

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

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Current Location: \_\_\_\_\_ Admission Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Type of facility:  Medical Facility  Psychiatric Facility  Nursing Facility  Community  Other: \_\_\_\_\_

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Admitting (or current) NF:  Same as above  Other: \_\_\_\_\_ Date Admitting: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Attending Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Legal Representative Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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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: \_\_\_\_\_

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:

<p><b>1. Does the resident have any of the following Major Mental Illnesses (MMI)?</b> <input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (select all that apply)</p> <p><input type="checkbox"/> Yes: (select all that apply)</p> <p><input type="checkbox"/> Schizophrenia <input type="checkbox"/> Major Depression <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Paranoid Disorder <input type="checkbox"/> Psychotic/Delusional Disord <input type="checkbox"/> Bipolar Disorder</p>	<p><b>2. Does the resident have any of the following mental disorders?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (select all that apply)</p> <p><input type="checkbox"/> Yes: (select all that apply)</p> <p><input type="checkbox"/> Personality Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression (mild or situational) <input type="checkbox"/> Other diagnosis (specify): _____</p>			
<p><b>3. Currently or within the past 6 months, has the resident exhibited interpersonal symptoms or behaviors [not due to a medical condition]?</b> <input type="checkbox"/> No</p> <p><input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions, or unstable employment <input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers</p>	<p><b>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]?</b> <input type="checkbox"/> No</p> <p><input type="checkbox"/> Serious difficulty completing tasks that s/he should be capable of completing <input type="checkbox"/> Required assistance with tasks for which s/he should be capable <input type="checkbox"/> Substantial errors with tasks in which s/he completes</p>			
<p><b>5. Currently or within the past 6 months, has the resident exhibited any symptoms related to adapting to change?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: (select all that apply)</p> <table border="0"> <tr> <td data-bbox="120 1644 532 1839"> <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (potential for harm)                 </td> <td data-bbox="574 1644 987 1839"> <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)                 </td> <td data-bbox="1029 1644 1500 1818"> <input type="checkbox"/> 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: _____                 </td> </tr> </table>		<input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (potential for harm)	<input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)	<input type="checkbox"/> 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: _____
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**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: <input type="checkbox"/> Not a PASRR significant status change <input type="checkbox"/> Document review of clinical information <input type="checkbox"/> Level II onsite evaluation	Comments: _____	Phone: _____