No

**Section III-G:** Based on the criteria **III-A through III-F**, does the individual have evidence of an ID as indicated by the presence of either a diagnosis of ID, presence of a condition that is associated with ID, or evidence of function that might be consistent with an ID?

Yes  No

## Section IV - Other Related Conditions (ORC)

“ORC” include physical, sensory or neurological disabilities which manifested prior to age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care.

**Section IV-A:** Does the individual have an ORC?

Yes - specify: \_\_\_\_\_  No

**Section IV-B:** Check all areas of substantial functional limitation which were present prior to age 22 and were directly the result of the ORC.

Self-care  Receptive and expressive language  Learning  Mobility  Capacity for independent living  Self-direction

**Section IV-C:** Is the ORC expected to continue indefinitely?

Yes  No

**Section IV-D:** Does the individual meet criteria of an ORC as defined in **IV-A through IV-C**?

Yes  No

## Section V - Home and Community Waiver

Was the individual/family informed of the Home and Community Based Waiver programs that are available?

Yes  No

# PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (LEVEL I) FORM

## **Section VI - Exceptional Admission**

Does the applicant/resident who is not dangerous to self and/or others meet criteria for Exceptional Admission to a facility without Preadmission Screening Evaluation?

Yes  No

**Section VI-A - Individual is an Exempted Hospital Discharge** - Must meet all the following and have a known or suspected MI, ID, or ORC:

- Admission to NF directly from hospital after receiving acute inpatient medical care, and
- Requires NF services for the condition for which he/she received care in the hospital,  
(Specify the condition: \_\_\_\_\_), and
- Physician has certified prior to NF admission that the **individual will require less than 30 calendar days of NF service and the individual's symptoms are stable.**

Yes  No

**Section VI-B - Individual requires Respite Care** - An individual with a serious MI, ID, or ORC may be admitted for respite care for a period of up to 14 days without further evaluation if he/she is certified by a referring or attending physician to require 24-hour nursing facility services and supervision.

Yes  No

**Section VI-C - Individual requires Emergency Placement** - An individual with a serious MI, ID, or ORC may be admitted for emergency placement for a period of up to 30 days without further evaluation if the Area Agency on Aging's (AAA) Protective Services has certified that such placement is needed.

Yes  No

**Section VI-D - Individual is in a coma or functions at a brain stem level** - An applicant/resident may receive nursing facility services without further evaluation if certified by the referring or attending physician to be in a coma or who functions at brain stem level. The condition must require intense 24-hour nursing facility services and supervision and is so extreme that the individual cannot focus upon, participate in, or benefit from specialized services.

Yes  No

**Note: If the individual's condition changes in any of the above or will be in residence for more than the allotted days, the NF must complete a new PASRR-ID and the Department of Public Welfare, Office of Long-Term Living must be notified on the MA 408 form within 48 hours for an evaluation to be completed.**

**Section VII - Type of Admission**

**Regular Admission** - No further PASRR evaluation is needed.

**Note:** Answers in Sections II-D, III-G and IV-D are all “No”.

Signature:	Telephone number:	Date:
------------	-------------------	-------

**Target Group** - (Report on MA 408, refer to AAA Assessment Unit/Field Operations Team for Level II PASRR evaluation and completion. All targeted residents must have program office approval prior to admission.)

**Note:** Level II PASRR evaluation is required. Answers in Sections II-D, III-G or IV-D are “Yes” and the answers to Section VI are “No”.

Signature:	Telephone number:	Date:
------------	-------------------	-------

**Exceptional Admission** - The applicant/resident was targeted for evaluation, but has a condition which meets the criteria for Exceptional Admission indicated in Section VI.

**Note:** One or more answers in Section II-D, III-G or IV-D are “Yes” and one answer in Section VI is “Yes”. Report on MA 408 form.

Print attending physician's name:	Telephone number:
Attending physician's signature:	Date:

**PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW IDENTIFICATION (LEVEL I) FORM**

**Section VIII - Individual Completing Form:**

Signature:	Telephone number:	Date:
------------	-------------------	-------

Affix Nursing Facility Field Operations stamp here: