



**Current location of applicant:**  Acute hospital  Psychiatric inpatient  Residential Nursing Facility

Home Address \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Other \_\_\_\_\_

**Check all that apply to the applicant/resident:**

- |  |  |
|--|--|
| <input type="checkbox"/> New admission                         | <input type="checkbox"/> Readmission to NF from psychiatric hospital |
| <input type="checkbox"/> Readmission to NF from acute hospital | <input type="checkbox"/> Transfer from residence to NF               |
| <input type="checkbox"/> Transfer between NF's                 | <input type="checkbox"/> Emergency, Requiring Protective Services    |
| <input type="checkbox"/> Respite care, less than 30 days       | <input type="checkbox"/> Out-of-state resident (OOS)                 |
| <input type="checkbox"/> Significant status change             | <input type="checkbox"/> Referral from ID/DD agency/DBHDD            |
| <input type="checkbox"/> Other: _____                          |  |

**\*Resident's OOS PASRR Contact information:**

\_\_\_\_\_

**Name**

\_\_\_\_\_

**Telephone #**

**CHECK ALL DIAGNOSES THAT APPLY TO PATIENT**

**1. Does the individual have a primary diagnosis of Dementia?**

Yes  No ICD-10 Diagnosis \_\_\_\_\_ Date of Onset, if known \_\_\_\_\_

**a. If yes, check the type of Dementia, due to:**

- |   |  |
|---|--|
| <input type="checkbox"/> Alzheimer's Disease  | <input type="checkbox"/> Head Trauma             |
| <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Vascular changes        |
| <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Pick's Disease          |
| <input type="checkbox"/> HIV                  | <input type="checkbox"/> Creutzfeldt-Jakob (ABE) |
| <input type="checkbox"/> Other _____          |  |

**b. If no, is there presenting evidence to indicate Dementia as a/an:**

1. Undiagnosed condition?  Yes  No or 2. Suspected diagnosis?  Yes  No

**2. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from \*specialized services?**

Yes  No

\* Specialized Services under Georgia's PASRR Program are any services or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services, which result in the implementation of an individualized plan of care that necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, skills training with rehab supports & therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.

Please specify the Physical Illness: \_\_\_\_\_

ICD-10 code(s), if known \_\_\_\_\_ Date of Onset, if known \_\_\_\_\_

- Severe Physical Illness likely to continue?  Yes  No
- Likely to interfere with mental/cognitive capacity/function?  Yes  No

3. Does the individual have a Terminal Illness which includes a medical prognosis that his/her life expectancy is 6 months or less?  Yes  No

Diagnosis \_\_\_\_\_ Date of Onset, if known \_\_\_\_\_

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**CHECK ALL DIAGNOSES THAT APPLY TO PATIENT**

4. Does the individual have a Primary Diagnosis of Serious Mental Illness or Mental Disorder?  Yes  No

Diagnosis \_\_\_\_\_ Date of Onset, if known \_\_\_\_\_ ICD-10 code(s) \_\_\_\_\_

If yes, check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Schizophrenia, Paranoid Type | <input type="checkbox"/> Schizophrenia, Disorganized Type     |
| <input type="checkbox"/> Depressive Disorder          | <input type="checkbox"/> Schizophrenia, Catatonic Type        |
| <input type="checkbox"/> Bipolar Disorder             | <input type="checkbox"/> Schizophrenia, Undifferentiated Type |
| <input type="checkbox"/> Anxiety Disorder             | <input type="checkbox"/> Schizophrenia, Residual Type         |
| <input type="checkbox"/> Somatoform Disorder          | <input type="checkbox"/> Substance Use Related Disorder       |
| <input type="checkbox"/> Other Mental Disorder        |   |

a. Does the treatment history indicate that the individual has received, is receiving, or has been referred to receive services from an agency for a serious mental illness or mental disorder?  Yes  No

b. Does the treatment history indicate the individual has experienced **at least ONE** of the following?

(1) In-patient psychiatric treatment/crisis stabilization unit within past 5 years.  Yes  No

(2) An episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.  Yes  No

c. The disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has **AT LEAST ONE** of the following characteristics on a continuing or intermittent basis:

(1) **Interpersonal Symptoms.** The individual may have serious difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others.  Yes  No

(2) **Completion of Tasks.** The individual may have serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks, requires assistance with tasks, lack concentration or persistence.  Yes  No

(3) **Adapting to change.** This individual may be self-injurious, self-mutilating, suicidal, or have episodes of physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, or withdrawal.  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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5. The individual has a **Diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) [prior to age 18] or a Related Condition [prior to age 22].**

Yes  No

a. Diagnoses of any of the following **disabilities** may indicate a **RELATED CONDITION**: Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

Diagnosis \_\_\_\_\_ Date of Onset, if known \_\_\_\_\_ ICD-10 code(s) \_\_\_\_\_

The individual is a "**PERSON WITH RELATED CONDITIONS**" having a severe, chronic disability that **meets all of the following conditions**:

(1) It is attributable to cerebral palsy, epilepsy or any other condition other than mental illness,

found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required by these persons.

(2) It is manifested before the person reaches age 22.

(3) Is likely to continue indefinitely.

(4) It results in substantial functional limitations in THREE or more of the following areas of major life activities:

- Self-care;
- Understanding and use of language;
- Learning;
- Mobility;
- Self direction; and
- Capacity for independent living.

b. If no, is there presenting evidence to indicate a suspected diagnosis for an **undiagnosed condition** as indicated by substantial functional limitations in THREE or more of the following areas of major life activities: (Refer to Section (4) Above)  Yes  No

c. Does the treatment history indicate that the individual has received, is receiving, or has been referred to services for ID/DD/RC from DBHDD or another agency?  Yes  No

(1) Has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.  Yes  No

(2) Has received Inpatient residential treatment.  Yes  No

**Comments:**

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**Do not admit** the applicant to the nursing facility until the DMA Medical Management Vendor and/or the PASRR Determination Unit approves this admission and issues the PASRR authorization code number.

**\*Admissions into a facility prior to the issued authorization code will result in the Department's denial of payment prior to the date that the PASRR authorization code is issued.** The authorization code must be documented on the applicant's DMA-6 form, in the appropriate 9A or 9B section.

The Level I screen is part of the Preadmission Screening/Resident Review (PASRR), and identifies whether an applicant to a nursing facility has indicators for a related condition of mental illness, intellectual disability or developmental disability. If there is no further evidence to indicate the possibility

of mental illness, intellectual disability or related condition, prior to admission into the nursing facility, the nursing facility may admit this applicant. If the nursing facility admits the applicant and discovers information that was not disclosed to the PASRR screeners, the nursing facility is required to contact the DMA Medical Management Vendor immediately.

**Admission to the facility does not constitute approval for Title XIX patient status.**

**A copy of this form, as well as a copy of the DMA-6, must be placed in each resident's file in the facility.**

Comments:

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I understand that this form may be considered in the payment of claims from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.