## ARIZONA Pre-Admission Screening and Resident Review (PASRR) LEVEL I
## Screening Document - Exhibit 1220 - 1

First Name: ☐ Middle Initial: ☐ Last Name: ☐ Date ☐

Address: ☐ City: ☐ State: ☐ Zip: ☐ Phone: ☐

Social Security #: ☐ Date of Birth: ☐ Marital Status: ☐ M ☐ S ☐ W ☐ D Gender: ☐ M ☐ F

Payment Method: Medicaid ID #: ☐ Medicare ID #: ☐ ☐ Self-Pay

Current Living Situation: ☐ NF ☐ Hospital ☐ Homeless ☐ Home with Family ☐ Home alone ☐ Group Home ☐ Other

Current Location: ☐ Medical Facility ☐ Psychiatric Facility ☐ Hospital ED ☐ Community ☐ Nursing Facility ☐ Other

Admitting Nursing Facility: Name of Facility : ☐ Admission date ☐

Street: ☐ City: ☐ State: ☐ Zip: ☐

PASRR Level I Review Type: ☐ Preadmission ☐ Status Change ☐ Conclusion of a Time Limited Approval

### MENTAL ILLNESS

**1. Does the individual have any of the following Serious Mental Illnesses (SMI)?** ☐ No

Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Major Depression
- ☐ Psychotic/Delusional Disorder
- ☐ Bipolar Disorder (manic depression)
- ☐ Paranoid Disorder

**2. Does the individual have any of the following mental disorders?** ☐ No

Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Depression (mild or situational)

**3.a Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)**

☐ No ☐ Yes (list diagnosis(es) below):

Diagnosis: ☐

**3.b. Does the individual have a substance related disorder?**

☐ No ☐ Yes (complete remaining questions in this section)

**b.1 List substance related diagnosis(es)**

☐

**b.2 Is NF need associated with this diagnosis?** ☐ No ☐ Yes

**b.3 When did the most recent substance use occur?** ☐ <7 days ☐ >7-14 days ☐ > 14-28 days ☐ > -28 days -2 months ☐ >2 - 3 months ☐ Unknown

### SYMPTOMS

**4. Interpersonal – Has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?**

☐ No ☐ Yes

- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

**5. Concentration/Task related symptoms – Has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?**

☐ No ☐ Yes

- ☐ Serious difficulty completing tasks that she/he should be capable of completing
- ☐ Required assistance with tasks for which s/he should be capable
- ☐ Substantial errors with tasks in which she/he completes

**Adaptation to change – Has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change?**

☐ No ☐ Yes (complete 6-8)

6.
- ☐ Self injurious or self mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats (with potential for harm)

7.
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious loss of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Physical threats (no potential for harm)

8. ☐ 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 symptoms. Describe Symptoms:

☐

### HISTORY OF PSYCHIATRIC TREATMENT

**9. Currently or within the past 2 years, has the individual received any of the following mental health services?** ☐ No

☐ Yes (the individual has received the following service(s) provide the date:

- ☐ Inpatient psychiatric hospitalization
- ☐ Partial hospitalization/day treatment
- ☐ Residential Treatment

**10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms?** ☐ No

☐ Yes (check all that apply):

- ☐ Legal intervention due to mental health symptoms
- ☐ Housing change because of mental illness
- ☐ Suicide attempt or ideation

Member Last Name: Date of Birth:

**9. continued**

☐ Other (specify)

Date of Service

**10. continued**

☐ Current Homelessness
☐ Homelessness within the past 6 months but not current
☐ Other

**11. Has the individual had a recent psychiatric/behavioral evaluation?**

☐ No ☐ Yes If yes, then what date?

## DEMENTIA

**12. Does the individual have a primary diagnosis of dementia or Alzheimer's disease?**

☐ No (proceed to 14)
☐ Yes
☐ No, the individual has dementia but it is not primary (proceed to 14)

**13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia?** ☐ No ☐ Yes (check all that apply):

☐ Dementia work up ☐ Comprehensive Mental Status Exam
☐ Other (specify):

## PSYCHOTROPIC MEDICATIONS

**14. Has the individual been prescribed psychotropic (mental health) medications now or within the past 6 months?** ☐ No ☐ Yes, list below

| Medication | Dosage MG/Day | Condition used to treat | Discontinued |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

## INTELLECTUAL DISABILITY (ID) & DEVELOPMENTAL DISABILITIES

**15. Does the individual have a diagnosis of intellectual disability (ID)?**

☐ No ☐ Yes

**16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?** ☐ No ☐ Yes

**17. Is there evidence of a cognitive or developmental impairment that occurred prior to age 18?** ☐ No ☐ Yes

**18. Has the individual ever received services from an agency that serves people with ID?** ☐ No ☐ Yes – which agency?

**19. Does the individual have a diagnosis which affects intellectual or adaptive functioning?**

☐ No ☐ Autism ☐ Epilepsy ☐ Blindness
☐ Yes – (specify) ☐ Cerebral Palsy ☐ Closed Head Injury
☐ Deaf ☐ Other

**21. If yes to #19, did this condition develop prior to age 22?**

☐ No ☐ Yes

**20. Are there substantial functional limitations in any of the following?**

☐ No ☐ Mobility ☐ Self-Care
☐ Yes (specify) ☐ Self Direction ☐ Learning
☐ Understanding/Use of Language
☐ Capacity for living independently

## EXEMPTION AND CATEGORICAL DECISIONS - THIS SECTION APPLIES ONLY TO PERSONS WITH KNOWN OR SUSPECTED MI AND/OR ID/RC

**22. *Does the admission meet criteria for 30 day Convalescent Care?**

☐ No ☐ Yes, meets the following criteria below:

Admission to Nursing Facility directly from hospital after receiving acute medical care

The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services

There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I at such time that is appears the individual's stay will exceed 30 days.

**23. Does the individual meet the following criteria for Respite admission for up to 30 calendar days:**

☐ No ☐ Yes, meets the following criteria below:

The individual requires respite care for up to 30 calendar days to provide relief to the family or caregiver

There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I at such time that is appears the individual's stay will exceed 30 days.

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**24. Does the individual meet one of the following criteria for NF approval as a result of terminal state or severe illness?:**

☐ No ☐ Yes, meets the following criteria below:

☐ **Terminal Illness**

Prognosis if life expectancy of < 6 months (records supporting the terminal state must be present)
There is no current risk to self or others and behaviors/symptoms are stable

☐ **Severe Illness**

Coma, ventilator dependent, brain-stem functioning, progressed ALS progressed Huntington's etc. so severe that the individual would be unable to participate in a program of specialized care associated with his/her MI and/or ID/RC. (documentation of the individual's medical status must be present)
There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I if the individual's medical state improves to the extent that she/he could potentially benefit from a program of services to address his/her MI and/or ID/Related Condition needs.

☐ No referral necessary for any Level II

☐ Yes a referral for Level II determination for MI only

☐ Yes a referral for Level II determination for ID only (ADES)

☐ Yes a referral for Level II determination for Dual ID/MI

**Signature of Member or Representative for Consent to a Level II PASRR**

***I understand that I am required to undergo a Level II evaluation as a condition of admission to or my continued residence in a Title XIX Medicaid Nursing Facility. I also give permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation.***

Member or Member's Representative Signature: Date

**25.** ***Primary Physician's Name*** Phone: Fax:

Street: City: State: Zip:

Additional Comments:

**Signature of Medical Professional Completing Level I PASRR**

***I understand that this report may be relied upon for payment of claims from Federal and State Funds, any willful falsification, or concealment of material fact may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge this information is true, accurate and complete. I acknowledge that information in this report may be shared with other State agencies.***

| Print Name: | Signature: | Date |
|---|---|---|
| Title: | Phone: | Fax: |

**Reviewer Individualized Specialized Service Recommendations (if applicable)**

☐ Evaluate psychotropic medications
☐ Supportive counseling
☐ Medication education
☐ Foreign language services

☐ Training in ADLs
☐ Explore/prepare for lower level of care
☐ Obtain prior behavioral health records to clarify need

☐ Training in self-health care management
Other (specify)
☐ No recommendations at this time