DEMOGRAPHICS			
Provide the following:	**First Name** **Middle Initial** **Last Name**	**Mailing** **Address City** **State**	**Zip Code** **County** **Phone**
Is this the individual's state of residence?	☐ No <*Specify state of residence*> ☐ Yes		
Type of identification:	☐ Social security number <*Provide*>		
Provide the following:	**Date of Birth** **Marital Status**	**Gender** **Race**	
Current Location:	☐ Community Setting/Home ☐ Medical Facility Medical Unit ☐ Medical Facility ER/ED Medical ☐ Facility Psychiatric Unit	☐ Psychiatric Facility ☐ Nursing Facility ☐ Other <*Specify*>	
Provide the following:	**Current Location** **Address City** **State**	**Zip Code** **Phone** **Fax**	**Contact Name** **Date of Admission** **Admitting Facility**
What is the individual's method of payment for nursing facility care?	☐ Self-Pay ☐ Private Pay ☐ Medicare <*Provide Medicare ID*> ☐ Medicaid <*Provide Medicaid ID, MCO*> ☐ Medicaid Pending <*Provide Medicaid ID, MCO*> ☐		
What has been his/her "typical" living situation over the past year?	☐ Home alone ☐ Home with natural supports/family ☐ Home with paid supports Assisted living ☐ Nursing home ☐ Homeless ☐	☐ Group home ☐ Psychiatric facility ☐ Jail/prison ☐ ICF/IID (Intermediate Care Facility) ☐ Other <*Specify*>	
GUARDIAN/INTERPRETER ***(Applies only to persons with known or suspected MI and/or ID/RC)***			
Does the individual have a legal guardian?	☐ No ☐ Yes <*Provide Guardian name, address, phone*>		
***IF YES:* Verify guardian status:**	☐ Upload or fax verification of guardian status ☐ Attestation		
Does the individual have a primary physician?	☐ No ☐ Yes <*Required: primary physician name, address, fax, and phone*>		
What is the individual's primary language/means of communication?	☐ English ☐ American Sign Language Arabic/Hindu ☐ Armenian ☐ Chinese ☐ Dutch ☐ French ☐ German ☐ Greek ☐ Hindi ☐ Italian ☐	☐ Japanese ☐ Korean ☐ Polish ☐ Portuguese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Yiddish ☐ Other <*Specify*>	
***IF SELECTION OTHER THAN ENGLISH:* Is an interpreter needed?**	☐ No ☐ Yes <*Note how interpreter service should be obtained*>		
MENTAL HEALTH DIAGNOSES			
Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: <*Indicate current or suspected*>	☐ No mental health diagnosis is known or suspected ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Major Depression ☐ Psychotic/Delusional Disorder ☐ Bipolar Disorder (manic depression) ☐ Paranoid Disorder ☐	☐ Personality Disorder ☐ Anxiety Disorder ☐ Trauma/Stress Related Disorder ☐ Panic Disorder ☐ Depression(mild or situational) ☐ Other mental health diagnosis <*Specify—do not include dementia*>	
SUBSTANCE-RELATED DIAGNOSES			

Does the individual have a substance related disorder (abuse or **dependency)? <*Indicate last known use: Less than 7 days, 7-14 days, 15-30 days, 31 days – 3 months, 4-6 months, 7-12 months, more than 12 months, unknown*>**	☐ **No** ☐ **Yes—if yes indicate: Alcohol** ☐ **Cannabis** ☐ **Phencyclidine** ☐ **Hallucinogens** ☐ **Inhalants** ☐ **Opioids** ☐ **Phencyclidine** ☐ **Sedatives/Anxiolytics/ Hypnotics Amphetamines** ☐ **Cocaine** ☐ **Other <*Specify*>**
Is the request for nursing home care in any way associated with or resulting from the substance related disorder (including any withdrawal related symptoms)?	☐ **No** ☐ **Yes**
DEMENTIA/NEUROCOGNITIVE DISORDERS	
Does the individual have a diagnosis of dementia/neurocognitive disorder?	☐ **No** ☐ **Yes <*If yes, complete rest of section questions*>**
Are the deficits due to dementia/ neurocognitive disorder so severe that the individual cannot live in the community because of those deficits?	☐ **No** ☐ **Yes**
Due to the dementia/neurocognitive disorder, does the individual present with:	**1. Significant difficulty communicating?** ☐ **No** ☐ **Yes** **2. Significant difficulty ambulating and/or completing routine motor tasks?** ☐ **No** ☐ **Yes** **3. Significant difficulty recognizing familiar people or familiar objects?** ☐ **No** ☐ **Yes** **4. Significant short-term memory impairments?** ☐ **No** ☐ **Yes** **5. Significant long-term memory impairments?** ☐ **No** ☐ **Yes**
Is corroborative testing or other information available to verify the presence or progression of the dementia?	☐ **No** ☐ **Yes—if yes indicate:** ☐ **Dementia work up** ☐ **Comprehensive Mental Status** ☐ **Exam Other <*Specify*>**
INTERPERSONAL BEHAVIORS	
Check any or all of the following interpersonal behaviors or symptoms experienced by this individual **recently or in the past: <*Indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years*>**	☐ **There are no known mental health behaviors which affect interpersonal interactions** ☐ **Serious difficulty interacting with others** ☐ **Altercations, evictions, or unstable employment** ☐ **Excessive isolation from or avoidance of others (such as would occur with a person with severe anxiety, paranoia, depression, or fear of strangers)**
CONCENTRATION/TASK COMPLETION	
Check whether any or all of the following task- or concentration-related behaviors or symptoms have occurred for this individual recently **or in the past: <*indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years*>**	☐ **There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which s/he should be physically capable of completing** ☐ **Serious difficulty thinking through or completing tasks that s/he should be capable of completing** ☐ **Requires assistance thinking through or completing tasks which s/he should be capable of thinking through or completing** ☐ **Substantial errors thinking through or completing tasks**
MENTAL HEALTH SYMPTOMS	

Check whether any of the following behaviors or symptoms have occurred for this individual recently or in the past: *<indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years>*	☐ None or No Symptoms experienced ☐ Self-injurious or self-mutilation ☐ Suicidal talk ☐ History of suicide attempt or gestures ☐ Physical violence ☐ Physical threats (with potential for harm) ☐ Physical threats (no potential for harm) ☐ Severe appetite disturbance	☐ Hallucinations or delusions ☐ Serious loss of interest in things ☐ Excessive tearfulness ☐ Excessive irritability ☐ 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 any ongoing symptoms. Describe symptoms.
BEHAVIORAL HEALTH SYMPTOMS		
Has the individual received any of the following mental health services now or in the past? *<indicate when last received: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years>*	☐ No ☐ Inpatient psychiatric hospitalization ☐ Partial hospitalization services ☐ Residential treatment services ☐ Mental health crisis services ☐ Other intensive services *<Specify>*	
BEHAVIORAL HEALTH IMPACT		
Has there been legal intervention due to mental health symptoms?	☐ No ☐ Yes *<indicate when last occurred>*	
Has the individual ever had to move to another setting because of mental health symptoms?	☐ No ☐ Yes *<indicate when last occurred>*	
Has the individual ever attempted suicide?	☐ No ☐ Yes *<indicate when last occurred>*	
Has the individual ever been homeless?	☐ No ☐ Yes *<indicate when last occurred>*	
Are there other examples where the individual's life has been seriously affected because of mental health symptoms?	☐ No ☐ Yes *<Describe and indicate when last occurred>*	
Are the individual's behaviors/symptoms stable (meaning that there is no evidence of dangerousness/risk to self or others)?	☐ No ☐ Yes	
PSYCHOTROPIC MEDICATIONS		
Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months?	☐ No ☐ Yes (list below)	
Do not list medications given for medical diagnoses.	*Select from dropdown medication list. Include dosage mg/day and corresponding diagnosis.*	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES		
Does the individual have a diagnosis of an intellectual disability?	☐ No ☐ Yes	
Does the individual have presenting evidence of Intellectual Disability (ID) that has not been diagnosed?	☐ No ☐ Yes	
Is there evidence of a cognitive or developmental impairment that occurred prior to age 18?	☐ No ☐ Yes	
Has the individual ever received services from an agency that serves people with Intellectual Disability (ID)?	☐ No ☐ Yes *<Provide Facility/Agency name and phone if known>*	

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 <*Specify*>
Did this condition develop prior to age 22?	☐ No ☐ Yes
Are there substantial functional limitations NOT due to the medical condition, dementia or mental illness?	☐ No ☐ Yes ☐ Mobility ☐ Self-Care ☐ Self-Direction ☐ Learning ☐ Understanding/use of language ☐ Capacity for living independently

CATEGORICAL DECISIONS *(Applies only to persons with known or suspected MI and/or ID/RC)*

To be eligible for short term exemption or categorical decision, the individual must be psychiatrically and behaviorally stable

When authorization is provided for a short term categorical or exemption, the NF must submit a new level I to Ascend.

Does the admission meet criteria for Hospital Convalescence?	☐ No ☐ Yes, meets all criteria for 30 day Exempted Hospital Discharge ☐ Yes, meets all criteria for 60 day Categorical Decision • Admission to NF directly from hospital after receiving acute medical care • **AND** need for NF is required for the condition treated in the hospital; <specify> • **AND** the attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services (exempted hospital discharge) **OR** The Attending physician has certified prior to NF admission the individual will require less than 60 **calendar days** of NF services (60 day categorical decision)
Does the individual meet one of the following criteria for Respite admission for up to 30 calendar days?	☐ No ☐ Yes, meets the following criteria: • The individual requires respite care for up to 30 calendar days to provide relief to the family and/or caregiver • The individual will be returning to the community at the conclusion of the respite stay
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 of life expectancy of ≤ 6 months, along with nursing care of supervision needs associated with the condition ☐ **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.)
Does the individual have co-occurring dementia and Intellectual Disability/Developmental Disability?	☐ No ☐ Yes —if yes, is the dementia progressed to the extent that the individual could not benefit from ID/DIDD services? ☐ No ☐ Yes

SUBMITTER ATTESTATION/SIGNATURE

Gives opportunity to provide any additional contacts to reach if questions arise and/or additional phone numbers. Text box available for additional notes/comments.

☐ **By checking this box, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I also attest this information was provided by a health care professional working in a clinical capacity for this facility. The health care professional who provided this submission information meets the required clinical qualifications.**

I understand that the state of Tennessee considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to be the best of my knowledge.

Please enter the name of the Clinical Professional who is signing off on the clinical information:

<Provides a field for submitter phone number and a text box for additional notes/comments>