MAXIMUS®

Mississippi PASRR
Level II Change in Status Request

Complete for NF residents experiencing a significant status change. Fax completed form to MAXIMUS at 877.431.9568 (ATTN: MS PASRR) for NF residents whose short-term authorization is concluding and for any NF residents experiencing a significant change in status.

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

Social Security #: _____-_____-_____ Date of Birth: _____ Marital Status: ☐M ☐S ☐W ☐D

Medicaid ID #: _____ Gender: ☐M ☐ F

Pay Source: ☐ Private Pay/Insurance ☐ Medicare ☐ Medicaid ☐ Medicaid Pending ☐ Dual Medicare/Medicaid

Current Location: _____ Admission Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____-_____-_____ Fax #: _____-_____-_____ Contact Name: _____

Type of facility: ☐ Medical Facility ☐ Psychiatric Facility ☐ Nursing Facility ☐ Community ☐ Other: _____

Admitting (or current) NF: ☐ Same as above ☐ Other: _____ Date Admitting: _____

Address: _____ City: _____ State: _____ Zip: _____

Attending Physician Name: _____ Phone #: _____-_____-_____ Fax #: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Legal Representative Name: _____ Phone #: _____-_____-_____ Fax #: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Legal Representative Type: ☐ Court-appointed Guardian/Conservator ☐ POA ☐ Other: _____

General Information:

Has the resident indicated a preference to be discharged from the Nursing Facility? ☐ No ☐ Yes

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

Does the resident have a primary diagnosis of neurocognitive disorder/dementia or Alzheimer's disease? ☐ No ☐ Yes

If yes, is corroborative testing available to verify the presence of the neurocognitive disorder/dementia? ☐ No ☐ Yes

If yes, select all that apply:

☐Comprehensive Mental Status Exam ☐Neurocognitive disorder/dementia work up ☐ Other:_____

Has the resident been transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay? ☐ No ☐ Yes

If yes, identify the following:

Facility: _____ Admission date: _____

Reason for inpatient treatment: _____ Discharge date: _____

Instructions: Complete all sections below

Section A: Has the resident previously been evaluated through PASRR? ☐ No (*if no, proceed to Section B*)

☐ Yes (Provide date: _____, identify any of the following which best characterize the change, and proceed to Section C)

☐ 1. Transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay as described above.

☐ 2. Increase in behavioral, psychiatric, or mood-related symptoms.

☐ 3. Behavioral, psychiatric, or mood related symptoms that have not responded adequately to ongoing treatment (e.g., significant changes in sleep, appetite, mood, energy, hopefulness, and self-care related to intellectual or developmental disability or that may have a psychiatric or psychological component).
Describe: _____

Please complete and fax to the MAXIMUS Mississippi Team at 877.431.9568
840 Crescent Centre Drive / Suite 400 / Franklin, TN 37067 / www.maximus.com

☐ 4. Sudden increase or decrease in weight.
Prior weight/date: _____ Current weight/date: _____
Reason for change: _____

Resident Name:

☐ 5. Significant physical change that in conjunction with behavioral, psychiatric, mood-related symptoms, or cognitive abilities, may influence adjustment.
Describe:_____

☐ 6. Improvement or decline in medical condition, such that the plan of care or placement recommendations may require modifications.
Describe the medical improvement: _____

☐ 7. Condition or treatment needs are significantly different than described in the last PASRR Level II evaluation.
If new diagnoses, specify_____ Date of diagnoses: _____
Describe how diagnosis/treatment has impacted the resident: _____

Section B: Is the resident presenting with a newly identified suspected mental illness, intellectual disability, or a developmental condition? ☐ No ☐ Yes (*proceed to Section C regardless of response*)

Section C: Mental Illness (Complete all of the following)

Is the resident known or suspected as having a diagnosis of mental illness (that is not neurocognitive disorder/dementia)?
☐ No, there is no evidence of mental illness (proceed to Section D)
☐ Yes, there is a known or newly suspected mental illness. ***If yes***, identify all of the following which best characterize the resident:

1. Does the resident have any of the following Major Mental Illnesses (MMI)? ☐ No
☐ Suspected: One or more of the following diagnoses is suspected (select all that apply)
☐ Yes: (select all that apply)
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Psychotic/Delusional Disord
- ☐ Major Depression
- ☐ Paranoid Disorder
- ☐ Bipolar Disorder

2. Does the resident have any of the following mental disorders?
☐ No
☐ Suspected: One or more of the following diagnoses is suspected (select all that apply)
☐ Yes: (select all that apply)
- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Depression (mild or situational)
- ☐ Other diagnosis (specify):_____

3. Currently or within the past 6 months, has the resident exhibited interpersonal symptoms or behaviors [not due to a medical condition]? ☐ No
- ☐ 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

4. Currently or within the past 6 months, has the resident exhibited any of the following symptoms or behaviors [not due to a medical condition]? ☐ No
- ☐ Serious difficulty completing tasks that s/he should be capable of completing
- ☐ Required assistance with tasks for which s/he should be capable
- ☐ Substantial errors with tasks in which s/he completes

5. Currently or within the past 6 months, has the resident exhibited any symptoms related to adapting to change?
☐No ☐Yes: (select all that apply)
- ☐ Self injurious or self mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats (potential for harm)
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious loss 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: _____

Section D: Intellectual disability/Developmental Disability (Complete all of the following)

Is the resident known or suspected as having intellectual disability or developmental disability (federally referred to as a condition related to intellectual disability)? ☐ No (*proceed to E*) ☐ Yes (identify all of the following which best characterize the resident)

1. ☐ Evidence of a cognitive or developmental impairment that occurred prior to age 18
2. ☐ A diagnosis which affects intellectual or adaptive functioning (select all that apply)
   ☐ Autism Spectrum Disorder ☐ Epilepsy ☐ Blindness ☐ Cerebral Palsy
   ☐ Closed Head Injury ☐ Deaf ☐ Other: _____
   ***If one of the above was identified,* did this condition develop prior to age 22?** ☐ No ☐ Yes

Resident Name:

3. ☐ Substantial functional limitations in any of the following? ☐ No ☐ Yes (select all that apply)
   ☐ Mobility ☐ Self-care ☐ Learning
   ☐ Self-direction ☐ Understanding/use of language ☐ Capacity for living independently

Section E: Check all applicable information and attach records to this submission

Include any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included:

☐ Physician's Notes ☐ Nursing Notes/Summary ☐ MAR Sheet(s) ☐ Hospital Records
☐ Medical Consultation(s) ☐ Psychiatric Evaluation(s) ☐ Intellectual Assessment(s) ☐ Plan of Care
☐ Other (List): _____

Section F: REFERRAL SOURCE SIGNATURE-To be completed by RN or Social Worker		
Print Name:_____	Signature:	Date: _____
Agency/Facility: _____	Phone: _____	Fax: _____
Section G: PASRR OUTCOME-To be completed by Ascend		
Print Name: _____	Signature: _____	Date: _____
Outcome: ☐Not a PASRR significant status change ☐Document review of clinical information ☐Level II onsite evaluation	Comments: _____	Phone: _____