Massachusetts Executive Office of Health and Human Services

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL I SCREENING

SCREENING TYPE

☐ Preadmission ☐ Expiration of Exempted Hospital Discharge/Categorical Determination (Section G)

☐ Resident Review (Level I Screening form required if Significant Change in Condition: newly indicated Serious Mental Illness (SMI), exacerbation of SMI, or improvement/decline in condition.)

Date:

IDENTIFICATION AND BACKGROUND INFORMATION (Complete all items.)

NURSING FACILITY APPLICANT

Name:	☐ Male ☐ Female	Date of birth:
Home address:	Phone:	Cell:
	Email:	

Marital Status	Coverage Information (choose all that apply)	Accommodations or interpreter needed?
☐ Married	☐ MassHealth	☐ No ☐ Yes ☐ Unknown
☐ Divorced	☐ MassHealth pending	Specify accommodations and/or interpreter needs:
☐ Single	☐ Medicare	
☐ Widowed	☐ Private insurance	
	☐ Self (Private pay)	

Current Location

☐ Acute hospital
What was the primary medical reason for hospital treatment?:

☐ Chronic disease and rehabilitation hospital
What was the primary medical reason for hospital treatment?:

☐ Psychiatric hospital or unit
What was the primary medical reason for hospital treatment?:

☐ Nursing facility

☐ Emergency room
What was the primary medical reason for emergency room treatment?:

☐ Home/community

☐ Other:

Name of current facility (if applicable):

ATTENDING PHYSICIAN

Name:	Email:

PRIMARY CARE PHYSICIAN (PCP)

Name:	Email:

PATIENT REPRESENTATIVE/ADDITIONAL POINT OF CONTACT (if applicable)

Name:	Phone:	Cell:
Address:	Email:	

Relationship to applicant

☐ Child ☐ Spouse ☐ Parent ☐ Sibling ☐ Other:

Is this person an authorized representative designated to act on behalf of the patient?

☐ Yes ☐ No ☐ Unknown

If yes, proof of authorization

☐ power of attorney for health care ☐ invoked health care proxy ☐ legal guardian

☐ other:

ADMITTING NURSING FACILITY (if known)

Facility name:	Phone:	Fax:
Address:	Facility contact's name:	Professional title ☐ RN/LPN ☐ MEd ☐ Social worker ☐ PhD ☐ MD ☐ NP ☐ LMHC ☐ PA
	Email:	
Anticipated admission date:	Actual admission date: (for resident review or significant change)	

SECTION A: SCREEN FOR INTELLECTUAL OR DEVELOPMENTAL DISABILITY (ID/DD)

1. Does the applicant have a suspected or documented diagnosis, or treatment history, of ID with a date of onset **before age 18**?
   ☐ No ☐ Yes. List agency that provided services (if known) and diagnosis that pertains to ID.

Agency:

Diagnosis:

2A. Does the applicant have a suspected or documented diagnosis, or treatment history, of DD, also known as Related Condition, with a date of onset **before age 22**?

☐ No

☐ Yes. List diagnosis and agency that provided services (if known).

Agency:

Diagnosis:

2B. Does the individual's suspected or diagnosed severe, chronic disability meet ALL of the following criteria?

1) It is attributable to
   a) cerebral palsy or epilepsy; or
   b) any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID, and requires treatment or services similar to those required for those persons;
2) It is likely to persist throughout the individual's life; and
3) It results in substantial functional limitations in three or more of the following areas of major life activity:
   a) self-care;
   b) understanding and the use of language;
   c) learning;
   d) mobility;
   e) self-direction;
   f) capacity for independent living.

Have ALL of the preceding criteria been met?

☐ No ☐ Yes

ID/DD SCREENING RESULTS

3. If you answered YES to question 1 or if you answered YES to *both* question 2A *and* question 2B, check "Positive ID/DD screen" below. Otherwise, check "Negative ID/DD screen."

☐ Positive ID/DD screen
☐ Negative ID/DD screen (Level II PASRR Evaluation is not indicated.)

SECTION B: SCREEN FOR SERIOUS MENTAL ILLNESS (SMI)

4A. Does the applicant have one of the following documented diagnoses of a mental illness or disorder (MI/D)?

☐ No
☐ Unknown
☐ Yes. Check all that apply.

☐ Schizophrenia (any type)
☐ Somatoform disorder
☐ Delusional disorder*
☐ Mood (i.e., bipolar disorder, major depression)
☐ Post-traumatic stress disorder
☐ Severe anxiety/panic disorder
☐ Schizoaffective disorder
☐ Other psychotic disorder*
☐ Paranoia*
☐ Personality disorder
☐ Other mental disorder that may lead to a chronic disability

*Not medication-induced

4B. Does the applicant have a substance use disorder (SUD) that may lead to chronic disability?

☐ Yes ☐ No ☐ Unknown

Substance(s), if known:

Most recent use occurred?

☐ More than 90 days ago
☐ Less than 90 days ago
☐ Unknown

4C. Does the applicant have an eating disorder?

☐ Yes
☐ No
☐ Unknown

5A. **Within the past two years,** is the applicant known to have required one of the treatments listed below that is, or may be, due to mental illness or disorder (MI/D)?

☐ No
☐ Yes. Check all that apply.

☐ Inpatient psychiatric hospitalization
☐ Psychiatric day treatment
☐ Partial hospitalization program
☐ Intensive outpatient treatment
☐ Residential treatment
☐ Admission to a nursing facility
☐ Substance use disorder treatment
☐ DMH involvement/case management
☐ Outpatient/community mental health treatment
☐ Other:

5B. **Within the past two years,** did the applicant receive or would the applicant have benefited from one of the interventions listed below?

☐ No
☐ Yes. Check all that apply.

- ☐ Legal involvement (e.g., Rogers, eviction, criminal justice)
- ☐ Housing intervention (e.g., due to homelessness)
- ☐ Emergency mental health intervention (e.g., section 12, crisis team involvement, suicide attempt, overdose)
- ☐ Other significant disruption to living situation for which supportive services were required:

6. **Currently or within the past six months,** has the applicant had any limitation in major life activities in one of the areas listed below that is, or may be, due to mental illness or disorder (MI/D)?

☐ No
☐ Yes. Check all that apply.

Major Life Activity Areas/Functional Impairments

- ☐ Interpersonal functioning — serious difficulty interacting and/or communicating effectively with others: illogical comments, fear of strangers, frequently isolating or avoiding others, excessive irritability, easily upset or anxious, hallucinations, or a possible history of eviction, altercations, or unstable employment.
- ☐ Concentration, persistence, and pace — difficulty completing age-appropriate tasks and/or concentrating, completion timeliness, serious loss of interest, makes frequent errors, or requires assistance with activities/tasks that the applicant should be capable of accomplishing.
- ☐ Adaptation to change — significant difficulty adapting to typical change associated with employment, home, family or social interactions, agitation, withdrawal due to adaptation difficulties, self-injurious behavior, self-mutilation, suicidal talks/ideations, physically violent or threatening, judicial intervention, severe appetite disturbance, excessive tearfulness.

SMI SCREENING RESULTS

7. If you answered YES to question 5A, 5B, or 6, check "Positive SMI screen" in the list that follows. Otherwise, check "Negative SMI screen."

☐ Negative SMI screen (Level II PASRR Evaluation is not indicated).
Next step: If you answered "Positive ID/DD screen" to question 3, then proceed to Section C. Otherwise, complete Section F at the end of this form, file the form in the applicant's medical record, and admit the applicant.

☐ Positive SMI screen
Next step: Complete Section C.

SECTION C: EXEMPTED HOSPITAL DISCHARGE (EHD) (ID/DD AND/OR SMI)

8. Check all that apply.

The applicant is:

- ☐ Being admitted to a nursing facility directly from an acute hospital after receiving inpatient acute medical care
- ☐ In need of nursing facility services to treat the same medical condition treated in the acute hospital
- ☐ Not a current risk to self or others, and behavioral symptoms, if present, are stable
- ☐ Expected to stay in a nursing facility for less than 30 calendar days as certified by the hospital's attending or discharging practitioner

9. Did you check **ALL** of the boxes in Question 8?

☐ No. Go to Question 10.
☐ Yes. If the applicant screened positive for ID/DD, select **Option A** below. If the applicant screened positive for SMI, select **Option B** below. If the applicant screened positive for both ID/DD and SMI, select both **Options A** and **B**.

☐ **Option A: Applicant screened positive for ID/DD only. However, Level II PASRR Evaluation for ID/DD is not indicated *at this time* due to Exempted Hospital Discharge (maximum 30 calendar days).**

Next step: Complete contact information below as well as Section F, and file this form in the person's medical record and admit. Within 48 hours of admission to the nursing facility, notify DDS of the nursing facility to which an individual was actually admitted by sending an email to DDS at DDS.PASRR@mass.gov. The email must contain the following: (1) a completed Level I form and a physician's order certifying a nursing facility stay of less than 30 days unless they have already been submitted to DDS; (2) the patient's first and last name, date of birth, name of the admitting facility, and date of admission.

Contacted DDS PASRR office at phone number (617) 624-7796. Date:

Form submitted to DDS PASRR office. Date:

Name of DDS PASRR office staff contacted:

Certifying practitioner's name:

Certification date:

☐ **Option B: Applicant screened positive for SMI only. However, Level II PASRR Evaluation for SMI is not indicated *at this time** due to Exempted Hospital Discharge (maximum 30 calendar days).**

Next step: Complete contact information below as well as Section F, and file this form in the person's medical record and admit. Within 48 hours of admission to the nursing facility, notify DMH/Designee of the nursing facility to which an individual was actually admitted by sending an email to DMH/Designee at DMHPASRR@umassmed.edu. The email must contain the following: (1) a completed Level I form unless it has already been submitted to DMH; (2) the patient's first and last name, date of birth, name of the admitting facility, and date of admission.

Date form submitted to DMH PASRR office:

Date of admission/anticipated admission:

Certifying practitioner's name:

Certification date:

*If the nursing facility determines that the resident's stay will exceed the 30-day exemption period, the nursing facility must complete Section G in this form and submit the Level I form to DMH/Designee by no later than the 25th calendar day after admission.

10. Did you answer "Positive ID/DD screen" in Question 3?

☐ No. Go to Question 11.
☐ Yes. Select **Option C** below.
☐ **Option C: Level II PASRR Evaluation for ID/DD is required and must be completed by DDS before admission.**

Next step: Contact DDS at (617) 624-7796 or DDS.PASRR@mass.gov to request an individualized Preadmission Level II Evaluation, and complete the fields below. Complete Section F. Do not admit applicant to a nursing facility until Level II PASRR Evaluation is completed and admission approved.

Called/emailed DDS PASRR office. Date:
Form submitted to DDS PASRR office. Date:
Contacted DDS PASRR office staff. Date:

SECTION D: ADVANCED DEMENTIA EXCLUSION (ADE) (SMI ONLY)

11. Has the applicant screened positive for SMI only and the applicant also has a documented diagnosis of Alzheimer's disease and/or related dementias (ADRD) certified by a practitioner?

☐ No. Go to Section E. ☐ Yes

12. Which of the following were used to establish the Alzheimer's disease and/or related dementias (ADRD)? Check all that apply.

☐ Mental status exam
☐ Neurological exam/testing
☐ History and symptoms
☐ Unknown
☐ Other:

13. Has a practitioner documented and certified that Alzheimer's disease and/or related dementias (ADRD) are **both** primary and so advanced that the applicant would be unable to benefit from specialized services?
☐ No ☐ Yes

Name of certifying practitioner: Contact information:

Next step: Complete Section F, then submit this form and all supporting documentation for an Abbreviated Preadmission Level II Evaluation. Do not admit to a nursing facility until a Level II PASRR Determination Notice/written report has been received from DMH/Designee. Within 48 hours of admission to the nursing facility, notify DMH/Designee of the nursing facility to which an individual was actually admitted by sending the patient's first and last name, date of birth, name of the admitting facility, and date of admission to DMH/Designee at **DMHPASRR@umassmed.edu**.

SECTION E: CATEGORICAL DETERMINATION (CD) (SMI ONLY)

14. Has the applicant screened positive for SMI only, and does the applicant possibly qualify for a categorical determination?

☐ No. Complete Section F. Request a Preadmission Level II Evaluation from DMH/Designee. **Do not admit applicant to a nursing facility until a Level II PASRR Determination Notice/written report has been received from DMH/Designee. Within 48 hours of admission, the nursing facility must notify DMH/Designee of the nursing facility to which an individual was actually admitted by sending the patient's first and last name, date of birth, name of the admitting facility, and date of admission to DMH/Designee at DMHPASRR@umassmed.edu.**

☐ Yes. Check only one categorical determination below. Complete Section F. Submit this form and all supporting documentation to DMH/Designee for an Abbreviated Preadmission Level II Evaluation. **Do not admit to a nursing facility until a Level II PASRR Determination Notice/written report has been received from DMH/Designee. Within 48 hours of admission, the nursing facility must notify DMH/Designee of the nursing facility to which an individual was actually admitted by sending the patient's first and last name, date of birth, name of the admitting facility, and date of admission to DMH/Designee at DMHPASRR@umassmed.edu.**

CATEGORICAL DETERMINATIONS

☐ Severe Illness
- ☐ Coma
- ☐ Persistent vegetative state
- ☐ Parkinson's disease (End stage)
- ☐ Huntington's chorea (End stage)
- ☐ Congestive heart failure (CHF) (End stage)
- ☐ Chronic obstructive pulmonary disease (COPD) (End stage)
- ☐ Amyotrophic lateral sclerosis (ALS) (End stage)
- ☐ Chronic respiratory failure, ventilator dependent

☐ Convalescent care (Maximum 30 calendar days)*
☐ Provisional emergency (Maximum seven calendar days)*
☐ Respite (Maximum 15 calendar days)*
☐ Terminal illness

* The nursing facility must complete Section G below and resubmit the Level I form to DMH/Designee if the NF determines that the resident's stay will exceed the permitted duration. Requests must be made by no later than the 25th day after admission for convalescent care, the 2nd day after admission for provisional emergency, and 10th day after admission for respite.

SECTION F. CERTIFICATION

I certify that I am the person who completed this form and did so pursuant to all federal and state rules and regulations, and that the information provided is accurate to the best of my knowledge. I understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud. Name:	Professional title ☐ RN/LPN ☐ MEd ☐ Social worker ☐ PhD ☐ MD ☐ NP ☐ LMHC ☐ PA	
Organization:	Phone:	Fax:
Address:	Email:	
Signature: ..... :	Date:	Time: ☐ a.m. ☐ p.m.

SECTION G: EXPIRATION OF EHD/CD (SMI ONLY)

If you answered YES to Question 9 or answered YES to Question 14 and selected a time-limited categorical determination, and the resident now requires a Level II PASRR Evaluation from DMH/Designee, please select the reason for request.

- ☐ The nursing facility determined that the resident will not be discharged before the expiration of the **exempted hospital discharge (EHD)** and is requesting a Level II PASRR Evaluation from DMH/Designee.
- ☐ The nursing facility has determined that the resident will not be discharged before the expiration of the **categorical determination** selected below and is requesting a Level II PASRR Evaluation from DMH/Designee.
  - ☐ Convalescent care
  - ☐ Provisional emergency
  - ☐ Respite