SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Department of Health and Human Services
Preadmission Screening and Resident Review (PASRR)

LEVEL I PASRR SCREENING TOOL

For serious mental illness and/or intellectual disability or related disability

Preadmission screening and resident review (PASRR) is a federal requirement documented in the Code of Federal Regulations, Title 42, Part 483, Subpart C. PASRR is a process to identify people with a serious mental illness, intellectual disability or related disability, who apply to, or reside in, a Medicaid-certified nursing facility to ensure that nursing facility admission is appropriate. PASRR is also intended to ensure that people with a serious mental illness, intellectual disability or related disability are receiving all the necessary specialized services.

This screening must be completed for **ALL** persons applying for admission to a Title XIX-certified nursing facility (facility that accepts Medicaid), regardless of the payment source for the nursing facility services AND the individual's known diagnosis.

Applicant's legal name *(print)* _____

Social Security number _____ **Date of birth** _____

Medicaid identification number *(If applicable.)* _____

Date of review_____

Present location of applicant being evaluated _____

☐ Nursing facility ☐ Hospital ☐ Home ☐ Assisted living facility ☐ Group home ☐ Other

List all medical diagnosis. *(Do not include ICD codes.)* _____

_____

_____

_____

_____

_____

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_____

Applicant's Name _____

Section 1: Mental Illness

Mental illness or suspected serious mental illness *(Check all that apply.)*

☐ Anxiety
☐ Bipolar disorder
☐ Delusional disorder
☐ Dissociative disorder
☐ Major depressive disorder
☐ Obsessive-compulsive disorder
☐ Panic disorder
☐ Personality disorder
☐ Psychotic disorder
☐ Post-traumatic stress disorder
☐ Schizoaffective disorder
☐ Schizophrenia
☐ Somatic symptom disorder
☐ Substance abuse
☐ Other mental health diagnosis/disorder that may result in disability *(Specify.):* _____

A. Has the applicant shown any of the following behaviors? *(Check all that apply.)*

Self-injurious or self-mutilating behaviors *(Check all that apply.)*

☐ Danger to others, aggressive, assaultive
☐ Danger to self, suicidal ideation, threats or attempts
☐ Serious loss of interest in things that used to be pleasurable

Interpersonal functioning *(Check all that apply.)*

☐ Serious difficulty interacting appropriately and communicating effectively
☐ History of altercations ☐ History of evictions ☐ History of job loss ☐ Fear of strangers
☐ Avoidance of interpersonal relationships/social isolation

Concentration, persistence and pace *(Check all that apply.)*

☐ Serious difficulty in sustaining focused attention ☐ Serious difficulty in maintaining concentration
☐ Inability to complete simple tasks
☐ Serious difficulty in adapting to changes (agitation, exacerbated symptomology, requires intervention)
☐ Other *(Specify.):* _____

Note: The individual's mental Illness must have resulted in functional limitations in major life activities within the past three to six months.

B. Has the applicant had any of the following DUE TO A MENTAL ILLNESS?

If **YES,** please provide as much of the information below as is known to you.

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

☐ 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 ☐ Unknown

☐ Law enforcement intervention.
☐ Yes ☐ No ☐ Unknown Date: _____

Applicant's Name _____

C. Mental illness treatments and/or services *(Check all that apply.)*

☐ Currently receiving services for mental illness ☐ Previously received services for mental illness

☐ Referred for mental illness services ☐ Additional information _____

If **YES,** then provide the name of the facility/provider. _____

D. Significant change *(For nursing facility use.)*

For a significant change, indicate the **date** of the significant change.

Date: _____

☐ Significant change in physical or mental condition

☐ Major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff

☐ Has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both

Note: Applicants who have attempted suicide within the last two years or who may be considered a danger to self or others MUST be referred for a Level II PASRR evaluation.

Section II: Intellectual Disability Or Related Disability

A. Intellectual disability or suspected intellectual disability *(Check all that apply.)*

☐ Current diagnosis of an intellectual disability - 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

Note: The presence of intellectual disability or the suspicion of intellectual disability must be referred for a Level II PASRR evaluation.

B. Related disabilities *(Check all that apply.)*

☐ Onset prior to 22 years of age.

Age of onset: _____

☐ Autism

☐ Cerebral palsy

☐ Down syndrome

☐ Epilepsy

☐ Fetal alcohol syndrome

☐ Muscular dystrophy

☐ Prader-Willi

☐ Spina bifida

☐ Traumatic brain injury

☐ Other *(Specify.)* _____

Functional criteria *(Check all that apply.)*

Results in substantial functional limitations in three or more major life activities.

☐ Likely to continue indefinitely

☐ Capacity for independent living

☐ Learning

☐ Mobility

☐ Self-direction

☐ Self-care

☐ Understanding and use of language

Applicant's Name _____

Finding is based on *(Check all that apply.)*

☐ Documented history ☐ Behavioral observations ☐ Individual, legal representative or family report medications

☐ Other *(Specify.)* _____

Note: If three or more of the criteria are met or these conditions result in substantial limitations that severely alter everyday functioning, they must be referred for Level II PASRR evaluation.

Section III: Other Indications for PASRR Screen Decision Making

1. Does the applicant have a primary diagnosis of dementia? ☐ Yes ☐ No
   Related neurocognitive disorder (including Alzheimer's disease)? ☐ Yes ☐ No
2. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is a serious mental Illness or intellectual disability? ☐ Yes ☐ No
3. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)? ☐ Yes ☐ No *(Check all that apply.)*
   - ☐ Dementia work-up
   - ☐ Comprehensive mental status exam
   - ☐ Medical/functional history prior to onset
   - ☐ Other (Specify.): _____

PASRR regulations related to a dementia diagnosis permit Level II evaluations to be **terminated** if the Level II evaluator finds the following:

1. The individual does not have mental illness, intellectual disability or a related disability.
2. The individual has a confirmed primary diagnosis of dementia, including Alzheimer's disease or a related disorder.
3. A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness and does not have a diagnosis of intellectual disability or a related condition.

Note: The PASRR process cannot be halted if the person has an intellectual disability, regardless of the presence of dementia.

Section IV: Level I PASRR Completion

☐ **Proceed to Level II evaluation based on mental illness indicators.** *(Must have at least one of the indicators below).*

- Mental Health diagnosis + impairment + hospitalization or treatment
  Note: The individual need not have received treatment. The severity of the impairment and how recently it occurred are important, not whether the individual was hospitalized or was seen by a mental health professional.
- Suicide attempt within the last two years
- Considered to be a danger to self or others

Applicant's Name _____

☐ **Proceed to Level II evaluation based on intellectual disability Indicators**.

- The presence of an intellectual disability MUST be referred for Level II review.
- For a related disability, if three or more of the criteria are met or these conditions result in substantial limitations that severely alter everyday functioning, they must be referred for Level II PASRR.
- Note: The presence of a dementia diagnosis with intellectual disability does not cancel the need for Level II evaluation.

☐ **No further evaluation recommended, but indicators present.**

Mental health diagnosis present and controlled with medication and no impairment or hospitalizations or treatment.

☐ **No further evaluation recommended.**

No mental health diagnosis, intellectual disability or related disability, impairments or hospitalization or treatment.

Section V: Advanced Categorical Determination
(SCDHHS/CLTC Use Only)

Categorical decisions and exemptions apply to people with Level II conditions to expedite decisions regarding a person's needs when a full Level II assessment is not necessary or can be delayed.

☐ The individual could not participate in or benefit from specialized services due to a comatose or semi-comatose state or functioning at brain stem level, as documented in the medical record.

☐ The individual has an illness which results in a level of physical impairment so severe the individual cannot be expected to benefit from specialized services.

☐ The individual has a diagnosis of dementia in combination with an intellectual disability or related disability. In these cases, the dementia diagnosis must be substantiated by a mini-mental state examination.

☐ The individual is being admitted to the nursing facility on a provisional basis for a period not to exceed 14 calendar days to provide respite for in-home caregivers.

☐ The individual is being admitted to the nursing facility on a provisional basis not to exceed seven calendar days while alternative arrangements can be made. The admission must be at the request of the South Carolina Department of Social Services Division of Protective Services due to suspicion of abuse or neglect on an emergency basis. The Level II evaluation must be completed within seven days of admission, on or before (date) _____

☐ The individual is being admitted directly to the nursing facility from acute inpatient care for a period not to exceed 30 calendar days, as certified by the attending physician. The admission must be for treatment of the same condition that necessitated the hospitalization and must not be due to a psychiatric condition. If the individual's stay at the nursing home exceeds 30 calendar days, the Level II process **MUST** be completed by the fortieth calendar day. It is the CLTC reviewer's responsibility to monitor all assigned cases for advanced determinations and the time frame of a case for advanced determination.

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

Applicant's Name _____

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.

Information obtained from *(Check all that apply.)*

☐ Applicant ☐ Medical Records ☐ Family ☐ Other *(Specify.)*_____

Screener's name *(Printed)* **_____**

Signature _____

Credentials_____Date_____Phone_____

Place of employment: _____

Fax _____ Email _____

Admitting nursing facility: _____ Date of Admission (If known): _____

Note: Send accompanying documentation with completed Level I PASRR screen.

_____

FOR CLTC USE ONLY

Reviewed by nurse consultant _____

Date PASRR reviewed _____