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KEPRO
INTELLIGENT VALUE

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:

This Level I PASRR screen must be filed in the individual's nursing facility record.

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	☐ Excessive irritability	☐ Significant communication difficulties
☐ Avoidance of others	☐ Fearful of strangers	☐ Social isolation
☐ Easily upset/anxious	☐ Hallucinations	☐ Substance abuse
☐ Evictions	☐ Illogical comments	☐ 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

☐ **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 <u>less than 30 days</u> 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 EXCLUSION

☐ **Dementia – <u>only for MI</u>**

Check all indicators that apply:

☐ Advanced dementia ☐ Alzheimer's	☐ Organic disorder
Disorientation to: ☐ Person ☐ Situation ☐ Place ☐ 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

HOSPITAL DISCHARGE EXEMPTION	DEMENTIA EXCLUSION
☐ 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

	MI	ID/DD	RC
Not requiring PASRR involvement	☐ 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

DOCUMENTATION CONFIRMATION/PASRR DISPOSITION

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NAME:_____ **MID#**_____ **DOB**_____

SUSPECTED DIAGNOSIS OF MI, ID/DD, OR RC

Documentation submitted is enough to suspect this individual/applicant may have a diagnosis of:

☐ MI	☐ ID/DD	☐ RC

☐ Documentation submitted is not enough to suspect this individual/applicant may have MI, ID/DD, or RC

REFERRAL

☐ This individual was referred for a Level II based on submitted documentation	Date of referral for Level II:
☐ This individual was not referred for a Level II based on submitted documentation	

CATEGORICAL GROUP DETERMINATION

☐ Meets categorical group determination criteria for a temporary stay	Days approved For temporary stay:
☐ This individual/applicant is approved to be admitted to the nursing facility beginning on and ending on .	

☐ Does not meet categorical group determination criteria

☐ Appeal rights were provided to individual/legal representative

RECOMMENDATION FOR SPECIALIZED SERVICES (SS) FOR CATEGORICAL DETERMINATION:

Are (SS) being recommended for categorical? ☐ Yes ☐ No

If recommending SS, please specify what type:

PASRR EVALUATOR REVIEWING THIS LEVEL I:

Name and credentials: _____ Printed name of PASRR evaluator _____ Signature of PASRR evaluator *(Include credentials such as CRC, QMHP, RN or social worker)*	Date: _____

This Level I PASRR screen must be filed in the individual's nursing facility record.