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
2555 Meridian Blvd / Suite 350 / Franklin, TN 37067
www.maximusclinicalservices.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
- ☐ Other diagnosis (specify):_____
- ☐ Panic Disorder
- ☐ Depression (mild or situational)

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:

Please complete and fax to the Maximus Mississippi Team at 877.431.9568
2555 Meridian Blvd Suite #350/ Franklin, TN 37067
www.maximusclinicalservices.com.

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 Maximus		
Print Name:	Signature:	Date:
Outcome: ☐Not a PASRR significant status change ☐Document review of clinical information ☐Level II onsite evaluation	Comments:	Phone:

Please complete and fax to the Maximus Mississippi Team at 877.431.9568
2555 Meridian Blvd / Suite 350 / Franklin, TN 37067
www.maximusclinicalservices.com.

Last Name: First Name:

To be completed by a knowledgeable caregiver. Note: this form and its instructions are entirely based upon the MS Division of Medicaid (PAS) Application for Long Term Care. Refer to instructions from the PAS for any areas requiring clarification.

Points	Weight	Points X Weight	Max Points	CRITERIA
				ADL/IADL: *SCALE: **(0 POINTS) INDEPENDENT**:* independently completes activity safely; ***(1 POINT) SUPERVISION**:* Completes activity safely with cueing, set-up or standby assist or limited occasional physical hands-on assistance; ***(2 POINTS) PHYSICAL ASSISTANCE**:* Can participate but requires physical/hands on assistance to complete safely; ***(3 POINTS) TOTAL DEPENDENCY**:* Completely dependent on others to complete activity safely**.**
	7.0	0	**21.0**	1. **Mobility/Ambulation:** How well can the individual purposefully move within his/her residence/living environment?
	.5	0	**1.5**	2. **Community Mobility:** How well can the individual move around neighborhood or community? This includes accessing buildings, stores, restaurants and using (including enter/exit) any mode of transportation (such as walking, wheelchair, cars, buses, taxis, etc.).
	7	0	**21.0**	3. **Transferring:** How much human assistance is needed on a consistent basis for safe transfer, including bed/chair to wheelchair, walker or standing; onto and off toilet; into and out of bath/shower?
	5.0	0	**15.0**	4. **Eating:** How well is the individual able to eat/drink safely, including chew and swallow? If tube or IV fed, circle 0 if individual can feed self independently, or circle 1, 2, or 3 if another person is required to assist. Excludes meal prep.
	1.0	0	**3.0**	5. **Meal Prep:** How well is the individual able to safely obtain and prepare routine meals? (Includes ability to independently open containers & use appliances). If tube or IV fed, circle 0 if individual can prep tube/IV feeding independently, or circle 1,2, or 3 if another person is required to assist
	5.0	0	**15.0**	6. **Toileting:** How well can the individual use toilet, commode, bedpan or urinal safely? This includes flushing, cleansing of self, changing of protective garment, adjusting clothing, washing hands, managing an ostomy or catheter. Excludes transfer and continence (Note – limited hands-on assistance includes emptying bedpans.)
	5.0	0	**15.0**	7. **Bathing:** How well is the individual able to bathe, shower or take sponge baths safely for the purpose of maintaining adequate hygiene and skin integrity? Includes washing hair. Excludes transfer (Note – limited hands-on assistance includes helping with hard to reach areas, such as the back.)
	5.0	0	**15.0**	8. **Dressing:** How well is the individual able to safely dress and undress as necessary, regardless of clothing type? This includes ability to put on prostheses, braces, anti-embolism hose and choice of appropriate clothes for the weather and for personal comfort. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. (Note: if individual can dress independently, but normally requires 30 minutes or longer doing so, score as "Supervisory" (1).)
	5.0	0	**15.0**	9. **Personal Hygiene:** How well is the individual able to perform personal hygiene/grooming activities safely, including but not limited to combing hair, shaving, oral care? Exclude nail care and washing hair.
	5.0	0	**15.0**	10. **Med Management:** How well is the individual able to safely manage and administer pills, liquids, inhalers, nebulizers, eye drops, ear drops, self-administered injectables, IV medications, medication pumps? Excludes insulin and monthly injections, such as B-12 shots.
				11. **DOES THE INDIVIDUAL USE INSULIN?** *How well is the individual able to safely manage and administer insulin? If individual does not use insulin, select N/A for all items. Consider the past 30 days. Score based on functionality achieved with assistive device(s), if used.* ☐N ☐Y (if yes, answer 11 a-c; if no, proceed to 12)
	Capped .5	0	**1.0**	11a. Can individual administer finger sticks and understand Accu-Chek® (glucose testing) results? ☐N (1 point) ☐Y (0 points) ☐N/A 11b. If on a fixed dose, can individual self-inject insulin with a pre-filled syringe? ☐N (1 point) ☐Y (0 points) ☐N/A 11c. If on a sliding scale, can individual draw up the correct amount and inject insulin? ☐N (1 point) ☐Y (0 points) ☐N/A
				CONTINENCE: (CONSIDER THE PAST 30 DAYS; SCORE BASED ON FUNCTIONALITY ACHIEVED WITH ASSISTIVE DEVICES, IF USED. INCLUDES CATHETER AND OSTOMY) *SCALE: **(0 POINTS) COMPLETE VOLUNTARY CONTROL; (1 POINT) INCONTINENT EPISODES LESS THAN WEEKLY; (2 POINTS) INCONTINENT EPISODES ONCE PER WEEK; (3 POINTS) INCONTINENT EPISODES TWO OR MORE TIMES PER WEEK***
	5.0	0	**15.0**	12. **BLADDER CONTINENCE** – How well is the individual able to voluntarily control the discharge of body waste from the bladder?
	5.0	0	**15.0**	13. **BOWEL CONTINENCE** –How well is the individual able to voluntarily control the discharge of body waste from the bowel?
	Capped 1.0	0	**10.0**	14. **UNDERLYING CAUSES OF ADL/IADL LIMITATIONS** – Check all Physical Impairments and Supervision Needs that apply below. (Each option results in one point; maximum = 10) # selected:_____

Last Name: First Name:

Physical Impairments				
☐ Amputation	☐ Balance Problems	☐ Paralysis	☐ Physiological Defect	
☐ Catheter	☐ Bladder incontinence	☐ Tube feeding	☐ Sensory Impairment – Hearing	
☐ Choking	☐ Bowel incontinence	☐ Poor Dentition	☐ Sensory Impairment – Vision	
☐ Pain	☐ Decreased Endurance	☐ Weakness	☐ Fine or gross motor impairment	
☐ Oxygen use	☐ Neurological Impairment	☐ Ostomy	☐ Swallowing Problems	
☐ Obesity	☐ Shortness of Breath	☐ Muscle Tone	☐ Limited Range of motion	
☐ Fractures	☐ Lack of assistive devices	☐ History of falls	☐	
Supervision Needs/Mental Health (Check all that apply. Each option results in one point)				
☐ Behavioral Issues	☐ Lack of motivation/apathy	☐ Memory impairment	☐ Cognitive Impairment	
☐ Other (describe)				

II. VISION: THE ABILITY TO SEE IN ADEQUATE LIGHT AND WITH GLASSES, IF USED.

15. **Vision Rating: 0= ADEQUATE** – Sees fine detail, including regular print in newspapers/books; **1= MILDLY IMPAIRED** – Sees large print, but not regular print in newspapers/books; **2= MODERATELY IMPAIRED** – Limited vision; not able to see newspaper headlines, but can identify objects; **3= HIGHLY IMPAIRED** – Object identification in question, but eyes appear to follow objects; **4= SEVERELY IMPAIRED** – No vision OR sees only light, colors and shapes; eyes do not appear to follow objects; **UNK=Unable to determine appropriate score**

	1.0	0	**4.0**

III. ORIENTATION: Report the total number of No responses for a-k (0-11)

16. **Orientation Ratings**

Q.1 Person; At time of screen:

a. Does the individual know his/her First name? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
b. Does the individual know his/her Last name? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
c. Does the individual know caregiver's name? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine

Q.2 Place; At time of screen, does individual know his/her:

d. Immediate environment? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
e. Place of residence? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
f. City? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
g. State? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine

Q.3 Time; At time of screen, does individual know his/her:

h. Day? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
i. Month? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
j. Year? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine
k. Time of Day? ☐N **(1 Pt)** ☐Y **(0 pts)** ☐Unable to determine

	3.0	0	**33.0**

IV. BEHAVIORS: Consider **behaviors** during the past 90 days that required some level of intervention; Mark 'H' if > 90 days but within the past 2 years); Consider the most common level of **intervention** required; "*Easily altered*" refers to redirection verbally without difficulty; *"Not easily altered*" refers to redirection verbally with difficulty or need for physical or chemical restraints (to the extent allowed by law)

17. *A. **VERBALLY AGGRESSIVE (THREATENING/SCREAMING/CURSING) ASSIGN POINTS SCORE BASED ON FREQUENCY:***

(0) Has not occurred in 90 days; **(2)** Frequent & requiring intervention ≥1 X/week and < 1X/day;
(1) Occasional (within 90 days)& requiring intervention ≤1 X/week; **(3)** Constant & requiring intervention daily
(H) historically occurred (>90 days ago) AND <2 years ago

	3.0	0	**9.0**

*B. **VERBALLY AGGRESSIVE:** Check applicable behaviors (If score > 0, select all that apply)*

☐Falsely accuses others of stealing ☐Spitting at others ☐Screaming/cursing at others
☐Verbal threats ☐Other *(please specify):*

*C. **VERBALLY AGGRESSIVE (INTENSITY):*** **If *Frequency* is > 0, what *intensity*** of intervention is required? Behavior is:
☐ **(0 Pts)** easily altered ☐ **(1 Pt)** not easily altered

	3.0	0	**3.0**

18. *A. **PHYSICALLY AGGRESSIVE (HITTING/SHOVING/SCRATCHING/SEXUAL ABUSE) ASSIGN POINTS SCORE BASED ON FREQUENCY:***

(0) Has not occurred in 90 days; **(2)** Frequent & requiring intervention ≥1 X/week and < 1X/day;
(1) Occasional (within 90 days)& requiring intervention ≤1 X/week; **(3)** Constant & requiring intervention daily
(H) historically occurred (>90 days ago) AND <2 years ago

	3.0	0	**9.0**

*B. **PHYSICALLY AGGRESSIVE:** Check applicable behaviors (If score > 0, select all that apply)*

☐Combative regarding personal care ☐Hits/shoves/scratches others ☐Sexually abusive
☐Throws items at others ☐Intimidating/threatening physical harm
☐Other *(please specify):*

*C. **PHYSICALLY AGGRESSIVE (INTENSITY):*** **If *Frequency* is > 0, what *intensity*** of intervention is required? Behavior is:
☐ **(0 Pts)** easily altered ☐ **(1 Pt)** not easily altered

	3.0	0	**3.0**

	3.0	0	**9.0**	19. *A. **WANDERING/ELOPEMENT (MOVEMENT WITH NO RATIONAL PURPOSE, SEEMINGLY OBLIVIOUS TO NEEDS OR SAFETY) ASSIGN POINTS SCORE BASED ON FREQUENCY:*** **(0)** Has not occurred in 90 days; **(1)** Occasional (within 90 days)& requiring intervention ≤1 X/week; **(2)** Frequent & requiring intervention ≥1 X/week and < 1X/day; **(3)** Constant & requiring intervention daily **(H)** historically occurred (>90 days ago) AND <2 years ago *B. **WANDERING/ELOPEMENT:** Check applicable behaviors (If score > 0, select all that apply)* ☐ Leaves home and becomes lost ☐ Wanders - seeking exit ☐ Wanders - not seeking exit ☐ Other *(please specify):*
	3.0	0	**3.0**	*C. **WANDERING/ELOPEMENT (INTENSITY):** **If *Frequency* is > 0, what *intensity*** of intervention is required? Behavior is: ☐ **(0 Pts)** easily altered ☐ **(1 Pt)** not easily altered
	3.0	0	**9.0**	20. *A. **INAPPROPRIATE/UNSAFE (INCLUDES SOCIALLY INAPPROPRIATE, UNSAFE, AND DISRUPTIVE BEHAVIORS. EXCLUDES AGGRESSION) ASSIGN POINTS SCORE BASED ON FREQUENCY:*** **(0)** Has not occurred in 90 days; **(1)** Occasional (within 90 days)& requiring intervention ≤1 X/week; **(2)** Frequent & requiring intervention ≥1 X/week and < 1X/day; **(3)** Constant & requiring intervention daily **(H)** historically occurred (>90 days ago) AND <2 years ago *B. **INAPPROPRIATE/UNSAFE:** Check applicable behaviors (If score > 0, select all that apply)* ☐ Breaks objects ☐ Hiding items ☐ Hoarding ☐ Inappropriate noises ☐ Inappropriate talk/action ☐ Inappropriate toileting/menses ☐ Puts inappropriate non-food items in mouth ☐ Repetitive movements ☐ Rummaging/takes belongings ☐ Unsafe cooking ☐ Unsafe smoking ☐ Other *(please specify):*
	3.0	0	**3.0**	*C. **INAPPROPRIATE/UNSAFE (INTENSITY):** **If *Frequency* is > 0, what *intensity*** of intervention is required? Behavior is: ☐ **(0 Pts)** easily altered ☐ **(1 Pt)** not easily altered
	3.0	0	**9.0**	21. *A. **SELF-INJURIOUS (REPEAT BEHAVIORS THAT CAUSE SELF-HARM. CAN INCLUDE SUICIDALITY) ASSIGN POINTS SCORE BASED ON FREQUENCY:*** **(0)** Has not occurred in 90 days; **(1)** Occasional (within 90 days)& requiring intervention ≤1 X/week; **(2)** Frequent & requiring intervention ≥1 X/week and < 1X/day; **(3)** Constant & requiring intervention daily **(H)** historically occurred (>90 days ago) AND <2 years ago *B. **SELF-INJURIOUS:** Check applicable behaviors (If score > 0, select all that apply)* ☐ Biting/Scratching/picking at self ☐ Head slapping/banging ☐ Suicidal (describe in detail in narrative) ☐ Other *(please specify):*
	3.0	0	**3.0**	*C. **SELF-INJURIOUS (INTENSITY):** **If *Frequency* is > 0, what *intensity*** of intervention is required? Behavior is: ☐ **(0 Pts)** easily altered ☐ **(1 Pt)** not easily altered

				V. NEUROLOGICAL MEDICAL CONDITIONS: (CHECK ONLY THOSE DIAGNOSES THAT HAVE A CURRENT RELATIONSHIP TO ADL STATUS, COGNITIVE/BEHAVIORAL STATUS, MEDICAL TREATMENTS, SKILLED NURSING CARE, OR RISK OF DEATH)
	20.0	0	**20.0**	22. ☐ Alzheimer's disease/Dementia
	5.0	0	**5.0**	23. ☐ Paralysis (Hem/Para/Quad)
	20.0	0	**20.0**	24. ☐ Traumatic Brain injury
	20.0	0	**20.0**	25. ☐ Severe Orthopedic/neurological impairment with rehabilitative potential

				VI. HEALTH RELATED SERVICES				
				Services Needed or Receiving	**Currently receives**	**Needs**	**No Need Identified**	**Comments**
	10.0	0	**10.0**	26. ☐ Catheter care	1	1	0	
	10.0	0	**10.0**	27. ☐ Occupational Therapy	1	1	0	
	10.0	0	**10.0**	28. ☐ Ostomy Care	1	1	0	
	10.0	0	**10.0**	29. ☐ Oxygen	1	1	0	
	10.0	0	**10.0**	30. ☐ Physical Therapy	1	1	0	
	10.0	0	**10.0**	31. ☐ Pressure/Other Ulcer Care	1	1	0	
	10.0	0	**10.0**	32. ☐ Tube Feeding	1	1	0	
	10.0	0	**10.0**	33. ☐ Turning and positioning	1	1	0	
TOTAL	0							

Last Name: First Name:

Use the space below to provide any additional pertinent information:

Provide copies of 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:
☐MD Notes ☐Nursing Notes ☐MAR Sheet(s) ☐Hospital Records ☐Medical Consultation(s) ☐Psychiatric Evaluation(s)

Other (List): Date form was submitted to Maximus:

I attest that the information provided herein is a true and accurate representation of the individual's medical status and needs

Completed by:

Signature: _____ Printed Name & credentials:

Facility: Phone:

Assessor: Date:

