Preadmission Screening and Resident Review (PASRR) Level I Screen Form

Instructions

A. Acronyms and abbreviations:

a. AHCA – Agency for Health Care Administration
b. CARES – Florida Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services Program
c. CFR – Code of Federal Regulations
d. CMAT – Children's Multidisciplinary Assessment Team
e. DOH – Florida Department of Health
f. DOEA – Florida Department of Elder Affairs
g. F.A.C. – Florida Administrative Code
h. HIPAA – Health Insurance Portability and Accountability Act
i. ID – Intellectual Disability or Related Conditions
j. MI – Mental Illness
k. MID – Medicaid Identification Number
l. MM/DD/YYYY – Month, Day, Year
m. N/A – Not Applicable
n. NF – Medicaid-certified Nursing Facility
o. PASRR – Preadmission Screening and Resident Review
p. RR – Resident Review
q. SMI – Serious Mental Illness

B. Instructions

The Level I PASRR Screen, AHCA MedServ Form 004 Part A, March 2017, must be fully and accurately completed, and distributed in accordance with Rule 59G-1.040, F.A.C. Incomplete submissions will not be accepted, and may prohibit Florida Medicaid payment for nursing facility services. Information inserted manually must be legible. Any illegible information will result in the Level I Screen Form being deemed unacceptable.

Steps to Complete the Screen:

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Fill in the blanks with the individual's demographics, screening site, insurance information, etc. Check the boxes to best answer the individual's current location at time of screening, and include the individual's parent, guardian, or legal representative's information, if applicable.

Enter the Medicaid or 'Other Health Insurance' identification information if available.

Enter up to three NFs (if uncertain), in the section entitled 'Requesting Admission to'.

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Fill in the name of the individual being evaluated and date of birth at the top of this page and each page going forward.

Section I: PASRR Screen Decision-Making

1. Review any pertinent medical information available for condition(s) to consider for a suspicion or diagnosis of SMI, ID or both.

   Check the appropriate box(es) in column A for history or suspicion of an MI and specify, if applicable, any other diagnosis or condition that is not listed on the form.

Check applicable box(es) in column B for history or suspicion of ID and specify, if applicable, any other diagnosis or condition that is not listed on the form.

2. Check the appropriate box if the individual has, has had, or has been referred for services from an agency or entity that serves individuals with an intellectual or developmental disability such as the Agency for Persons with Disabilities (APD), or provides services for an MI.
3. Include additional information if necessary pertaining to MI or ID history.

Indicate the source of all the information gathered for the individual's Level I PASRR screen.

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Section II: Other Indications for PASRR Screen Decision-Making

Check 'Yes' or 'No' in the box after each question as it pertains to the individual.

The boxed text contains additional information in relation to the decision-making process, throughout the Level I PASRR screen.

If the box checked in question four of Section II is 'Yes,' a Level II evaluation must be requested.

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Section II: Other Indications for PASRR Screen Decision-Making, continued

Continue to check the appropriate box pertaining to the individual concerning questions five through seven.

The boxed text contains additional information in relation to the decision-making process.

Section III: PASRR Screen Provisional or Hospital Discharge Exemption.

If the individual being admitted is not a provisional admission, check the box indicating such and proceed to Section IV.

If the individual being admitted is a provisional admission, or a hospital discharge exemption, check the appropriate box. Check only one box.

Check the box for the type of provisional admission. Fill in the blank where indicated with the anticipated Level II evaluation completion date based on the type of provisional admission.

If the individual is being admitted under the hospital discharge exemption, check the box and ensure the section is signed by the attending physician. A hospital discharge exemption only pertains to the timeframe for completion of the Level II PASRR evaluation and determination. The box for a hospital discharge exemption is not to be checked if the individual has no diagnosis or suspicion of SMI, ID, or both. An individual being admitted with no diagnosis or suspicion of SMI, ID or both, is not a hospital discharge exemption according to PASRR regulations.

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Section IV: PASRR Screen Completion

1. Determine whether the individual may, or may not, be admitted to an NF and check the applicable box indicating the finding.
2. Fill in the information fields pertaining to the person who has completed the screen.
3. If the individual requires a Level II evaluation, forward the Level I PASRR along with other required documentation, to the appropriate Level II screener as follows:
    - CARES for individuals age 21 years and older
    - DOH for individuals under the age of 21 years

Complete the distribution area of the form indicating where the Level I PASRR screen and accompanying documents must be sent, as appropriate. Check all that apply.

Obtain the signature for consent for the Level II evaluation and determination, if applicable, from the individual being assessed or the individual's legal representative.

If an individual is unwilling or unable, and has no legal representative or health care agent to sign the consent for a Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented.

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

_____ _____ _____
Name of Individual Being Evaluated (print) Social Security Number* Date of Birth

☐ Male ☐ Female _____ _____
Age Individual's or Residency Phone Number

_____ _____ _____
Present Location of Individual Being Evaluated Street Address, City State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other_____

_____ _____ _____
Legal Representative's Name (if applicable) Street Address, City State, Zip

Representative's Phone Number _____

_____ _____
Medicaid Identification Number if Applicable Other Health Insurance Name and Number if Applicable

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

Name of Individual Being Evaluated _____ Date of Birth _____

Section I:PASRR Screen Decision-Making

A. MI or suspected MI (check all that apply):

☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Dissociative Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ Psychotic Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Somatic Symptom Disorder
☐ Substance Abuse
☐ Other (specify):_____

B. ID or suspected ID (check all that apply):

☐ Current diagnosis of an ID, mild, moderate, severe or profound.
☐ IQ of 70 or less, if available.
☐ Onset prior to 18 years of age. Age of onset: _____
☐ Impaired adaptive behavior

Related Condition:

☐ Onset prior to 22 years of age. Age of onset: _____
☐ Autism
☐ Cerebral Palsy
☐ Down Syndrome
☐ Epilepsy
☐ Muscular Dystrophy
☐ Prader Willi
☐ Spina Bifida
☐ Traumatic Brain Injury
☐ Other (specify): _____

Functional Criteria:

☐ Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (**check all that apply**):

☐ Capacity for independent living
☐ Learning
☐ Mobility
☐ Self care
☐ Self direction
☐ Understanding and use of language

Services:

☐ Currently receiving services for MI.
☐ Previously received services for MI.
☐ Referred for MI services.

☐ Currently receiving services for ID.
☐ Previously received services for ID.
☐ Referred for ID services.

Additional Information: _____

Finding is based on (check all that apply):

☐ Documented History ☐ Behavioral Observations ☐ Individual, Legal Representative or Family Report

☐ Medications ☐ Other (specify): _____

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. ☐Yes ☐No

B. 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, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in 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. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a 'yes' checked in Section II.1, II.2, or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

Name of Individual Being Evaluated _____ Date of Birth _____

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:

Dementia? ☐Yes ☐No
Related Neurocognitive Disorder (including Alzheimer's disease)? ☐Yes ☐No

6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?

☐Yes ☐No

7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?

☐ No

☐ Yes (**Check all that apply.** Send accompanying documentation with completed Level I PASRR screen):

- ☐ Dementia work-up
- ☐ Comprehensive mental status exam
- ☐ Medical/functional history prior to onset
- ☐ Other – Specify: _____

A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.128(m)(2)(i) or 42 CFR §483.128(m)(2)(ii).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

☐ **Not a provisional admission** ☐ **Hospital Discharge Exemption**

☐ **Provisional admission (choose one)**

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID or both, and the box in Section II.4 is checked 'no'. A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES for adults or DOH*** for individuals under the age of 21 years within the time frames indicated in this section.**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14-day time limit, on or before (date): _____

☐ The individual is being admitted under the 30-day hospital discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _____

An attending physician's signature is required for those individuals admitted under a 30-day hospital discharge exemption.

_____ _____

ATTENDING PHYSICIAN'S SIGNATURE DATE

Name of Individual Being Evaluated _____ Date of Birth _____

Section IV: PASRR Screen Completion

Individual <u>may</u> be admitted to an NF (check one of the following):	**Individual <u>may not</u> be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.	☐ SMI ☐ ID ☐ SMI and ID
☐ Provisional admission	
☐ Hospital Discharge Exemption	

******Incomplete forms will not be accepted******

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener's Name (Printed) _____ **Signature** _____

Credentials _____ **Date** _____ **Phone** _____

Place of Employment _____ **Fax** _____

Completed Level I screen **distributed to (check all that apply)**:

☐ Local DOH*** office, for individuals under the age of 21 years

☐ Accompanying documents attached

Date:_____

☐ Local CARES** office, for adults age 21 years or older

Date: _____

☐ Accompanying documents attached

☐ Nursing Facility

Date: _____

☐ Discharging Hospital (if applicable):

Date: _____

Name: **Date:**

Consent for Level II Evaluation and Determination

In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history.
I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

If the individual requires a Level II PASRR evaluation, submit the completed Level I PASRR screen, documented informed consent, completed AHCA 5000-3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation, or supporting documentation to CARES or DOH for facilitation to the state authority for SMI or ID.

If an individual is unwilling, unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

_____

_____

_____

_____

_____

****Florida Department of Elder Affair's Comprehensive Assessment and Review for Long-Term Care Services**

*****Florida Department of Health**