|  |  |  |  |
| --- | --- | --- | --- |
| PASRR Office for New Hampshire  3653 Cagney Drive, Suite 202  Tallahassee, FL 32309  Number: 1-844 526-4480  TDY: 1-855-843-4776  Fax: 1-844-490-9555  [NHReviews@kepro.com](mailto:NHReviews@kepro.com) |  |  | **New Hampshire**  **Pre Admission Screening and resident Review**  **(PASRR)** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PURPOSE:** Completion of this form is mandatory for all individuals applying for admission to a Medicaid certified nursing facility to determine the appropriateness of the nursing facility placement. | | | | | | |
| Name of person submitting form: | | | | | Date Submitted: | |
| Determination to be faxed to: | | | | Fax Number (required): | | |
| **SECTION 1. IDENTIFYING INFORMATION** | | | | | | |
| **INDIVIDUAL/APPLICANT** | | | | | | |
| Name: | | | Date of Birth: | | | |
| Gender:  Female  Male | Marital status:  Married  Divorced  Single  Widowed | | | | | |
| Home Address:  (not a PO Box) | | Phone (if any): | | | | |
| Current living situation:  Group home  Home alone  Homeless  Home with family  Hospital  Nursing facility  Other, specify: | | Other method of  contact, If applicable: | | | | |
| Special accommodations or translator:  Yes  No | | If needed, specify  accommodations: | | | | |
| **LEGAL REPRESENTATIVE/LEGAL GUARDIAN** | | | | | | |
| Legal representative’s name: | | | Phone: | | | |
| Address: | | | Other method  of contact: | | | |
| **ATTENDING PHYSICIAN** | | | | | | |
| Attending physician’s name: | | | Phone: | | | |
| Address: | | | Other method  of contact: | | | |
| **PAYOR SOURCE: CHECK ALL THAT APPLY** | | | | | | |
| Private Pay  Other insurance, if any:  Medicare Medicare number:  NH Medicaid NH Medicaid number: | | | | | | |
| **PROPOSED FACILITY** | | | | | | |
| Name of proposed facility for admission: | | | Phone: | | | |
| Address: | | | Contact’s name: | | | |
| **DISCHARGING FACILITY INFORMATION** | | | | | | |
| Name of discharging facility: | | | Phone: | | | NPI # (required): |
| Address: | | | Contact’s name: | | | |
| **REVIEW TYPE** | | | | | | |
| Pre-Admission screen  Conclusion of a time-limited approval  Significant change | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION 2. SCREENING FOR MENTAL ILLNESS (MI)** | | | |
| **2A. Suspected Diagnosis:** Has the individual been diagnosed with or is suspected of having MI?  Yes  No  **If not suspecting MI, proceed to section 3.** | | | |
| **PLEASE CHECK ALL THAT APPLY (SUPPLY ICD-10 CODES)** | | | |
| Bipolar  Delusional        Paranoia  Eating disorder, specify:  Major depression  Personality, specify: | | Psychosis  Schizophrenia/schizoaffective  Severe Anxiety/panic  Somatoform  Other, specify: | |
| **CURRENT PSYCHIATRIC MEDICATION** | | **PURPOSES OF MEDICATIONS** | |
|  | |  | |
|  | |  | |
|  | |  | |
|  | |  | |
| **PSYCHIATRIC TREATMENT HISTORY (WITHIN PAST 2 YEARS)** | | **PSYCHIATRIC INTERVENTIONS** | |
| Inpatient: hospital psych unit or psych facility | | At-home supportive services (daily living support) | |
| Partial hospital/day treatment (structured group) | | Housing intervention due to MI | |
| Associated with a mental health agency  Specify agency: | | Legal intervention due to MI | |
| Medication management | | Suicide attempt, specify date(s): | |
| Individual/group therapy | | Substance abuse intervention | |
| Other treatment, specify: | | Other intervention, specify: | |
| Comments: | | | |
| **2B. Interpersonal Function:** Please indicate if any of these symptoms occurred based in history.  If yes, please indicate how recent. | | | |
| Altercations  Avoidance of others  Easily upset/anxious  Evictions | Excessive irritability  Fearful of strangers  Hallucinations  Illogical comments | | Significant communication difficulties  Social isolation  Substance abuse  Other, specify: |
| Comments: | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2C. Concentration/Task Limitations:** Please indicate if any of these symptoms occurred based in history.  If yes, please indicate how recent. | | | | | |
|  | Difficulty keeping pace | |  | Serious difficulty concentrating | |
|  | Numerous errors in tasks in which the individual is capable of performing | |  | Serious difficulty completing age or cultural related tasks | |
|  | Requires assistance with tasks in which the individual should be physically capable of performing | |  | Unable to maintain employment | |
|  | Serious loss of interest in tasks or hobbies | |  | Other, specify: | |
| Comments: | | | | | |
| **2D. Adaptation to Changes:** Please indicate if these symptoms occurred due to history of possible MI (not due to medical conditions). If yes, please indicate how recent.  . | | | | | |
|  | Appetite disturbance | |  | Self-injurious, specify: | |
|  | Agitation due to adaption to changes | |  | Self-mutilation, specify: | |
|  | Irritability (sustained) | |  | Tearfulness (sustained) | |
|  | Mental health intervention due to increased symptoms | |  | Withdrawal due to adaption to changes | |
|  | Judicial intervention due to increased symptoms | |  | Other, specify: | |
|  | Physical violence or threats, specify: | |  |  | |
| Comments: | | | | | |
| Any checked response in 2A **AND** any box in 2B, 2C, or 2D would indicate that the individual meets criteria for the presence of MI or that the presence of MI is suspected. If no boxes were checked in 2A **OR** if yes In 2A but **no boxes** in 2B, 2C, or 2D, MI is negative. Please proceed to section 3. | | | | | |
| **For PASRR office use only:** | | **Is there enough documentation to suspect MI?** | | | Yes  No |
| **Was the individual referred for a Level II?** | | | Yes  No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SECTION 3. SCREENING FOR INTELLECTUAL DISABILITY/**  **DEVELOPMENTAL DISABILITY (ID/DD)** | | | | | | |
| **3A. Suspected Diagnosis:** Has the individual been diagnosed with or is suspected of having an ID/DD?  Yes  No  **If not suspecting ID/DD, proceed to section 4.** | | | | | | |
| Individual has been diagnosed with ID/DD  Specify ID/DD, if known: | | | Individual has history of ID/DD services  Specify name of area agency: | | | |
| Age of onset was before 18-years-old  Specify age of onset, if known: | | | Individual history/condition are such that there are concurrent impairments in adaptive behavior for age group/ culture | | | |
| Individual has an IQ score of 70 or less through standardized cognitive testing (sub-average intelligence) | | | Substance abuse | | | |
| ID/DD is suspected but not diagnosed  Specify suspected ID/DD: | | | Comments: | | | |
| **3B. Concurrent Impairments:** Please check all limitations that apply based on history. | | | | | | |
| **CONCURRENT IMPAIRMENTS:** These include impairments in adaptive functioning that occurred prior to the age of 18 and are likely to continue. | | | | | | |
|  | Academic skills (functional) | | |  | Use of community resources | |
|  | Communication | | |  | Safety awareness | |
|  | Health | | |  | Self-care | |
|  | Home living | | |  | Self-direction | |
|  | Interpersonal skills (social) | | |  | Work | |
|  | Leisure | | |  | Other, specify: | |
| Comments: | | | | | | |
| When ID/DD is suspected or diagnosed prior to 18 years old as indicated above in section 3 box, ID/DD is screened as positive. If evidence is not present to suspect ID/DD, ID/DD is negative. Please proceed to section 4. | | | | | | |
| **For PASRR office use only:** | | **Is there enough documentation to suspect MI?** | | | | Yes  No |
| **Was the individual referred for a Level II?** | | | | Yes  No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SECTION 4. SCREENING FOR RELATED CONDITION (RC)** | | | | | |
| **4A. Suspected Diagnosis:** Has the individual been diagnosed with or is suspected of having an RC?  Yes  No  *A related condition is a disability that is attributable to traumatic brain injury, autism spectrum disorder, epilepsy, cerebral palsy, or any other condition other than mental illness, found to be closely related to ID/DD because it impairs intellectual function or would require services normally provided to an individual with impaired intellectual function.*  **If not suspecting RC, proceed to section 5.** | | | | | |
| Individual has been diagnosed with RC  Specify RC, if known: | | | Individual has history of ID/DD services  Specify name of area agency: | | |
| Age of onset was before 22-years-old  Specify age of onset, if known: | | | Substance abuse | | |
| RC is suspected but not diagnosed  Specify suspected ID/DD: | | | Comments: | | |
| **4B. Functional Limitations:** Please check all limitations that apply based on history. | | | | | |
| **FUNCTIONAL LIMITATIONS:** These include physical, neurological, or sensory disabilities that occurred prior to the age of 22 and are likely to continue. | | | | | |
|  | Capacity for independent living | |  | Self-care | |
|  | Capacity for new learning | |  | Self-direction | |
|  | Mobility | |  | Understanding/use of language | |
| Comments: | | | | | |
| When RC is suspected or diagnosed prior to 22 years old as indicated above in section 4 box, RC is screened as positive. If evidence is not present to suspect RC, RC is negative. Please proceed to section 5. | | | | | |
| **For PASRR office use only:** | | **Is there enough documentation to suspect MI?** | | | Yes  No |
| **Was the individual referred for a Level II?** | | | Yes  No |

|  |  |  |
| --- | --- | --- |
| **SECTION 5. UNDIAGNOSED CONDITION** | | |
| Is there evidence that the individual has an undiagnosed condition?  Yes  No | | |
| If yes, please specify undiagnosed indicators and interventions, if any: | |  |
| Comments: |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If not applying for an exemption/exclusion, please proceed to section 7.  **SECTION 6. EXEMPTION/EXCLUSION**  Please indicate the applicable situation for temporary, time-limited admission consideration. If the stay will be a hospital discharge exemption or dementia exclusion (MI only), proceed to page 8 for signature **and** to page 9 to conclude PASRR involvement. Please forward this Level I PAS with the individual to the facility. | | | | |
|  | | | | |
| **HOSPITAL DISCHARGE EXEMPTION** | | **DEMENTIA EXCLUSION** | | |
| **Hospital discharge:**  He-M 1302.05 Criteria   * Individual is admitted to a NF from a hospital after receiving acute care. * Requires services for the same condition for which he/she received acute care at the hospital. * Individual needs NF services. * Attending physician certifies the individual is likely to require NF services *less than* 30 days.   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name of physician certifying the individual will require less than 30 days of NF services  Date:  Note: If the NF stay is 30 days or longer, a new PASRR screen and resident review must be performed within 40 calendar days of admission. | | **Dementia – only for MI**  Check all indicators that apply:     |  |  | | --- | --- | | Advanced dementia  Alzheimer’s | Organic disorder | | Disorientation to:  Person  Place | Situation  Time | | Paranoid ideation | | | Severe appetite disturbance | | | Short term memory loss | | | Significant confusion | | | Sleep disturbance | | | Other, specify: | |   Was a thorough mental status exam completed?  Yes  No  Based on documentation, does dementia appear to be the **primary** diagnosis?  Yes  No | | |
| If not applying for categorical, please proceed to section 8. However, a signature is required below.  **SECTION 7. CATEGORICAL DETERMINATIONS**  Please indicate the applicable situation to consider temporary, time-limited nursing facility admission | | | | |
|  | | | | |
|  | |  | | |
| Convalescent stay  Direct admit from hospital for same acute condition treated for at hospital based on physician’s order, the maximum length of stay is 90 days.  Acute condition:  Days requesting: | | Respite  Providing relief to the family or caregiver, the maximum length of stay is 20 days in on fiscal year.  Days requesting: | | |
| Delirium  Accurate diagnosis cannot be made until delirium clears; the maximum length of stay is 30 days.  Days requesting: | | Severe physical illness/condition  Diagnosis would impact level of functioning to the point that the individual would not be able to participate in programs/services associated with MI, ID/DD, or RC (e.g., coma), no risk to self or others. | | |
| Protective services  Referred to by state protective service agency, behavior symptoms are stable, no risk to self or others, maximum length of stay is 7 days.  Protective agency/contact: | | Terminal illness  Physician attests that the individual is estimated to have less than 6 months to live and is not at risk to self or others, behavior symptoms are stable. | | |
| If one of the above 6 categories is checked for temporary admission consideration, please attest that this information is accurate and that you have submitted the necessary documentation required (outlined below). | | | | |
| **MI INDIVIDUALS** | | **ID/DD/RC INDIVIDUALS** | | |
|  | History and Physical (H&P) |  | History and Physical (H&P) | |
|  | Detailed social history | |
|  | PASRR referral form |  | PASRR referral form | |
|  | Psychiatric consultation/evaluation |  | Psychometric testing/IQ, if available | |
| **Medical professional signature is required below for ALL Level 1 screens:** | | | | |
| **ATTESTATION TO ACCURATE INFORMATION** | | | | |
| I certify that this Level I screen information is accurate to the best of my knowledge:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name of medical professional  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of medical professional  *(Credentials need to be a MD, APRN, or PA)* | | | | Date: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 8. LEVEL I SCREENING SUMMARY**  As of 3/15/15, Level II PASRRs are completed face-to-face to facilitate a person-centered review process. Below, please indicate the applicable situation you are requesting for MI, ID/DD, or RC | | | | | | | | | |
| **Not requiring PASRR involvement** | | **MI** | | **ID/DD** | | | | | **RC** |
| Dementia exclusion | |  | | | | |  |
| Not MI | | Not ID/DD | | | | | Not RC |
| Hospital discharge 30 day exemption | | Hospital discharge 30 day exemption | | | | | Hospital discharge 30 day exemption |
| **Requires PASRR involvement** | | Categorical | | Categorical | | | | | Categorical |
| Level II face-to-face | | Level II face-to-face | | | | | Level II face-to-face |
|  | | | | |  | | | | |
| **Length of stay requesting for Level II** | | Long-term care | Short-term care | | | | Specify length of stay (days)  Requesting: | | |
| For individuals suspected of having MI, ID/DD, or RC who do not meet categorical criteria, submit the following forms for ALL full Level II screens. Please check all forms that are being submitted. | | | | | | | | | |
| **ALL LEVEL I SCREENS** | | | | | **ADDITIONAL FORMS FOR MI** | | | | |
|  | PASRR referral form | | | |  | Psychiatric consultation/evaluation | | | |
|  | Discharge summary | | | |  | Mental health assessment | | | |
|  | History and Physical (H&P) | | | | **ADDITIONAL FORMS FOR ID/DD, or RC** | | | | |
|  | Medical Eligibility Assessment (MEA) (Medicaid only) | | | |  | Agency Service Agreement or IEP | | | |
|  | Medication (current med lists) | | | |  | Detailed social history | | | |
|  | Neurological assessment | | | |  | Psychometric testing/IQ, if available | | | |
|  | Nursing/MD notes (2 weeks) | | | |  | Other, specify: | | | |
|  | OT/PT/SLP evaluations | | | |
|  | Specialty assessments | | | |
|  | | | | | | | | | |
| **PERSON COMPLETING THIS LEVEL I FORM** | | | | | | | | | |
| Name and title of person who completed this form:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name of person completing this form  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of person completing this form | | | | | | | | Date: | |
| **Please submit to Kepro PASRR team via:**  **FAX:** 1-844-490-9555  **Mail:** 400 Technology Way  Scarborough, ME 04074 | |