

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Instructions: This screening must be completed for all persons applying for admission to a Medicaid certified nursing facility regardless of payment source. Fax the completed, signed form to 225-389-8198 or 225-389-8197. The Level of Care Eligibility Tool (LOCET) must also be called in to 877-456-1146 in order for the Office of Aging and Adult Services to process admission requests.

Illegible or incomplete forms will be rejected.

Section I: Referral Source Information					
Name of Hospital/ Nursing Facility/ Other Source Completing Level I Screen:					
Date:	Fax:	Phone:			
Printed Name, Title and Credentials* of Preparer:			Preparer Signature:		
Preparer's Email:					
Email for Receipt of 142 if different:					
SECTION II: Applicant Information					
Applicant Name	First and Middle				
	Last				
Applicant Address (Partial)	Town/ City:			State:	
Social Security #:	Date of Birth:	Medicaid # (If Applicable):			
Will the individual be admitted to the nursing facility using their Medicare Skilled Nursing Facility benefit?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a Legally Authorized Representative/ Guardian? Limit to curator, tutor, guardian or agent under a health care power of attorney.	<input type="checkbox"/> Not applicable. Applicant does not have a known legal representative of the type listed.				
	Name				
	Street				
	City			State	
	Zip			Phone	
	E-mail				

*Note: The list of individuals deemed to have the proper credentials to complete the Level I Screen are listed in the **Instructions for Completing the PASRR Level I Screen** (located on the OAAS website).

SECTION III: Mental Illness

1.	Do you suspect the applicant has, or has the applicant ever been diagnosed as having a mental illness? Include mental disorders that may lead to chronic disability. If yes, please check the diagnosis below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Delusional Disorder <input type="checkbox"/> Other Psychotic Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Major Depressive Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Posttraumatic Stress Disorder <input type="checkbox"/> Personality Disorder (specify): _____ <input type="checkbox"/> Other mental health diagnosis/disorder that may lead to chronic disability (specify):		
2.	Has the applicant shown any of the following symptoms? (Do not include symptoms that are caused only by dementia or acute illnesses related to medical conditions or temporary situations.) If yes, check all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Self-injurious or self-mutilating behaviors <input type="checkbox"/> Danger to others, aggressive, assaultive <input type="checkbox"/> Danger to self, suicidal ideation, threats, or attempts <input type="checkbox"/> Serious loss of interest in things that used to be pleasurable <input type="checkbox"/> <u>Interpersonal functioning (check all that apply):</u> <input type="checkbox"/> Serious difficulty interacting appropriately and communicating effectively <input type="checkbox"/> History of altercations <input type="checkbox"/> History of evictions <input type="checkbox"/> History of job loss <input type="checkbox"/> Fear of strangers <input type="checkbox"/> Avoidance of interpersonal relationships/social isolation <input type="checkbox"/> <u>Concentration, persistence and pace (check all that apply):</u> <input type="checkbox"/> Serious difficulty in sustaining focused attention <input type="checkbox"/> Serious difficulty in maintaining concentration <input type="checkbox"/> Inability to complete simple tasks <input type="checkbox"/> Serious difficulty in adapting to changes (agitation, exacerbated symptomology, requires intervention) <input type="checkbox"/> Other (specify):		
3.	Has the applicant had any of the following DUE TO A MENTAL ILLNESS? If yes, please provide as much of the information below as is known to you.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Inpatient psychiatric treatment. Date(s):		
<input type="checkbox"/> Partial hospitalization / day treatment. Date(s):		
<input type="checkbox"/> Law enforcement intervention. Date(s):		

SECTION IV: Intellectual Disability, Developmental Disability and Related Conditions		
4.	Does the applicant have a diagnosis of an intellectual disability (formerly referred to as mental retardation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Does the applicant have a diagnosis of a developmental disability or related condition other than an intellectual disability? <ul style="list-style-type: none"> • A developmental disability is a severe, chronic disability that is attributable to an intellectual or physical impairment (or combination), occurs prior to age 22, is likely to continue indefinitely, is not solely attributable to mental illness, and results in substantial functional limitations in major life areas (e.g., learning, language, mobility, self-care, independent living, etc.). • A related condition is a disability that manifested prior to age 22, is not solely attributable to mental illness, and impairs intellectual functioning or adaptive functioning and requires services normally delivered to individuals with intellectual disabilities. If yes, please specify all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Autism <input type="checkbox"/> Genetic Syndrome Associated with Delay <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head Injury/TBI <input type="checkbox"/> Other (specify): _____		
6.	Does the applicant have presenting evidence of intellectual disability, developmental disability or a related condition that has not been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	If "yes" was marked for questions 4, 5, and/or 6, is there any information available to the preparer that this condition began before age 22? Age at which the condition began? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
8.	If "yes" was marked for questions 4, 5, and/or 6, are there substantial functional limitations attributable to the suspected intellectual disability, developmental disability or a related condition that are not attributable to a medical condition, dementia or mental illness? If yes, please specify all that apply: <input type="checkbox"/> Mobility <input type="checkbox"/> Self-Direction <input type="checkbox"/> Self-Care <input type="checkbox"/> Learning <input type="checkbox"/> Understanding/ Use of Language <input type="checkbox"/> Capacity for Living Independently <input type="checkbox"/> Economic Self-Sufficiency (If the applicant is 18 years or older)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
9.	Is the applicant currently receiving services, ever in the past received services, or been referred from an agency that serves people with intellectual and developmental disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide as much of the information below as is known to you:		
Agency:		
Dates:		

FOR RESEARCH PURPOSES: Information provided here does not affect the determination of need for a Level II review.

In the past 12 months, has the applicant had to stay in a place not meant for human habitation (such as the streets, a car, an abandoned building); stay in a homeless shelter; or live doubled up with family or friends because he/she didn't have housing ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the applicant been diagnosed with a substance use or addictive disorder? If yes, please specify type(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

SECTION V. Hospital Exemption and Categorical Determinations

Complete this section if any item was checked “yes” in the Sections III or IV **AND** the applicant meets the criteria for one of the conditions described below. **If any item is selected, this page must be signed by the attending physician and supporting documentation must be attached.**

Not applicable: No item was checked “yes” in previous sections.

		SELECT ONE
10.	<p>The applicant meets all of the following criteria for a HOSPITAL EXEMPTION.</p> <ul style="list-style-type: none"> • The individual is being admitted directly to a nursing facility after receiving acute inpatient care in a hospital; • AND the individual needs nursing facility services for the condition for which the individual was admitted to the hospital; • AND the attending physician certifies by signing this form that the individual will require 30 days or less of nursing facility services. <p>What is the condition for which nursing facility care is needed?</p> <p>NOTE: Applications without a current H&P will not be processed.</p>	
11.	The applicant cannot be assessed because of DELIRIUM .	
12.	The applicant requires RESPITE care for up to 30 calendar days.	
13.	The applicant has a TERMINAL ILLNESS with a prognosis of a life expectancy of less than 6 months AND needs nursing care associated with the condition.	
14.	<p>The applicant has a PHYSICAL ILLNESS SO SEVERE (<i>such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure</i>) that the individual would be unable to participate in a program of specialized services.</p> <p>What is the condition?</p>	
15.	<p>The applicant needs CONVALESCENT CARE for no more than 100 days for an acute physical illness that:</p> <ul style="list-style-type: none"> • Required hospitalization for a serious illness and needs time to convalesce • AND does not meet all the criteria for an exempt hospital discharge. <p>What is the condition that requires convalescent care, and how long will the applicant need convalescent care?</p>	
16.	<p>The applicant has a diagnosis of DEMENTIA or Alzheimer’s disease that has progressed to the point that the individual would be unable to participate in a program of specialized services. How was the diagnosis determined?</p> <p>NOTE: Applications without records supporting this diagnosis will not be processed.</p>	
Physician Name: MD only. (Please print.)		Physician Signature:

Instructions for Completing the PASRR Level I Screen

Purpose of PASRR:

The Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals with mental illness and/ or intellectual or developmental disabilities (PASRR related conditions) are not inappropriately placed in nursing facilities. It seeks to answer two questions:

- (1) Does an individual with a PASRR related condition need nursing facility care? And, if so,
- (2) Does the individual need specialized services while in the nursing facility?

Individuals identified by the Level I Authority, Office of Aging and Adult Services (OAAS), as suspected of having a mental illness and/ or intellectual/developmental disability are referred for a Level II determination. Level II determinations are conducted by the Level II Authorities: Office of Behavioral Health (OBH) and/or the Office for Citizens with Developmental Disabilities (OCDD).

In General

The form is available for download from the Office of Aging and Adult Services website. It can be either: (1) completed as a fillable PDF and printed; or (2) printed and completed by hand. Whichever method is used, it must be submitted to OAAS through RightFax. The RightFax numbers are on the first page of the form.

If you are completing the form by hand, please print clearly. ***Illegible or incomplete applications will be rejected.***

Sections I: Referral Source Information

All items in Section I must be completed. Individuals with the credentials listed below may complete the Level I Screen (process and document) unless a hospital exemption or a categorical determination is requested. These individuals are considered to have the capacity to complete a clinical interview.

- Advanced Practice Registered Nurse (APRN)
- Licensed Addiction Counselor (LAC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Masters Social Worker (LMSW)
- Licensed Professional Counselor (LPC)
- Licensed Psychologist (PhD)
- Medical Psychologist (PhD)
- Nurse Practitioner (NP)
- Physician (MD)

- Physician Assistant (PA)
- Registered Nurse (RN)
- Registered Social Worker (RSW)

When a hospital exemption or a categorical determination is requested, the signature of the attending physician is required.

Section II: Applicant information

- The applicant's full name, social security number and date of birth are required.
- Only the town and state of the applicant's residence is required.
- The street name and number are not required.
- Please complete the remaining fields (Medicaid number, anticipated payment source, and legal representative) if the information is available to you.
- Please only include information for legal representatives of the following types: health care power of attorney, curators, tutors or guardians. Do not include individuals informally authorized to act on the applicant's behalf.

Section III: Questions relating to mental illness (MI)

Please complete this Section as indicated. While questions may be pre-filled based on a record review, the preparer must confirm their accuracy through interviews with the applicant or individuals involved in their care. This section must be completed for all applicants even if a mental illness is not known or suspected.

Section IV: Questions relating to intellectual disability (ID), developmental disability (DD) and related conditions (RC)

Please complete this Section as indicated. While questions may be pre-filled based on a record review, the preparer must confirm their accuracy through interviews with the applicant or individuals involved in their care. This section must be completed for all applicants even if an intellectual or developmental disability or related condition is not known or suspected.

Research Questions:

These questions address substance use and homelessness. They are intended to help us understand more about the service needs of individuals, but do not by themselves indicate a need for a Level II evaluation. With respect to homelessness, do not include situations where an individual may have voluntarily moved in with a friend or relative for the purposes of receiving caregiving assistance or supervision.

Section V: Hospital exemptions and categorical determinations

This section should be completed for applicants for whom MI/ID/DD/ RC are known or suspected, but who might qualify for consideration for a hospital exemption or a categorical determination. This section may be omitted or marked “Not Applicable” at the top of the section if the applicant:

- Is not suspected or known to have MI/DD/ID/RC; or
- Does not meet criteria for a hospital exemption or a categorical determination.

Requests for a hospital exemption are appropriate for individuals who:

- Are being directly admitted to a nursing facility after receiving acute inpatient care in a hospital;
- Need treatment for the acute condition for which they were hospitalized; **AND**
- Will need no more than **30 days** of nursing facility care for the same condition for which they were admitted.

If it happens that the individual needs more than the 30 days of nursing facility care, the nursing facility is required to request an extension 10 calendar days before the expiration date of the 142. A Level II evaluation will be conducted at that time if the individual continues to need nursing home level of care. The extension request should be submitted to the NFA Unit on the Continued Stay Request Form. The Form is located on the OAAS website.

Individuals who meet criteria for categorical determinations may, at the discretion of the Level II Authority, be admitted to a nursing facility without a **full** Level II evaluation. The burden is on the referral source to provide sufficient information for the Level II Authority to determine if the individual meets the categorical criteria.

The categories are:

- Dementia. This category is for individuals for whom a mental illness is known or suspected and the dementia has progressed to such a degree that they cannot benefit from specialized services.
- Delirium
- Respite care
- Terminal illness
- Severe physical illness
- Convalescent care

Supporting documentation is specified for hospital exemption and progressed dementia. Level I screens without this documentation will be returned as incomplete. Supporting documentation for the other categorical determinations is not specified, but should be sufficient to allow the Level II authority to make a more expedient determination.

In accordance with federal requirements, the signature of the attending physician is required when seeking a hospital exemption or categorical determination. The

signature must be that of an MD. Signatures of physician assistants (PAs) or nurse practitioner's (NPs) are not sufficient.

Submitting the form:

Fax the completed form to the Office of Aging and Adult Services to 225-389-8198 or 225-389-8197. Referral sources WILL NOT RECEIVE a CONFIRMATION that the RightFax has been received.

Please remember that Louisiana law allows for two working days for a response. If you are concerned that you have not yet received a response, **please do not resubmit the form**. Instead, call the OAAS Nursing Facility Admissions desk (337-262-1664) to confirm receipt.

Resources for conducting clinical interviews:

- <http://www.sprc.org/sites/default/files/PrimerModule4.pdf>
<http://cebmh.warne.ox.ac.uk/csr/clinicalguide/docs/Assessment-of-suicide-risk--clinical-guide.pdf>
- <https://www.drugabuse.gov/sites/default/files/sensitive-topics-lecture.pdf>
- <http://www.confidenceconnected.com/blog/2014/11/19/asking-three-questions-can-identify-suicide-risk/>
- <https://www.qprinstitute.com/research-theory>