

**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

<b>DATE SUBMITTED:</b>		<b>SCREENING TYPE:</b> <input type="checkbox"/> Initial (PAS) <input type="checkbox"/> Resident Review (RR) - Initial Date:	
<b>RECIPIENT INFORMATION</b>			
Name:		Recipient ID (if Medicaid eligible):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (not a P.O. box):			Phone:
Date of Birth:		Social Security Number:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Translator Required - Language:	
Known Diagnoses (codes or descriptions):			
Other Insurance Name:		Other Insurance ID#:	
Where is the recipient currently located? <input type="checkbox"/> Home <input type="checkbox"/> Inpatient Acute Care <input type="checkbox"/> ER/Observation <input type="checkbox"/> Group Home/Assisted Living <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Rehabilitation/Hospital <input type="checkbox"/> Other - specify:			
On what date will the recipient be going into the Nursing Facility? (Enter date if known.)			
<b>RESPONSIBLE PARTY INFORMATION</b> (required if recipient has indicators of MI, MR/RC)			
Name:		Phone:	
Address:		Relationship to Recipient:	
<b>ATTENDING PHYSICIAN INFORMATION</b> (required if recipient has indicators of MI, MR/RC)			
Name:		Address:	
Phone:	Fax:	NPI:	
<b>REQUESTING FACILITY OR PROVIDER INFORMATION</b>			
Name:		Address:	
Phone:	Fax:	NPI:	
Contact Name:		Professional Title:	
<b>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.</b>			
<b>Name and Professional Title of Person Completing this Form:</b>			
<b>Date Completed:</b>			
<b>ADMITTING FACILITY INFORMATION</b> (if known)			
Name:		Address:	
Phone:	Fax:	NPI:	
Contact Name:		Contact Phone:	
<b>SECTION 1: MENTAL ILLNESS (MI) SCREENING</b>			
<b>1A. Psychiatric Diagnosis</b> (Check each disorder that applies.)			
<input type="checkbox"/> Bipolar <input type="checkbox"/> Delusional <input type="checkbox"/> Major Depression <input type="checkbox"/> Psychotic <input type="checkbox"/> Schizoaffective <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Severe Anxiety/Panic			
<input type="checkbox"/> Somatoform <input type="checkbox"/> Eating-specify: _____ <input type="checkbox"/> Personality-specify: _____			
<input type="checkbox"/> Other-specify: _____			
<b>1B. Current Psychiatric Medications</b>		<b>Diagnosis/Purpose of Medication</b>	
1. _____	_____		
2. _____	_____		
3. _____	_____		

**2A. Psychiatric Treatment** (Identify treatment dates within the last two years. Omit outpatient treatment.)

Inpatient Psychiatric Treatment (in psychiatric facility or hospital psychiatric unit)—dates: \_\_\_\_\_

Partial Hospital/Day Treatment (participated in structured, outpatient group program)—dates: \_\_\_\_\_

Other Treatment—specify (e.g., psychiatric consultations, group/individual therapy)—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—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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 MR/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 MR/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, MR/RC will return. (Time Limit = 30 days)

**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 is attached (may be required if recipient has indicators of MI, MR/RC).
- Physician certification to justify EHD is attached (states that recipient will require no more than a 30 day stay).
- Physician certification of terminal illness is attached (states that recipient's life expectancy is less than 6 months).

**NOTES:**