maximus

Connecticut Level I Form
Pre-Admission Screening and Resident Review (PASRR)

First Name:_____ Middle Initial:_____ Last Name:_____

Mailing Address:_____ City:_____ State:___ Zip:_____ Phone: _____

Social Security #: ___ ___ _____ Date of Birth:___/_____/_____

Marital Status: ☐ M ☐ S ☐ W ☐ D Gender: ☐Male ☐Female

Payment Method: ☐ Medicare #_____ ☐ Self Pay ☐ Medicaid Pending ☐ Medicaid #: _____

Current Living Situation: ☐NF ☐Hospital ☐Homeless ☐Home with Family ☐Home alone ☐Group home
☐ Other_____

Current Location: _____ Admission Date: _____ ☐ N/A

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

Location Street Address: _____ City: _____ State: _____ Zip: _____

Admitting Nursing Facility:_____ Date Admitting: _____/___/_____

Admitting Nursing Facility Address:_____ City:_____ State:_____ Zip:_____

Review Type: ☐Preadmission ☐Status Change ☐ Conclusion of a Time Limited Approval

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

☐No

☐Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Major Depression
- ☐ Psychotic/Delusional Disorder
- ☐ Bipolar Disorder (manic depression)
- ☐ Paranoid Disorder

2. Does the individual have any of the following mental disorders?

☐ No

☐ Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Depression (mild or situational)

3.a Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)

☐ No ☐ Yes (if yes, list diagnosis(es) below):

☐ Diagnosis 1:_____

☐ Diagnosis 2:_____

3.b. Does the individual have a substance related disorder?

☐ No ☐ Yes (if yes, complete remaining questions in this section)

b.1 List substance related diagnosis(es)

Diagnosis _____ Diagnosis_____

Diagnosis _____ Diagnosis_____

b.2 Is NF need associated with this diagnosis?

☐ No ☐ Yes

b.3 When did the most recent substance use occur?

☐ Less than 7 days ☐ 7–14 days ☐ 15–30 days

☐ 31 days-3 months ☐ 4-6 months ☐ 7-12 months

☐ Greater than 12 months ☐ Unknown

Section II: SYMPTOMS

4. Interpersonal—Currently or in the past, 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

If yes, how recent:

☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months

☐ 13-24 months ☐ 25 months-5 years

☐ Greater than 5 years

5. Concentration/Task related symptoms—Currently or in the past, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?

☐ No ☐ Yes

☐ Serious difficulty completing tasks that she/he should be capable of completing

☐ Required assistance with tasks for which s/he should be capable

☐ Substantial errors with tasks in which she/he completes

If yes, how recent:

☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months

☐ 13-24 months ☐ 25 months-5 years

☐ Greater than 5 years

Adaptation to change—Currently or in the past, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? ☐ No (proceed to Section III) ☐ Yes (complete 6-8)

Last Name_____ First Name_____ DOB_____

6. ☐ Self-injurious or self-mutilation
☐ Suicidal talk
☐ History of suicide attempt or gesture
☐ Physical violence
☐ Physical threats (with potential for harm)

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months
☐ 7-12 months
☐ 13-24 months
☐ 25 months-5 years
☐ Greater than 5 years

7. ☐ Severe appetite disturbance
☐ Hallucinations or delusions
☐ Serious loss of interest in things
☐ Excessive tearfulness
☐ Excessive irritability
☐ Physical threats (no potential for harm)

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months
☐ 7-12 months
☐ 13-24 months
☐ 25 months-5 years
☐ Greater than 5 years

8. ☐ 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:

_____
_____

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months
☐ 7-12 months
☐ 13-24 months
☐ 25 months-5 years
☐ Greater than 5 years

Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or in the past, has the individual received any of the following mental health services?
☐ No ☐ Yes (the individual has received the following service[s]):
☐ Inpatient psychiatric hospitalization (if yes, provide date:_____)
☐ Partial hospitalization/day treatment (if yes, provide date:_____)
☐ Residential treatment (if yes, provide date:_____)
☐ Other:_____
(if yes, provide date:_____)

If yes, how recent:
☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

10. Currently or in the past, has the individual experienced significant life disruption because of mental health symptoms?
☐ No ☐ Yes (check all that apply):
☐ Legal intervention due to mental health symptoms (date:_____)
☐ Housing change because of mental illness (date:_____)
☐ Suicide attempt or ideation (date[s]_____)
☐ Current Homelessness
☐ Homelessness within the past 6 months but not current
☐ Other:_____
(date:_____)
If yes, how recent:
☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

11. Has the individual had a recent psychiatric/behavioral evaluation? ☐ No ☐ Yes (date:_____)

Section IV: DEMENTIA

12. Does the individual have a primary diagnosis of dementia or Alzheimer's disease?
☐ No (proceed to 14)
☐ Yes
☐ No, the individual has dementia but it is not primary (proceed to 14)

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia? ☐ No ☐ Yes (check all that apply):
☐ Dementia work up ☐ Comprehensive Mental Status Exam
☐ Other (specify):
_____

Section V: PSYCHOTROPIC MEDICATIONS

14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months?
☐ No ☐ Yes (list below) [use separate sheet if necessary]

Medication	Dosage MG/Day	Diagnosis	Discontinued
			☐
			☐
			☐
			☐

VI: INTELLECTUAL & DEVELOPMENTAL DISABILITIES

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

16. Does the individual have presenting evidence of ID that has not been diagnosed? ☐ No ☐ Yes

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

18. Has the individual ever received services from an agency that serves people with ID? ☐ No ☐ Yes
Agency:_____

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19. Does the individual have a diagnosis which affects intellectual or adaptive functioning?

☐ No ☐ Yes – (Specify)

○Autism ○ Epilepsy ○ Blindness ○Cerebral Palsy

○ Closed Head Injury ○ Deaf ○ Other:_____

21. If yes to #19, did this condition develop prior to age 22? ☐ No ☐ Yes

20. Are there substantial functional limitations in any of the following? ☐ No ☐ Yes (Specify)

○ Mobility ○ Self-Care

○ Self-Direction ○ Learning

○ Understanding/Use of Language

○ Capacity for living independently

VII: EXEMPTION AND CATEGORICAL DECISIONS (SECTION VII APPLIES ONLY TO PERSONS WITH KNOWN OR SUSPECTED MI AND/OR ID/RC)

(with the exception of Provisional Emergency, Maximus must approve use of categories and exemptions prior to admission)

22. *Does the admission meet criteria for 30 day Exempted Hospital Discharge? ☐ No ☐ Yes, meets all the following criteria:

- Admission to NF directly from hospital after receiving acute medical care
- Need for NF is required for the condition treated in the hospital; Specify diagnosis(es)_____

_____

_____

- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services
- There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I and complete a NF Level of Care screens at such time that is appears the individual's stay will exceed 30 days. Screens must be updated by or before the 30th calendar day.

23. **Does the admission meet criteria for provision emergency or provisional delirium? ☐ No ☐ Yes, meets the following criteria:

- ☐ **Provisional Emergency**: The individual has been identified as having a Level II condition, there is an urgent need for NF services due to the individual's medical needs (excludes need associated with psychiatric conditions alone), lower level of care is not available and/or appropriate, and the authorization was provided by an appropriate state employee or authorized designee (Ombudsman, Protective Services Worker, DSS, DDS, or the entity assigned by DSS to approve/authorize categorical decisions). The admitting NF must notify Maximus, via submission of this form, within one business day of the individual's admission under this category.
- The admitting NF must submit a LOC form to Maximus for review
- The admission must be initiated by an authorized entity. Identify name and contact information of authorized entity.
- There is no current risk to self or others and behaviors/symptoms are stable

Authorized Entity Name_____ Phone_____ Address _____

City _____ Zip_____

☐ **Provisional Delirium**: presence of delirium precluded the ability to make accurate diagnosis and records supporting the dementia state must accompany this screen).

**The NF must update the Level I and NF Level of Care screen by or before the 7th calendar day if the individual is expected to remain in the NF.

24. Does the individual meet the following criteria for Respite admission for up to 30 calendar days:

☐ No ☐ Yes, meets the following criteria:

*__Respite__:

- The individual requires respite care for up to 30 calendar days to provide relief to the family or caregiver
- The referral source must submit a Level of Care (LOC) form which must be approved by Maximus before the admission can occur
- There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I and NF Level of Care screens at such time that is appears the individual's stay will exceed 30 days. Screens must be update by or before the 30th calendar day.

25. Does the individual meet the following criteria for convalescent care for up to 60 calendar days: ☐ No

☐ Yes, meets the following criteria:

*__Convalescent care__:

- Admission to NF directly from hospital after receiving acute medical care
- Need for NF is required for the condition treated in the hospital; Specify diagnosis(es)

_____

The attending physician has certified prior to NF admission the individual will require less than 60 calendar days of NF services

- There is no current risk to self or others and behaviors/symptoms are stable

*The NF must update the Level I and complete a NF Level of Care screens at such time that is appears the individual's stay will exceed 60 days. Screens must be updated by or before the 60th calendar day.

Last Name_____ First Name_____ DOB_____

26. * Does the individual meet one of the following criteria for categorical NF approval as a result of terminal state or severe illness?:**

☐ No ☐ Yes, meets the following criteria:

☐ **Terminal Illness**:
- Prognosis if life expectancy of ≤ 6 months (records supporting the terminal state must accompany this screen)
- There is no current risk to self or others and behaviors/symptoms are stable

☐ **Severe Illness**:
- Coma, ventilator dependent, brain-stem functioning, progressed ALS, progressed Huntington's, etc. so severe that the individual would be unable to participate in a program of specialized care associated with his/her MI and/or ID/RC. (Documentation of the individual's medical status must accompany this screen.)
- There is no current risk to self or others and behaviors/symptoms are stable

***The NF must update the Level I and NF Level of Care screens if the individual's medical state improves to the extent that s/he could potentially benefit from a program of services to address his/her MI and/or ID/RC needs.

Section VIII: Guardianship & Physician Information (Required only for individuals with known or suspected Level II conditions)

27. *Does the individual have a legal representative/guardian?*

☐ ***No legal representative/Conservator/guardian.*** ☐ ***Yes, information is below:***

Legal Representative Last Name_____ First Name_____
Phone:_____

Street_____ City_____ State_____ Zip_____

28. *Primary Physician's Name*:_____ Phone:_____ Fax:_____

Street_____ City_____ State_____ Zip_____

Section IX: REFERRAL SOURCE SIGNATURE: *By entering my name and credentials, I attest that I am the person who completed this form. I understand that CT DSS considers knowingly submitting inaccurate, incomplete, or misleading LOC information to be Medicaid fraud.*

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Maximus Use Only: Reviewer Individualized Service Recommendations (applies if categorical approval [#22-25] was issued.

☐ Evaluate psychopharmacologic medications
☐ Supportive counseling
☐ Medication education
☐ Foreign language services
☐ Training in ADLs
☐ Explore/prepare for lower level of care
☐ Training in self-health care management
☐ Obtain prior behavioral health records to clarify need
☐ Other (specify) _____
_____
_____
☐ No recommendations at this time

The outcome will be reflected on the computerized screen.