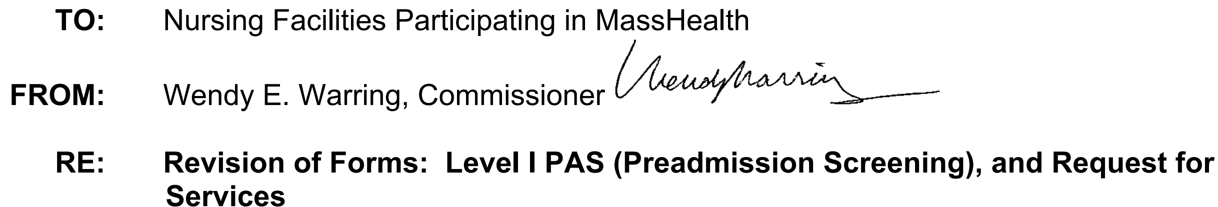
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth
Nursing Facility Bulletin 121
October 2002

TO: Nursing Facilities Participating in MassHealth

FROM: Wendy E. Warring, Commissioner



RE: Revision of Forms: Level I PAS (Preadmission Screening), and Request for Services

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Background

The Division is updating two of its nursing facility forms in an effort to facilitate communication between nursing facility providers and the Division.

Revision to Level I Preadmission Screening *Form*

The *Level I PAS* has been revised. Effective **October 1, 2002**, the Division will accept only the revised form. Before admission, the nursing facility must complete the *Level I PAS* for all admissions, regardless of payment source. If the *Level I PAS* indicates a need for Level II PAS, the nursing facility must make a referral to the Department of Mental Retardation (DMR) for individuals with mental retardation and/or developmental disability. For individuals with mental illness, a referral to a Health and Educational Services (HES)-contracted agent for the Department of Mental Health (DMH) must be made.

Revision to Request for Services *Form*

The *Request for Services* form (formerly called the *MassHealth Long Term Care Assessment* form for nursing facilities) has been revised. Effective October 1, 2002, the Division or its agent will accept only the *Request for Services* form. To determine the applicant's or member's clinical eligibility, nursing facilities must complete this form and submit it, with copies of the most recent comprehensive Minimum Data Set (MDS) 2.0 and the current quarterly MDS, to your local Aging Services Access Points (ASAPs), the Division's agent.

Completing the Forms

A nurse or social worker, licensed by the Massachusetts Board of Registration, must complete the *Level I PAS*.

A registered nurse, licensed by the Massachusetts Board of Registration in Nursing, must complete the *Request for Services* form.

Obtaining the MassHealth Forms

Copies of the *Level I PAS* and *Request for Services* forms are attached. You may photocopy the forms as needed. To obtain supplies of the forms, mail or fax a written request to the following address or fax number.

MassHealth
Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 617-576-4087

Effective Date

You must begin using these forms by **October 1, 2002**. Please discard all previous versions of these forms.

Questions

If you have any questions about this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

Request for Services

Date ______________________

Type of clinical eligibility determination all requested services.

Service(s) requested

- ☐ Pre-admission nursing facility (NF)
- ☐ Adult day health (ADH)
- ☐ Adult foster care (AFC)
- ☐ Group adult foster care (GAFC)
- ☐ Home and community based services (HCBS) waiver
- ☐ Program for All-inclusive Care for the Elderly (PACE)
- ☐ Other ______________________

Nursing facility use only

- ☐ Conversion
- ☐ Continued stay
- ☐ Short term review
- ☐ Transfer NF to NF
- ☐ Retrospective

Member information

Member/applicant

Last name	First name	Telephone	
Address		City	Zip

Check one

- ☐ MassHealth member — ______________ MassHealth ID number
- ☐ MassHealth application pending — ______________ Date application filed
- ☐ GAFC/ Assisted living residence — ______________ Date SSI-G application filed

Next of kin/Responsible party

Last name	First name	Telephone	
Address		City	Zip

Physician

Last name	First name	Telephone	
Address		City	Zip

Screening for mental illness, mental retardation, and developmental disability

Does the member/applicant have any of the following diagnoses/conditions? Check all that apply.

- ☐ Mental illness Specify: ______________________
- ☐ Mental retardation without related condition
- ☐ Developmental disability with related condition that occurred prior to age 22. **Check all that apply.**
  - ○ Autism
  - ○ Blindness/severe visual impairment
  - ○ Cerebral palsy
  - ○ Cystic fibrosis
  - ○ Deafness/severe hearing impairment
  - ○ Epilepsy/seizure disorder
  - ○ Head/brain injury
  - ○ Major mental illness
  - ○ Multiple sclerosis
  - ○ Muscular dystrophy
  - ○ Orthopedic impairment
  - ○ Speech/language impairment
  - ○ Severe learning disability
  - ○ Spina bifida
  - ○ Spinal cord injury

Name of member/applicant ______________________________

Community services recommended

Check all that apply.

○ Skilled nursing	○ HCBS waiver	○ Rest home	○ Homemaker
○ Physical therapy	○ Personal emergency response system	○ Elderly housing	○ Meals
○ Occupational therapy	○ Adult foster care	○ Adult day health	○ Transportation
○ Speech therapy	○ Group adult foster care	○ PACE	○ Chore service
○ Mental health services	○ Assisted living	○ Home health aide	○ Grocery shopping/delivery
○ Social worker services	○ Congregate housing	○ Personal care/homemaker	○ Other: __________

Additional information

1. Is the home or apartment available for the member or applicant? ○ yes ○ no
2. Is there a caregiver to assist the member in the community? ○ yes ○ no
3. Has the member or applicant experienced unexplained weight gain in the last 30 days? ○ yes ○ no
4. Does the member or applicant receive personal care/homemaker services? ○ yes ○ no

   If yes:

days per week	hours per week

5. Has the member or applicant experienced a significant change in condition in the last 30 days? ○ yes ○ no

   If yes: ☐ improvement ☐ deterioration

   Indicate the changes below. ______________________________

For nursing facility requests only

1. Does the nursing facility member/applicant express an interest to remain in or return to the community? ○ yes ○ no
2. Is the nursing facility stay expected to be short-term (up to 90 days)? ○ yes ○ no
3. Is the nursing facility stay expected to be long-term (more than 90 days)? ○ yes ○ no

Referral source Name of registered nurse completing this form

Signature	Print name	Title
Name of organization		Telephone
Address		City / Zip

For community providers: Attach the MDS-HC and Physician's Summary form according to provider's regulations/guidelines.

For nursing facility providers: Attach the most recent comprehensive MDS, current quarterly MDS, and current physician orders.

Level I Preadmission Screening (PAS)

This form must be completed by the nursing facility for all individuals who, regardless of payment source, are admitted to a nursing facility. This form must be kept permanently in the resident's medical record. A licensed nurse or licensed social worker employed by the nursing facility must complete both sides of this form **before the applicant's admission.**

Nursing Facility Provider Information	**Nursing Facility Applicant Information**
Provider Number: 0 9 __ __ __ __ __	MassHealth ID or SSN:
Name:	Name: Sex: F M
Address:	Address:
Town/Zip:	Town/Zip:
Telephone Number:	Date of Birth:

Section I. PAS for Mental Retardation or Developmental Disability

1. Does the nursing facility applicant have a documented diagnosis or treatment history of mental retardation or developmental disability? ☐ Yes ☐ No
2. Has the nursing facility applicant received services for mental retardation or developmental disability from an agency that serves individuals with mental retardation and/or developmental disability? ☐ Yes ☐ No
3. Does the nursing facility applicant exhibit any evidence that may indicate mental retardation or developmental disability? ☐ Yes ☐ No

Section II. Convalescent Care

Is the nursing facility applicant seeking admission for convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay? ☐ Yes ☐ No

Section III. Level I Determination for Mental Retardation or Developmental Disability Check all that apply.

☐ Level II PAS is not indicated because there is no diagnosis or evidence of mental retardation or developmental disability.

☐ Level II PAS is not indicated because the applicant is seeking admission for convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay.

☐ **Level II PAS is indicated and must be completed before admission.** Date of completion: ______________

☐ Approved by DMR for nursing facility admission. (The DMR approval letter must be in the medical record.)

Date of nursing facility admission:_________________________________

Comments: ____

____

Signature:______________________________ RN, LPN, LSW Date: _______________ Time:______________
(Circle one.)

NOTE: You must notify DMR only when MR/DD is indicated.

Did you call and notify DMR (508-977-8112) on the day of admission? • Yes (Date) _______________ ☐ No

Did you fax this page within 48 hours to DMR (508-977-8123)? ☐ Yes (Date) _______________ • No

Complete other side.

MA-NRS-1 (Rev. 10/02)
GEN-007

Name of Applicant:____

Section IV. PAS for Mental Illness

1. Does the nursing facility applicant have a documented diagnosis or treatment history of any of the following major mental disorders? Check all that apply.

Psychoses
- ☐ Schizophrenia
- ☐ Paranoia
- ☐ Atypical psychosis

Affective Disorders
- ☐ Schizo-affective disorder
- ☐ Bipolar disorder (formerly manic depression)
- ☐ Unipolar depression more than 10 years with psychiatric hospitalization or ECT psychoactive medication (date of diagnosis: ____________________)

Severe Anxiety and Somatoform Disorders All must apply for Level II PAS referral.
- ☐ Two years' duration with documented symptoms in the last six months
- ☐ Inpatient psychiatric treatment for anxiety disorder
- ☐ Psychoactive medication(s) administered for anxiety disorder

2. Does the nursing facility applicant exhibit any evidence of a major mental disorder? ☐ Yes ☐ No

3. Has the nursing facility applicant ever received any of the following treatments?
   a. Inpatient or outpatient psychiatric treatment ☐ Yes ☐ No
   b. Electro-convulsive therapy ☐ Yes ☐ No
   c. Psychoactive medications ☐ Yes ☐ No
   If yes: name of current medication(s) and dosage: ______________________________
   Reason for administration: ______________________________

Section V. Primary Diagnoses/Conditions

Does the nursing facility applicant have any of the following diagnoses or conditions or meet any of the following descriptions? Check all that apply.

- ☐ Alzheimer's disease or other dementia (requires supporting documentation)
- ☐ Comatose
- ☐ Ventilator dependent
- ☐ Terminal illness with less than six-month prognosis as certified by a physician
- ☐ Severe brain injury
- ☐ Unipolar depression, less than 10 years' duration
- ☐ Convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay (this does not include a psychiatric hospitalization)

End Stage (ES) (severe, debilitating and bed-bound, or bed-to-chair)
- ☐ ES COPD with 24-hour oxygen
- ☐ ES CHF with 24-hour oxygen
- ☐ ES Amyotrophic Lateral Sclerosis (ALS)
- ☐ ES Huntington's Chorea
- ☐ ES Parkinson's disease

Section VI. Level I Determination for Mental Illness Check all that apply.
- ☐ Level II PAS is not indicated because there is no diagnosis or evidence of mental illness as noted in Section IV.
- ☐ Level II PAS is not indicated because the applicant has one of the diagnoses or conditions in Section II.
- ☐ **Level II PAS is indicated and must be completed before admission.** Date of completion: ______________
- ☐ Approved by Health and Education Services (HES) for the Department of Mental Health for nursing facility admission. (The HES approval letter must be in the medical record.) Contact HES at 978-745-2440, x126.

Comments: ____

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Signature:______________________________ RN, LPN, LSW (Circle one.) Date: _______________ Time:______________

Level I and Level II PAS must be kept permanently in the medical record.