

Initial PASRR identification and evaluation must take place prior to admission to a Medicaid certified nursing facility (NF). If a referral for a Level II is indicated, the member must not be admitted to a Medicaid certified nursing facility until the Level II evaluation has been completed.

DEMOGRAPHICS

First Name: _____ Middle Initial: _____ Last Name: _____ Date: _____

Date of Birth: _____ Marital Status: M S W D Gender: M F

Payment Method: _____ AHCCCS ID #: _____ Medicare ID #: _____ Self-Pay:

Current Living Situation:
(Individual's Place of Residence)

<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Homeless <input type="checkbox"/> Home with Family <input type="checkbox"/> Home Alone <input type="checkbox"/> Group Home <input type="checkbox"/> Other

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Current Location:
(Individual's location at the time form is completed)

<input type="checkbox"/> Medical Facility <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Hospital ED <input type="checkbox"/> Community <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other

Name of Current Location/Facility: _____ Admission Date: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PASRR Level I Review Type: Pre-Admission Status Change Conclusion of a Time Limit Approval
If individual is in the facility < 30 days

EXEMPTIONS AND CATEGORICAL DETERMINATIONS (SECTION A)

*If any questions below result in a "yes" answer, **NO REFERRAL IS NECESSARY** and the remaining questions need not be answered. **Proceed to sections D and F.***

Does the admission meet criteria for 30 day Convalescent Care? No Yes, meets criteria below:

- Admission to the NF directly from hospital after receiving acute medical care, and
- The attending physician has certified, prior to NF admission, individual will require < 30 calendar days of NF services, and
- 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 it appears the individuals' stay will exceed 30 days*

Does the individual meet the following criteria for Respite admission for up to 30 calendar days?

No Yes, meets criteria below:

- The individual requires respite care for up to 30 calendar days to provide relief to the family or caregiver, and
- 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 it appears the individuals' stay will exceed 30 days*
 Does the individual meet one or more of the following criteria for NF approval as a result of terminal state or severe illness?

- No Yes, meets criteria below:
- Terminal Illness:
- Prognosis of life expectancy of < 6 months (records supporting the terminal state must be present), and
 - There is no current risk to self or others and behaviors/symptoms are stable.
- Severe Illness:
- Coma state, ventilator dependent, brain-stem dysfunction, progressed ALS, progressed Huntington's disease, etc., of such severity that the individual would be unable to participate in a program of specialized care associated with his/her MI and/or ID or related condition.
 - 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 s/he could potentially benefit from a program of services to address his/her MI and/or ID/RC.*

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

- No
- No, individual has dementia but it is not primary
- Yes *If yes, is corroborative testing or other information available to verify the presence of or progression of the Dementia? Check all that apply:* None Dementia workup Comprehensive Mental Status Exam
- Other (specify): _____

MENTAL ILLNESS (SECTION B)
 (ANSWER ALL QUESTIONS IF APPLICABLE)

<p>Does the individual have any of the following Serious Mental Illnesses (SMI)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected – <i>one or more of the following diagnoses is suspected</i></p> <p><input type="checkbox"/> Yes (check all that apply)</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Schizoaffective Disorder</p> <p><input type="checkbox"/> Major Depression</p> <p><input type="checkbox"/> Psychotic/Delusional Disorder</p> <p><input type="checkbox"/> Bipolar Disorder (Manic Depression)</p> <p><input type="checkbox"/> Paranoid Disorder</p>	<p>Does the individual have any of the following mental disorders?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected – <i>one or more of the following diagnoses is suspected</i></p> <p><input type="checkbox"/> Yes (check all that apply)</p> <p><input type="checkbox"/> Personality Disorder</p> <p><input type="checkbox"/> Anxiety Disorder</p> <p><input type="checkbox"/> Panic Disorder</p> <p><input type="checkbox"/> Depression (mild or situational)</p> <p><input type="checkbox"/> Other (list): _____ <i>*Do not list Dementia here</i></p>	<p>Does the individual have a substance related disorder?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>List all substance related diagnoses: _____</p> <p>Is NF need associated with this diagnosis? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>When did the most recent substance use occur?</p> <p><input type="checkbox"/> ≤ 7 days <input type="checkbox"/> 7-14 days</p> <p><input type="checkbox"/> 14-28 days <input type="checkbox"/> 28 days – 2 months</p> <p><input type="checkbox"/> 2-3 months <input type="checkbox"/> Unknown</p>
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SYMPTOMS
(ANSWER ALL QUESTIONS IF APPLICABLE)

<p>Interpersonal – Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions or unstable employment <input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers 	<p>Concentration/Task related symptoms – Has the individual exhibited any of the following symptoms or behaviors (not due to a medical condition)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty completing tasks that s/he should be capable of completing <input type="checkbox"/> Required assistance with tasks for which s/he should be capable <input type="checkbox"/> Substantial errors with tasks which s/he completes
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Adaptation to Change – Has the individual exhibited any of the following symptoms related to adapting to change? (Check all that apply)

<ul style="list-style-type: none"> <input type="checkbox"/> Self injurious or self-mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm) 	<ul style="list-style-type: none"> <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious lack of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm) 	<ul style="list-style-type: none"> <input type="checkbox"/> 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: _____ _____ _____
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HISTORY OF PSYCHIATRIC TREATMENT
(ANSWER ALL QUESTIONS IF APPLICABLE)

<p>Currently, or within the <u>past 2 years</u>, has the individual received any of the following mental health services?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inpatient psychiatric hospitalization <input type="checkbox"/> Partial hospitalization/day treatment <input type="checkbox"/> Residential treatment <input type="checkbox"/> Other: _____ <p>Date of Service: _____</p>	<p>Currently, or within the <u>past 2 years</u>, has the individual experienced significant life disruption because of mental health symptoms?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Legal intervention due to mental health symptoms <input type="checkbox"/> Housing change because of mental illness <input type="checkbox"/> Suicide attempt or ideation <input type="checkbox"/> Current homelessness <input type="checkbox"/> Homelessness within the past 6 months (but not current) <input type="checkbox"/> Other: _____
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Has the individual had a recent psychiatric/behavioral evaluation?

No Yes If yes, what date: _____

PSYCHOTROPIC MEDICATIONS
(COMPLETE THIS SECTION IF APPLICABLE)

Has the individual been prescribed psychotropic (mental health) medications now or within the last 6 months?

No Yes (list below):

Medication	Dosage MG/Day	Condition used to treat	Discontinued?
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

INTELLECTUAL DISABILITY (ID) AND DEVELOPMENTAL DISABILITIES (DD) (SECTION C)
(ANSWER ALL QUESTIONS IF APPLICABLE)

Does the individual have a diagnosis of intellectual disability (ID)? No Yes

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

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

Has the individual ever received services from an agency that serves people with ID? No Yes

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

- No Yes:
- Autism Epilepsy
 - Blindness Cerebral Palsy
 - Closed head injury Other

Are there substantial functional limitations in any of the following?

- No Yes:
- Mobility Self-Care
 - Self-Direction Learning
 - Understanding/Use of Language
 - Capacity for living independently

If yes, did this condition develop prior to age 22?
 No Yes

REFERRAL DETERMINATION (SECTION D)

- No referral necessary for any Level II
- Yes, referral for Level II determination for ID only (ADES)
- Yes, referral for Level II determination for MI only
- Yes, referral for Level II determination for Dual ID/MI

Reviewer Individualized Service Recommendations (if applicable):

- Evaluate psychotropic medications
- Supportive counseling
- Explore/prepare for lower level of care
- Other:
- Training in ADLs
- Medication education
- Obtain prior behavioral health records to clarify need
- Training in self-health care management
- Foreign Language services

SIGNATURE OF INDIVIDUAL OR HEALTH CARE DECISION MAKER FOR CONSENT TO A LEVEL II PASRR (SECTION E)

THE INDIVIDUAL MUST SIGN HERE, OR IF THE INDIVIDUAL HAS A HEALTH CARE DECISION MAKER (AS SPECIFIED IN AMPM 320-I), THE HEALTH CARE DECISION MAKER MUST SIGN HERE. IF THERE IS NO HEALTH CARE DECISION MAKER AND THE INDIVIDUAL CANNOT SIGN DUE TO HIS/HER MI/ID ISSUES, A DOCTOR MAY SIGN ALONG WITH SUBMITTING A STATEMENT INDICATING THE REASON FOR HIS/HER SIGNATURE.

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. (Primary Care Physician information must be completed)

Individual or Health Care Decision Maker Signature: _____ Date: _____

Primary Physician's Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Additional Comments: _____

SIGNATURE OF MEDICAL PROFESSIONAL COMPLETING LEVEL I PASRR (SECTION F)

I understand that this report may be relied upon for payment of claims from Federal and State funds, and 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: _____ Email: _____

*The PASRR Level I Screening Tool must be completed in its entirety and the following documents must be submitted in order for the request to be processed:

- Hospital or Facility Face Sheet/Demographics
- Current History and Physical
- Current medication list
- Health Care Decision Maker documentation and information (if applicable)
- Current Nurses/Physicians progress notes (last 2 days prior to transfer)
- Any recent psychiatric consults and/or evaluations

Email the entire packet together.

For individuals with mental illness, please email to: PASRRProgram@azahcccs.gov
For individuals with an intellectual disability, please email to: DDDPASRR@azdes.gov