State of Florida Agency for Health Care Administration

Pre-Admission Screening and Resident Review (PASRR)
Level I Screening for Serious Mental Illness (SMI) / Intellectual Disability or Related Conditions (ID)
Use for Medicaid Certified Nursing Facility (NF) Only

_____ _____-_____-_____ _____
Name of Individual Being Evaluated (print) SSN* DOB (mm/dd/yyyy)

☐ Male ☐Female Age:_____

_____ _____ _____
Present Location of Individual Being Evaluated Street Address, City State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home

☐ Other _____ Individual's or Residency Phone Number: _____/_____/_____

_____ _____ _____
Legal Representative's Name (if applicable) Street Address, City State, Zip

Representative's Phone Number: _____/_____/_____

_____ _____
Medicaid Number if Applicable Screening Date (mm/dd/yyyy)

_____
Other Health Insurance Name and Number if Applicable

*WHY ARE WE ASKING FOR YOUR SOCIAL SECUITY NUMBER? Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you (42 CFR 435.910). You do not have to fill in your Social Security number, but if you do it will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so.

Section I: Nature of the Request for PASRR Level I Screening

☐ **Request for admission to an NF**

☐ **Resident Review of an individual already residing in an NF**

Significant Physical Change
- ☐ Improvement
- ☐ Decline

Significant Mental Change
- ☐ Improvement
- ☐ Decline

New Suspicion of SMI or ID
- ☐ SMI
- ☐ ID
- ☐ SMI and ID

Section II: PASRR Screen Decision-Making

☐SMI or suspected SMI (check all that apply):

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depressive Disorder
- ☐ Dissociative Disorder
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Somatic Symptom Disorder
- ☐ Other (specify)

_____

_____

- ☐ Substance Abuse

☐ID or suspected ID (check all that apply):

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Intellectual Disability with an IQ lower than 70 (specify):

_____

- ☐ Prader-Willi Syndrome
- ☐ Spina Bifida
- ☐ Other (specify)

_____

_____

Age of onset for intellectual disability?*	____Years
Age of onset for any related condition?*	____Years

*If known.

Finding is based on:

- ☐ Documented History
- ☐ Medications
- ☐ Behavioral Observation
- ☐ Individual, Legal Guardian, or Family Report
- ☐ Other (specify)

_____

Additional Information:

_____

_____

_____

_____

If any of the above items are checked, a Level II evaluation must be completed.

Other Indications for PASRR Screen Decision-Making

1. Is there an indication within the past 3 to 6 months the individual has a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐ Yes ☐ No

2. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

   A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been fired. ☐ Yes ☐ No

   B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐ Yes ☐ No

   C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances

associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐ Yes ☐ No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

   A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization). ☐ Yes ☐ No

   B. Within the last two years, due to the mental illness, 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

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others?
   ☐ Yes ☐ No

If any of the above items are checked YES, a Level II evaluation must be completed.

Section III: PASRR Screen Provisional Determination

☐ **Not a provisional admission**

☐ **Provisional admission (choose one of the following):**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____.
(mm/dd/yyyy)

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14 day time limit, on or before (date): _____.
(mm/dd/yyyy)

☐ The individual is being admitted under the 30-day hospital discharge exemption (attach Form 3008 and physician signature required below). If the individual's stay exceeds 30 days, the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _____.
(mm/dd/yyyy)

An attending physician's signature is required for those individuals admitted under this 30-day hospital discharge exemption. The signature is not necessary if already on the 3008 Form.

_____ _____
ATTENDING PHYSICIAN'S SIGNATURE DATE (mm/dd/yyyy)

If a provisional admission is indicated, the individual may enter the NF without a Level II evaluation if the Level I screen indicated a suspicion of SMI and/or ID. However, a Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES or DOH within the time frame indicated in Section III.

Section IV: PASRR Screen Completion

☐ **Individual <u>may</u> be admitted to the NF (check one of the following):**	☐ **Individual <u>may not</u> be admitted to the NF. Refer for Level II evaluation because there is a diagnosis or suspicion of:**	☐ **Significant change in a nursing facility resident:**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II evaluation not required.	☐ SMI	☐ SMI
☐ Provisional admission	☐ ID	☐ ID
	☐ SMI and ID	☐ SMI and ID

_____

Screener's Name (print)

_____

Signature

_____

Credentials

_____ **Date** (mm/dd/yyyy)

_____/_____/_____ **Fax**

_____/_____/_____ **Phone**

_____

Place of Employment

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

Completed Level I screen form **distributed to**:

☐ Local DOH** office, under the age of 21

Dates: _____ (mm/dd/yyyy)

☐ Local CARES*** Office, age 21 or older

Date: _____ (mm/dd/yyyy)

☐ Nursing Facility

Date: _____ (mm/dd/yyyy)

☐ Discharging Hospital if applicable

Date: _____ (mm/dd/yyyy)

Notice of referral for Level II, if applicable, **distributed to** (including information on how to obtain the evaluation):

☐ Individual/Representative
Date: _____ (mm/dd/yyyy)

If the individual requires a Level II evaluation, submit the completed Level I form, documented informed consent, completed AHCA 3008 form, other relevant medical documentation including case notes, medication administration records and any available psychiatric evaluation to CARES or DOH.

**Department of Health

*** Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services