POLICY 680-C – ATTACHMENT A – ARIZONA PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL I SCREENING TOOL

Initial Pre-Admission Screening and Resident Review (PASRR) identification and evaluation must take place prior to admission to a Medicaid certified Nursing Facility (NF). If a referral for a Level II is indicated, the member must not be admitted to a Medicaid certified NF until the Level II evaluation has been completed.

DEMOGRAPHICS

First Name: ______________________ Middle Initial: ____ Last Name: ______________________ Date: _________________

Date of Birth: _______________ Marital Status: ☐M ☐S ☐ W ☐D Gender: ☐M ☐F☐

Payment Method: AHCCCS ID #:________________ Medicare ID #:_________________

Self-Pay: ☐

Commercial: ☐

Current Living Situation: (*Individual's Place of Residence*)

☐Nursing Facility ☐Hospital ☐Homeless ☐Home with Family ☐Home Alone ☐Group Home ☐Other

Address: ________________________ City: ______________________ State: ____ Zip: ________ Phone: ________________

Current Location: (*Individual's location at the time form is completed*)

☐Medical Facility ☐Psychiatric Facility ☐Hospital ED ☐Community ☐Nursing Facility ☐Other

Name of Current Location/Facility: ______________________________ Admission Date: _____________________

Address: ________________________ City: ______________________ State: ____ Zip: ________ Phone: _______________

PASRR Level I Review Type: ☐Pre-Admission ☐ Status Change ☐ Conclusion of a Time Limit Approval *If individual is in the facility < 30 days*

Effective Dates: 11/27/18, 10/01/19, 05/15/23, 07/22/25
Approval Dates: 09/09/18, 09/05/19, 03/16/23, 05/29/25

EXEMPTIONS AND CATEGORICAL DETERMINATIONS (SECTION A)

If any questions below result in a "yes" answer, ***NO REFERRAL IS NECESSARY,*** *and the remaining questions need not be answered.* ***<u>Proceed to sections D and F.</u>***

Does the admission meet criteria for 30-day convalescent care? ☐ No ☐ Yes, meets criteria below:

- Admission to the NF directly from hospital after receiving acute medical care, and
- The attending physician has certified, prior to NF admission, individual will require < 30 calendar days of NF services, and
- There is no current risk to self or others and behaviors/symptoms are stable.

**The NF must update the Level I at such time that it appears the individual's stay will exceed 30 days*

Does the individual meet the following criteria for respite admission for up to 30 calendar days?

☐ No ☐ Yes, meets criteria below:

- The individual requires respite care for up to 30 calendar days to provide relief to the family or caregiver, and
- There is no current risk to self or others and behaviors/symptoms are stable.

**The NF must update the Level I at such time that it appears the individual's stay will exceed 30 days*

Does the individual meet one or more of the following criteria for NF approval as a result of terminal state or severe illness?

☐ No ☐ Yes, meets criteria below:

☐ Terminal Illness:

- Prognosis of life expectancy of < 6 months (records supporting the terminal state must be present), and
- There is no current risk to self or others and behaviors/symptoms are stable.

☐ Severe Illness:

- Coma state, ventilator dependent, brain-stem dysfunction, progressed ALS, progressed Huntington's disease, etc., of such severity that the individual would be unable to participate in a program of specialized care associated with their MI and/or ID or related condition.
- There is no current risk to self or others and behaviors/symptoms are stable.

**The NF must update the Level I if the individual's medical state improves to the extent, they could potentially benefit from a program of services to address their MI and/or ID/RC.*

Does the individual have a **primary** diagnosis of dementia or Alzheimer's disease?

☐ No

☐ No, individual has dementia, but it is not primary

☐ Yes, *If yes, is corroborative testing or other information available to verify the presence of or progression of the Dementia? Check all that apply:* ☐ None ☐ Dementia workup ☐ Comprehensive Mental Status Exam

☐ Other (specify):__________________

MENTAL ILLNESS (SECTION B) (Answer all questions if applicable)		
Does the individual have any of the following Serious Mental Illnesses (SMI)?	**Does the individual have any of the following mental disorders?**	**Does the individual have a substance related disorder?**
☐ No	☐ No	☐ No ☐ Yes
☐ Suspected – *one or more of the following diagnoses is suspected*	☐ Suspected – *one or more of the following diagnoses is suspected*	List all substance related diagnoses:
☐ Yes (check all that apply)	☐ Yes (check all that apply)	Is NF need associated with this diagnosis?
☐ Schizophrenia	☐ Personality Disorder	☐ No ☐ Yes
☐ Schizoaffective Disorder	☐ Anxiety Disorder	When did the most recent substance use occur?
☐ Major Depression	☐ Panic Disorder	☐ ≤ 7 days ☐ 7-14 days
☐ Psychotic/Delusional Disorder	☐ Depression (mild or situational)	☐ 14-28 days ☐ 28 days – 2 months
☐ Bipolar Disorder (Manic Depression)	☐ Other (list):__________________	☐ 2-3 months ☐ Unknown
☐ Paranoid Disorder	**Do not list Dementia here*	

SYMPTOMS
(Answer all questions if applicable)

Interpersonal – Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?

☐ No ☐ Yes:

- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

Concentration/Task related symptoms – Has the individual exhibited any of the following symptoms or behaviors (not due to a medical condition)?

☐ No ☐ Yes:

- ☐ Serious difficulty completing tasks that they should be capable of completing
- ☐ Required assistance with tasks for which they should be capable
- ☐ Substantial errors with tasks which they complete

Adaptation to Change – Has the individual exhibited any of the following symptoms related to adapting to change? (Check all that apply)

- ☐ Self-injurious or self-mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats (with potential for harm)
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious lack of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Physical threats (no potential for harm)
- ☐ Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms). Describe symptoms:

HISTORY OF PSYCHIATRIC TREATMENT
(Answer all questions if applicable)

Currently, or within the past two years, has the individual received any of the following mental health services?

☐ No ☐ Yes:

- ☐ Inpatient psychiatric hospitalization
- ☐ Partial hospitalization/day treatment
- ☐ Residential treatment
- ☐ Other: ______________________________

Date of Service: ______________________________

Currently, or within the past two years, has the individual experienced significant life disruption because of mental health symptoms?

☐ No ☐ Yes:

- ☐ Legal intervention due to mental health symptoms
- ☐ Housing change because of mental illness
- ☐ Suicide attempt or ideation
- ☐ Current homelessness
- ☐ Homelessness within the past 6 months (but not current)
- ☐ Other: ____________________

Has the individual had a recent psychiatric/behavioral evaluation?

☐ No ☐ Yes If yes, what date: ______________________________

PSYCHOTROPIC MEDICATIONS
(Complete This Section If Applicable)

Has the individual been prescribed psychotropic (mental health) medications now or within the last 6 months?

☐ No ☐ Yes (list below):

Medication	Dosage MG/Day	Condition used to treat	Discontinued?
			☐
			☐
			☐
			☐
			☐

INTELLECTUAL DISABILITY (ID) AND DEVELOPMENTAL DISABILITIES (DD) (SECTION C)
(Answer All Questions if applicable)

Does the individual have a diagnosis of intellectual disability (ID)? ☐ No ☐ Yes

Is there evidence of a cognitive or developmental impairment that occurred prior to age 18?
☐ No ☐ Yes

Does the individual have a diagnosis which affects intellectual or adaptive functioning?
☐ No ☐ Yes:

☐ Autism ☐ Epilepsy
☐ Blindness ☐ Cerebral Palsy
☐ Closed head injury ☐ Other
☐ Down Syndrome

If yes, did this condition develop prior to age 22?
☐ No ☐ Yes

Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?
☐ No ☐ Yes

Has the individual ever received services from an agency that serves people with ID?
☐ No ☐ Yes

Are there substantial functional limitations in any of the following?
☐ No ☐ Yes:

☐ Mobility ☐ Self-Care
☐ Self-Direction ☐ Learning
☐ Understanding/Use of Language
☐ Capacity for living independently

REFERRAL DETERMINATION (SECTION D)

☐ No referral necessary for any Level II
☐ Yes, referral for Level II determination for ID only (ADES)
☐ Yes, referral for Level II determination for MI only
☐ Yes, referral for Level II determination for Dual ID/MI

Reviewer Individualized Service Recommendations (if applicable):

☐ Evaluate psychotropic medications ☐ Training in ADLs ☐ Training in self-health care management
☐ Supportive counseling ☐ Medication education ☐ Foreign Language services
☐ Explore/prepare for lower level of care ☐ Obtain prior behavioral health records to clarify need
☐ Other:

SIGNATURE OF INDIVIDUAL OR HEALTH CARE DECISION MAKER FOR CONSENT TO A LEVEL II PASRR (SECTION E)

The individual must sign below, or if the individual has a Health Care Decision Maker (as specified in AMPM 320-I), the Health Care Decision Maker must sign Section E. If there is no Health Care Decision Maker and the individual cannot sign due to their MI/ID issues, a doctor may sign along with submitting a statement indicating the reason for their signature.

I understand that I am required to undergo a Level II evaluation as a condition of admission to, or my continued residence in, a Title XIX Medicaid Nursing Facility. I also give permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation. **(Primary Care Physician information must be completed)**

Individual or Health Care Decision Maker Signature: ______________________________ Date: ________________

Primary Physician's Name: ______________________ Phone: __________________ Fax: __________________

Address: ___________________________________ City: __________________ State: ____ Zip: __________

Additional Comments: ____

SIGNATURE OF MEDICAL PROFESSIONAL COMPLETING LEVEL I PASRR (SECTION F)

I understand that this report may be relied upon for payment of claims from Federal and State funds, and any willful falsification or concealment of material fact may be prosecuted under Federal and State laws. I certify that to the best of my knowledge this information is true, accurate and complete. I acknowledge that information in this report may be shared with other State agencies.

Print Name: ______________________ Signature: _________________________ Date: ____________

Title: ________________________ Phone: _________________ Email: ____________________________

***The PASRR Level I Screening Tool must be completed in its entirety and the following documents must be submitted in order for the request to be processed:(Mark the checkbox for all items that are included in the submission)**

- ☐ Hospital or Facility Face Sheet/Demographics
- ☐ Current History and Physical
- ☐ Current medication list
- ☐ Health Care Decision Maker documentation and information (if applicable)
- ☐ Current Nurses/Physicians progress notes (last two days prior to transfer)
- ☐ Any recent psychiatric consultations and/or evaluations (email the entire packet together).

For individuals with mental illness, send via encrypted email to: PASRRProgram@azahcccs.gov
For individuals with an intellectual disability, send via encrypted email to: DDDPASRR@azdes.gov