LEVEL I SCREENING FORM

FORM INSTRUCTIONS

DETAILED FORM INSTRUCTIONS CAN BE FOUND ON THE PASRR WEBSITE AT:
https://maximusclinicalservices.com/svcs/south_dakota
*Indicates a required field. The PASRR will not be processed without these fields completed.

REMINDER – The entity completing this PASRR holds the responsibility of notifying the individual that the PASRR screening is being completed and the final outcome of the PASRR.

SCREENING TYPE

*WHAT TYPE OF PASRR SCREEN IS THIS?

☐ Pre-Admission (not currently residing in a NF) ☐ Resident Review (currently residing in a NF)

*If a Categorical is being requested, select appropriate option

Is the Terminal Illness Categorical outcome being requested? ☐ Yes ☐ No
(Applicable for Pre-Admission and Resident Reviews, requires documentation supporting end of life stage from physician)

Is the Severe Physical Illness Categorical outcome being requested? ☐ Yes ☐ No
(Applicable for Pre-Admission and Resident Reviews, requires valid and reliable documentation of severe physical illness)

Is the Convalescent 100 Day Categorical outcome being requested? ☐ Yes ☐ No
(Applicable for Pre-Admission only, must come from a hospital, requires a physician order)

Is the Respite Categorical outcome being requested? ☐ Yes ☐ No
(Applicable for Pre-Admission only, requires a physician order)

Is the Emergency Placement outcome being requested? ☐ Yes ☐ No
(Applicable for Pre-Admission only, requires documented involvement from Adult Protective Services or Law Enforcement and must follow the policy found in the PASRR provider manual
https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Institutional/PreAdmission_Screening_and_Resident_Review.pdf)

*RESIDENT REVIEW QUESTIONS (leave blank if Pre-Admission screen)

Is the review a result of a concluding 30-day Exempted Hospital Discharge? ☐ Yes ☐ No
End date:

Is the review a result of a concluding 100-day Convalescent Categorical? ☐ Yes ☐ No
End date:

Is the review a result of a concluding 30-day Respite Categorical? ☐ Yes ☐ No
End date:

Is the review a result of a concluding 7-day Emergency Placement Categorical ☐ Yes ☐ No
End date:

Is the review a result of a time limited Level II outcome by the State Mental Health Authority and/or State ID/DD Authority? ☐ Yes ☐ No
End date:

Is the review a result of a significant change in status? ☐ Yes ☐ No
Select change in status: ☐ Medication Change ☐ Symptom Change ☐ Diagnosis Change ☐ Recent Psychiatric Hospitalization ☐ Other

DEMOGRAPHICS		
*LAST NAME	*FIRST NAME	MI
*DATE OF BIRTH	*GENDER ☐ Male ☐ Female ☐ Other	
*CURRENT MAILING ADDRESS (street, city, state, zip)		
*SOCIAL SECURITY NUMBER	*MEDICAID ID (if applicable)	
*DOES THE INDIVIDUAL HAVE A LEGAL GUARDIAN? ☐ Yes ☐ No IF YES, ARE LEGAL GUARDIAN DOCUMENTS AVAILBLE FOR REVIEW? ☐ Yes ☐ No		
LEGAL GUARDIAN NAME (first and last)	LEGAL GUARDIAN PHONE NUMBER	
LEGAL GUARDIAN MAILING ADDRESS (street, city, state, zip)		
*WHAT HAS BEEN THE INDIVIDUAL'S TYPICAL LIVING SITUATION OVER THE LAST YEAR? ☐ Homeless ☐ Home Alone ☐ Home w/ family ☐ Home w/ supports ☐ Assisted Living ☐ Nursing Facility ☐ Group Home ☐ Other		
*WHERE DOES THE INDIVIDUAL SAY THEY WOULD LIKE TO LIVE WITHIN THE NEXT YEAR? ☐ Home ☐ Assisted Living ☐ Nursing Facility ☐ Group Home ☐ Other (explain)		

CURRENT LOCATION OF APPLICANT *Include best contact for interviews (if needed) in the Primary/Secondary Contact section.		
*WHERE IS THE INDIVIDUAL NOW? ☐ Inpatient Hospital ☐ Psychiatric Facility ☐ Home ☐ Group Home ☐ Assisted Living ☐ Nursing Facility ☐ Other (explain)		
*Current Location Name	*CITY	*STATE
*Current Location ADDRESS (if in home, include home address)	*ZIPCODE	*FAX
* PRIMARY CONTACT	*CONTACT EMAIL	*CONTACT PHONE
*SECONDARY CONTACT	*SECONDARY CONTACT EMAIL	*SECONDARY CONTACT PHONE

ADMITTING FACILITY (Only for Pre-Admission. Leave blank for Resident Review)		
*IS THE ADMITTING FACILITY KNOWN? ☐ Yes ☐ No		
FACILITY NAME (must write full name- no abbreviations)	CITY	STATE
FACILITY ADDRESS	ZIPCODE	FAX
FACILITY PRIMARY CONTACT	CONTACT EMAIL	CONTACT PHONE

ADMITTING DIAGNOSES
*PRIMARY DIAGNOSES WHICH LED TO THE NEED OF NURSING FACILITY LEVEL OF CARE
*DOES THE INDIVIDUAL HAVE A NEUROCOGNITIVE DISORER SUCH AS DEMENTIA/ALZHEIMER'S? ☐ No ☐ Yes If Yes, provide diagnosis (Reminder that Neurocognitive Disorders are not considered PASRR conditions and does not make the PASRR positive)

SERIOUS MENTAL ILLNESS SCREENING	YES	NO	SUSPECTED
*Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following disorders? (Required to check which disorder): ☐ Schizophrenia ☐ Schizoaffective ☐ Atypical psychosis ☐ Somatoform/Delusion/Paranoid Disorder ☐ Other psychotic disorder (not otherwise specified) ☐ Panic or Severe Anxiety Disorder ☐ Mood- Bipolar or Major Depressive Type ☐ Personality Disorder ☐ Post Traumatic Stress Disorder (If a diagnosis(es) are checked above, then mark Yes for the overall question.)	☐	☐	☐
*Is there evidence, based on available documentation, observations, interviews, and history that the individual has noted difficulty in the following areas related to their serious mental illness? Select all that apply: ☐ Interpersonal Functioning- difficulty interacting with others; altercations; evictions; unstable employment, frequently isolated; avoids others ☐ Completing Tasks- serious difficulty completing tasks; requires assistance with tasks; errors with tasks; difficulty with concentration; persistence and pace ☐ Adaptation to Change- self injurious or self-mutilation; suicidal; physical violence or threats; appetite disturbance; serious loss of interest; tearfulness; irritability; withdrawal (If any of the above are checked, then mark Yes for the overall question.)	☐	☐	☐
*Based on available documentation, observations, interviews, and history, within the last 2 years has the individual received any of the following services: Select all that apply: ☐ Psychiatric treatment episodes such as inpatient psychiatric care ☐ Referred to a mental health crisis center ☐ Has attended partial care/hospitalization for mental health needs ☐ Has received mental health case management services. (If any of the above are checked, then mark Yes for the overall question.)	☐	☐	☐

INTELLECTUAL – DEVELOPMENTAL DISABILITY SCREENING	YES	NO	SUSPECTED
*Does the individual have a confirmed or suspected diagnosis of an **intellectual disability** that was present prior to the age of 22? (An intellectual disability is a condition characterized by significant limitations in both intellectual functioning and adaptive behavior) If yes, specify diagnosis	☐	☐	☐
*Does the individual have a confirmed or suspected diagnosis of a **developmental disability** that was present prior to the age of 22? (A developmental disability is a chronic disability closely related to an intellectual disability that results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disabilities that require similar supports) If yes, select condition: ☐ Anoxia at birth ☐ Arthrogryposis ☐ Autism Spectrum Disorder ☐ Asperger Syndrome ☐ Cerebral Palsy ☐ Congenital Blindness ☐ Congenital Deafness ☐ Childhood Disintegrative Disorder ☐ Down Syndrome ☐ Encephalitis ☐ Epilepsy ☐ Expressive Language Disorder ☐ Fetal Alcohol Syndrome ☐ Fragile X Syndrome ☐ Friedreich's Ataxia ☐ Hydrocephaly ☐ Isodicentric Chromosome 15 Syndrome ☐ Klippel-Feil Syndrome ☐ Landau-Kleffner Syndrome ☐ Meningitis ☐ Pervasive Developmental Disorder ☐ Phenylketonuria (PKU) ☐ Polio ☐ Prader-Willi Syndrome ☐ Rett Syndrome ☐ Seizure Disorder ☐ Spina Bifida or Neuro Tube Defect ☐ Traumatic Brain Injury (TBI) ☐ Williams Syndrome ☐ XXY Syndrome ☐ Other (specify):	☐	☐	☐
*Is there evidence, based on available documentation, observations, interviews, and history that the individual has received special education services during their youth?	☐	☐	☐
*Is there evidence, based on available documentation, observations, interviews, and history that the individual has received services from an agency that provides supports to individuals with an intellectual or developmental disability?	☐	☐	☐
*Is there evidence, based on available documentation, observations, interviews, and history that the individual has substantial functioning limitation in any of the following areas related to the suspected or confirmed intellectual or developmental disability (ID/DD)? Select all that apply: ☐ Self-care skills are impacted due to the ID/DD ☐ Receptive and expressive language is affected due to the ID/DD ☐ Learning is impacted due to the ID/DD ☐ Mobility is impacted due to the ID/DD ☐ Self-direction is impacted due to the ID/DD ☐ Capacity for independent living is impacted due to the ID/DD ☐ Economic self-sufficiency is impacted due to the ID/DD (If one or more are selected, then mark Yes for the overall question.)	☐	☐	☐

SUPPORTING DOCUMENTATION CHECKLIST
***Please note that additional information may be requested at any time throughout the PASRR review**

PRE-ADMISSION
- ☐ Screening Form
- ☐ Demographic Face Sheet
- ☐ Current Medication List
- ☐ Psychological evaluation, if available
- ☐ Current History & Physical or Physician Progress Note (**must** include the diagnosis or assessment of the suspected SMI/ID/DD leading to the 'yes' or 'suspected' answer)

If requesting a categorical, please submit:
- ☐ Terminal Illness- medical provider statement
- ☐ Severe Physical Illness- medical provider statement
- ☐ 100 Day Convalescent- order by medical provider
- ☐ 30 Day Respite- order by medical provider
- ☐ Emergency Placement – APS/LE involvement

RESIDENT REVIEW
- ☐ New Screening Form
- ☐ Copy of Original Screening Form
- ☐ Demographic Face Sheet
- ☐ Current Medication List
- ☐ Copy of order for new diagnosis, medication, status change request reason (if applicable)
- ☐ Psychological evaluation, if available
- ☐ Current History & Physical or Physician Progress Note (**must** include the diagnosis or assessment of the suspected SMI/ID/DD leading to the 'yes' or 'suspected' answer)

*Are any questions under the Intellectual/Developmental Disability -or- Serious Mental Illness sections marked 'YES' or 'SUSPECTED'?

☐ No – This individual may be admitted without further evaluation and this form is to be saved in the individual's file.

☐ Yes – This individual needs to be referred to Maximus at PASRR@state.sd.us for further evaluation.

Referred to Maximus on _____ at _____
(date) (time)

_____ _____
*Signature of Designated Facility Representative *Date Signed

PASRR not valid if no signature or date