



195 North 1950 West
 Salt Lake City, Utah 84116
 (801) 538-3939
 (801) 538-9892 Fax
www.utah.gov

**UTAH DIVISION OF SUBSTANCE ABUSE AND
 MENTAL HEALTH
 PASRR LEVEL II
 PREADMISSION SCREENING RESIDENT REVIEW
 FOR SERIOUS MENTAL ILLNESS**

Personal Information

NAME (LAST, FIRST, MIDDLE)		LEVEL I DOCUMENT #	
SOCIAL SECURITY LAST FOUR DIGITS ###-##-	BIRTH DATE (MMDDYYYY)	AGE	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male

Assessment		Reassessment	
<input type="checkbox"/> Initial	<input type="checkbox"/> End of Convalescent Care Stay	<input type="checkbox"/> End of Convalescent Care Stay	<input type="checkbox"/> End of Short Stay
<input type="checkbox"/> Pre-Admission	<input type="checkbox"/> End of Short Stay	<input type="checkbox"/> End of Short Stay	<input type="checkbox"/> Significant Change in Condition
<input type="checkbox"/> Over 30 Day MD Certified Stay	<input type="checkbox"/> Assessment Update	<input type="checkbox"/> Significant Change in Condition	<input type="checkbox"/> Assessment Update
<input type="checkbox"/> End of Provisional Stay		<input type="checkbox"/> Assessment Update	

Determination Recommendation

<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Short Stay/Convalescent Care Stay	<input type="checkbox"/> NSMI
<input type="checkbox"/> Severity of Illness	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Denial

Referral Information

INITIAL REFERRAL DATE	ASSESSMENT START DATE	DATE MEDICAL/PHYSICAL INFO AVAILABLE I.E. H&P/IMD ORDER:
REFERRING AGENCY & CONTACT PERSON (PLEASE INCLUDE PHONE NUMBER)		
HOSPITAL ADMISSION <input type="checkbox"/> YES <input type="checkbox"/> NO	ADMIT DATE	DISCHARGE DATE
		ER ONLY <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF HOSPITAL AND PHONE NUMBER		

Facility Information

NURSING FACILITY	DATE OF ADMISSION
MAILING ADDRESS	CITY/STATE/ZIP
ATTENDING PHYSICIAN NAME <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Community Provider	

Legal Status

<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Legal Representative	NAME	PHONE #
<input type="checkbox"/> Commitment	<input type="checkbox"/> Self		
LEGAL GUARDIAN ADDRESS (IF DIFFERENT FROM SPOUSE/RELATIVE)			
SPOUSE/RELATIVE (LIST RELATION)	MAILING ADDRESS	CITY/STATE/ZIP	PHONE #
APPLICANT/RESIDENT AGREES TO LEGAL GUARDIAN/REP. AND/OR FAMILY PARTICIPATION <input type="checkbox"/> YES <input type="checkbox"/> NO		TRANSLATOR REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	REASON
Assessment Completed by:		Credential:	Community Mental Health Center:

MENTAL STATUS EXAMINATION/SUMMARY

Is Applicant/Resident open for mental health services at a Community Mental Health Center: YES NO

Name of Community Mental Health Center:

Comprehensive Mental Health/Substance Abuse & Psychiatric History:

- I. Medical justification for skilled nursing facility services
- II. Substance Abuse history and current symptoms
- III. Psychiatric history and current symptoms
- IV. All psychiatric diagnosis must be based on current Diagnostic and Statistical Manual of Mental Disorders (DSM) Criteria

Applicant/Resident Name: _____

MENTAL STATUS EXAMINATION/SUMMARY

Description:

Appearance: _____
 Attitudes: _____
 Overt Behavior: _____
 Affect: _____

Perceptual Disturbances: (i.e. Psychotic Symptoms) – Limit 630 Characters

Thought Form & Content: (i.e. linear, logical, tangential) – Limit 315 Characters

Speech Clarity & Modes of Expression: – Limit 315 Characters

Evaluation of Cognitive Functioning

Orientation: (Y)es, (P)artial, (N)o	Person	Place	Situation	Time
Consciousness:	<input type="checkbox"/> Alert	<input type="checkbox"/> Drowsy	<input type="checkbox"/> Stupor	<input type="checkbox"/> Coma

Judgment:

Independent <input type="checkbox"/>	Modified Independence <input type="checkbox"/>	Moderately Impaired <input type="checkbox"/>	Severely Impaired <input type="checkbox"/>
Recent Memory:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Intact
Remote Memory:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Intact

Additional Testing Results (if available); (i.e., Mini Mental Status Exam or other assessment tools. Attach copy behind page 3.) – Limit 210 Characters

Insight (Knowledge of Illness):	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good
---	-------------------------------	-------------------------------	-------------------------------

****Do your findings indicate the Applicant/Resident may be a substantial danger to himself/herself or others?** Yes No **If Yes, does the nursing facility's supervision and structure mitigate the danger?** Yes No

If yes, please explain the plan: – Limit 210 Characters

Applicant/Resident Name: _____

**VALIDATION OF APPLICANT/RESIDENT'S
SERIOUS MENTAL ILLNESS DIAGNOSIS**

Based on the data compiled, the following **Serious Mental Illness** diagnoses are verifiable and indicated based on assessments, evaluations and documentation attached to the PASRR Level II Assessment

DSM Coding:	Diagnosis Description:

Current Psychiatric Medications:

Medications	Dosage	Prescribing Physician

Comments/Diagnostic Impressions:– Limit 735 Characters

Psychiatric Treatment Recommendations: (Applicant/Resident's service needs, regardless of the Nursing Facility's ability to meet those needs) – Limit 735 Characters

M.D. or A.P.R.N. (please print)

Signature & Title: _____ **Date:** _____

Please stop assessment and sign below if NOT Seriously Mentally Ill (NSMI) per State Mental Health Authority definition.

Evaluator Signature: _____ **Date:** _____

Applicant/Resident Name: _____

PSYCHIATRIC SPECIALIZED SERVICES ASSESSMENT

If Applicant/Resident meets the State Mental Health Authority's definition of **SERIOUS MENTAL ILLNESS** criteria from Page #4, does the Applicant/Resident require "In-patient hospitalization for psychiatric specialized services" for the Serious Mental Illness?

YES NO *If yes, does the Applicant/Resident Medical needs outweigh psychiatric treatment needs at this time?* YES NO

IF RECOMMENDING DENIAL COMPLETE THE FOLLOWING SECTION. IF NOT GO TO THE NEXT PAGE.

RECOMMENDING DENIAL:

The Applicant/Resident requires "In-Patient Hospitalization for Psychiatric Specialized Services" for the following Serious Mental Illness Diagnosis:

DSM Coding	Diagnosis Description	DSM Coding	Diagnosis Description

M.D. or A.P.R.N. (please print)

Signature:

Date:

Please stop assessment and sign below if recommending Denial. Please contact the State Mental Health Authority PASRR Office as soon as possible if recommending Denial at 801-538-3939.

Evaluator Signature:

Date:

Applicant/Resident Name: _____

SERIOUS MENTAL ILLNESS CRITERIA

483.102(b)(1)(ii)(iii) Definition:

An Applicant/Resident is considered to have a **SERIOUS MENTAL ILLNESS** as defined by the State Mental Health Authority, if the individual meets all three of the following requirements: **DIAGNOSIS, LEVEL OF IMPAIRMENT, DURATION OF ILLNESS**

483.102(I)(A)(b) DIAGNOSIS

Diagnosable under the DSM:			
<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	Obsessive Compulsive Disorder
<input type="checkbox"/>	Schizoaffective Disorder	<input type="checkbox"/>	Panic Disorder
<input type="checkbox"/>	Delusional Disorder	<input type="checkbox"/>	Borderline Personality Disorder
<input type="checkbox"/>	Psychosis NOS	<input type="checkbox"/>	Somatization Disorder
<input type="checkbox"/>	Major Depression	<input type="checkbox"/>	Generalized Anxiety Disorder
<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Posttraumatic Stress Disorder

483.102(ii)(A)(B)(C) LEVEL OF IMPAIRMENT

Functional limitations in major life activities within the past 3 to 6 months. Must have at least one of the following characteristics on a continuing or intermittent basis:			
Adaptation to change (serious difficulty)			
<input type="checkbox"/>	Adapting to typical changes in circumstances associated with:		
<input type="checkbox"/>	Family	<input type="checkbox"/>	School
<input type="checkbox"/>	<input type="checkbox"/>	Social Interaction	<input type="checkbox"/>
<input type="checkbox"/>	Work		
<input type="checkbox"/>	Exacerbated signs and symptoms associated with the illness		
<input type="checkbox"/>	Manifests agitation		
<input type="checkbox"/>	Requires intervention of the mental health or judicial system		
<input type="checkbox"/>	Withdrawal from the situation		
Concentration, Persistence and Pace (serious difficulty)			
<input type="checkbox"/>	Difficulties in concentration		
<input type="checkbox"/>	Inability to complete simple tasks within an established time period		
<input type="checkbox"/>	Makes frequent errors		
<input type="checkbox"/>	Requires assistance in completion of these tasks		
<input type="checkbox"/>	Sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or work-like structured activities occurring in school or home settings		
Interpersonal Functioning (serious difficulty)			
<input type="checkbox"/>	Avoidance of interpersonal relationships	<input type="checkbox"/>	Firing
<input type="checkbox"/>	Communicating effectively with other persons	<input type="checkbox"/>	Interacting appropriately
<input type="checkbox"/>	Eviction	<input type="checkbox"/>	Possible history of altercations
<input type="checkbox"/>	Fear of strangers	<input type="checkbox"/>	Social Isolation

483.102(iii)(A)(B) RECENT TREATMENT

Document the treatment history which indicates that the individual has experienced at **least one** of the following:

<input type="checkbox"/>	Psychiatric treatment more intensive than outpatient care more than once in the past 2 years: (e.g., partial hospitalization/day treatment or in-patient hospitalization; crisis intervention) OR
-OR- Within the last 2 years	
<input type="checkbox"/>	Experienced an episode of significant disruption to the normal living situation:
<input type="checkbox"/>	Required supportive services due to serious mental illness , to maintain function at home or in a residential treatment environment OR
<input type="checkbox"/>	Resulted in intervention by housing or law enforcement officials

Applicant/Resident Name: _____

PSYCHOSOCIAL EVALUATION/SUMMARY

EVALUATION/SUMMARY INCLUDING THE FOLLOWING SPECIFIC INFORMATION:

1.	Applicant/Resident's place of residence prior to hospital or nursing facility placement:		
	<input type="checkbox"/> Home with family support	<input type="checkbox"/> Living with family	
	<input type="checkbox"/> Home without family support	<input type="checkbox"/> Homeless	
	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Other	
2.	Social History (Developmental, Educational, Special Education, Occupational, Marital and Social Supports) – Limit 1220 Characters		
3.	Psychosocial Strengths: – Limit 940 Characters		
4.	Psychosocial Weaknesses and Needs: – Limit 940 Characters		
5.	Nursing Facility Admission History: (Check the PASRR Online program)		
	Nursing Facility	Admission Date	Discharge Date

Applicant/Resident Name: _____

ATTACH THE FOLLOWING REQUIRED COLLATERAL

<input type="checkbox"/>	Level I Screening Form (Required to be completed and signed as indicated prior to PASRR Level II)
<input type="checkbox"/>	Physician Orders (Most Current Medication & Treatment Orders)
<input type="checkbox"/>	(MDS) Minimum Data Set (if available)
<input type="checkbox"/>	(H & P) History & Physical

COMPREHENSIVE PHYSICAL EXAMINATION SUMMARY

PAST MEDICAL HISTORY: (List past diagnosis, surgeries and medical procedures)
– Limit 1785 Characters

CURRENT MEDICAL DIAGNOSIS: (Specify weight and height if obesity is a factor)
– Limit 1785 Characters

Applicant/Resident Name: _____

APPLICANT/RESIDENT'S ACTIVITIES OF DAILY LIVING FUNCTIONAL ASSESSMENT

ACTIVITIES	N/A	SELF INITIATES ADL TASKS INDEPENDENT	SUPERVISION, OVERSIGHT, ENCOURAGEMENT OR CUEING	LIMITED ASSISTANCE RECEIVES PHYSICAL HELP (RESIDENT INVOLVED)	EXTENSIVE ASSISTANCE RESIDENT PERFORMED PART OF ACTIVITY	TOTAL DEPENDENCE COMPLETE NON-PARTICIPATION
1. Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bladder Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bowel Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Locomotion - On unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Off unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Wheelchair/Walker/Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Transfers: One/Two/Weight Bearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Verbal/Gestural or Written Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Self-Monitoring of Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Self Administration of Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Self-Directive Accessing Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Eating & Monitoring of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bathing-Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Dressing Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Handling of Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source of Information:

Applicant/Resident Name: _____

IDENTIFY THE SPECIFIC NURSING FACILITY SERVICES THAT ARE REQUIRED TO MEET THE APPLICANT/RESIDENT ASSESSED NEEDS

The Applicant/Resident requires medical services and treatment that are intensive and require the support level of nursing facility placement. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Assistance with ADL | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Catheter Care | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Colostomy Care | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> IV Antibiotics | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Monitor Diet | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Monitor Medications | <input type="checkbox"/> Total Care for ADL's |
| <input type="checkbox"/> Monitor Safety (i.e. falls, wandering risk) | <input type="checkbox"/> Other |

Discharge potential and prognosis for non-institutional residential living arrangements:

Poor

Fair

Good

Excellent

Could Applicant/Resident be referred to a home/community based waiver program?

YES NO

Could Applicant/Resident currently reside in a less restrictive community-based setting?

YES NO

Recommendations & Placements Options: – Limit 1365 Characters

Applicant/Resident Name: _____

PASRR LEVEL II NURSING FACILITY CRITERIA ASSESSMENT

Criteria for Level of Nursing Service for Applicant/Resident with a **SERIOUS MENTAL ILLNESS** as defined by the State Mental Health Authority.

The request for nursing facility care must document that the applicant/resident has **TWO or MORE** of the following elements according to Administrative Rule R414-5002:

- Due to diagnosed medical conditions, the Applicant/Resident requires at least substantial physical assistance with activities of daily living above the level of verbal promptings, supervising, or setting up;
- The attending physician has determined that the Applicant's/Resident's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program; or
(Documentation is provided to substantiate significant cognitive deficits – i.e., Mini Mental Status Exam or other assessment tools. Attach copy behind page 3)
- The medical condition and intensity of services indicate that the care needs of the Applicant/Resident cannot be safely met in a less structured setting or without the services and supports of an alternative Medicaid health care delivery program.
(Documentation is provided that less structured alternatives have been explored and why alternatives are not feasible – page 2)

RECOMMENDATIONS

All determinations must verify the existence of a **SERIOUS MENTAL ILLNESS** as defined by the State Mental Health Authority and assess the need for specialized services.

- Nursing Facility Services (Long Term Care)
- Short Stay/Convalescent Care Stay: (Convalescent Care Stay requires prior medical hospitalization)
- Provisional Admission: (Admit by Adult Protective Services for Delirium and/or Emergency) **Prior approval is needed from State MH Authority (DSAMH) BEFORE ADMISSION – Level II is required if provisional admission exceeds 7 days**
- Severity of Illness: (Such as: Ventilator, Coma, COPD, CHF, Parkinson's, Huntington's, Amyotrophic Lateral Sclerosis, and functioning at Brain Stem Level) Medical/Physical Fragility: (Level of debilitation is severe and results in a level of impairment deemed not to benefit from mental health services)
- Terminal Illness: (Such as: Metastatic CA, Etc.) – Not receiving hospice care
- Denial (due to absence of medical need). Please contact the State Mental Health Authority PASRR Office as soon as possible if recommending Denial at 801-538-3939.

Additional Comments: – Limit 210 Characters

M.D. or A.P.R.N. (please print)

Signature: _____ Date: _____

Assessment Completed by: _____ Credential: _____ Community Mental Health Center: _____

Signature: _____ Date: _____

Applicant/Resident Name: