Nevada Medicaid and Nevada Check Up Programs
First Health Services Corporation
LEVEL I IDENTIFICATION SCREENING (for PASRR) ***"CONFIDENTIAL"***

PHONE: 1-800-525-2395 FAX: 1-866-480-9903

DATE SUBMITTED to FHSC: INITIAL___ UPDATE___

PLEASE TYPE OR PRINT

Patient Name: _____ SS #: _____

Home Address: _____ Medicaid Billing #: _____ Sex: _____

_____ DOB: _____ Pmt. Source: _____ Marital Status: _____

Known Diagnoses: _____ Original Admit Date: _____ Admit Date: _____

Legal Representative: _____ Admitting Facility: _____

Provider ID#: _____ Address: _____

Requesting Facility: _____ Contact Name: _____

Address: _____ Telephone: _____ Fax: _____

Telephone: _____ Fax: _____ Patient's Current Location Home____ Acute In-Patient____ ER____

Requestor: _____ Acute ObservBed _____ NF____ Rehab Hosp/Unit___ Other_____

SECTION I: MENTAL ILLNESS (MI) SCREENING

1.A. Psychiatric Diagnoses

- [ ] Severe Anxiety/Panic Disorder
- [ ] Bipolar Disorder
- [ ] Delusional Disorder
- [ ] Schizoaffective disorder
- [ ] Major depression
- [ ] Personality disorder (specify) _____
- [ ] Other : _____
- [ ] Psychotic disorder
- [ ] Somatoform disorder
- [ ] Schizophrenia
- [ ] Eating disorder (specify)

1.B. Psychiatric Meds / Diagnosis/Purpose

FHSC USE ONLY: Meets diagnosis criteria for chronicity? [ ] **Y** [ ] **N**

2.A. Psychiatric treatment more intense than outpatient received in past 2 years: (MORE THAN ONCE)

- [ ] inpatient psych. hosp.(dates) _____
- [ ] partial hosp./day treatment(dates) _____
- [ ] other(dates) _____

2.B. Intervention to prevent hospitalization: (give dates)

- [ ] supportive living due to MI(dates) _____
- [ ] housing intervention due to MI(dates) _____
- [ ] legal intervention due to MI(dates) _____
- [ ] suicide attempt(dates) _____
- [ ] other _____

FHSC USE ONLY: Meets criteria for duration? [ ] **Y** [ ] **N**

3. Role limitations in past 6 months due to MI: (excluding medical problems)
Indicate: "F" Frequently, "O" Occasionally, or "N" Never

3. A. Interpersonal Functioning (exclude problems w/medical basis)

F O N	Altercations	F O N	Social isolation/avoidance
F O N	Evictions	F O N	Excessive irritability
F O N	Fear of strangers	F O N	Easily upset/anxious
F O N	Suicidal talk	F O N	Hallucinations
F O N	Illogical comments	F O N	Serious communication difficulties
F O N	Other _____	F O N	Other _____

Notes: _____

3.B. Concentration/task limitations within past 6 months and due to MI (exclude problems with medical basis):

- F O N Serious difficulty completing age related tasks.
- F O N Serious loss of interest in things.
- F O N Serious difficulty maintaining concentration/attention.
- F O N Numerous errors in completing tasks which he/she should be physically capable of accomplishing.
- F O N Requires assistance with tasks for which he/she should be physically capable of accomplishing.
- F O N Other: _____

Notes: _____

3.C. Significant problems adapting to typical changes within past 6 months and due to MI (exclude problems with medical basis):

- Y N Requires mental health intervention due to increased symptoms.
- Y N Requires judicial intervention due to symptoms.
- Y N Symptoms have increased as a result of adaptation difficulties.
- Y N Serious agitation or withdrawal due to adaptation difficulties.
- Y N Other _____

Notes: _____

FHSC USE ONLY: **MI Decision:**
Meets criteria for disability? [ ] **Y** [ ] **N** **Meets criteria for SMI:** [ ] **Y** [ ] **N**

SECTION II: MENTAL RETARDATION (MR) AND RELATED CONDITIONS (RC) SCREENING

1.A. MR diagnosis: _____ N _____ Y (specify) _____

B. Undiagnosed but suspected MR: _____ N _____ Y _____ N/A

C. History of receipt of MR services: _____ N _____ Y
(if yes, specify): _____

2. Occurrence before age 18: _____ N _____ Y
(if yes, specify age): _____

2.A. Related conditions which impair intellectual functioning or adaptive behavior. _____ Blindness _____ Deafness
_____ Cerebral Palsy _____ Autism _____ Epilepsy
_____ Closed head injury _____ Other _____

B. Substantial functional limitations in 3 or more of the following:
_____ Self-care _____ Mobility _____ Learning
_____ Self-direction _____ Capability for independent living
_____ Understanding/use of language

C. Was the condition manifested before age 22?
_____ N _____ Y (specify) _____

FHSC USE ONLY: Meets criteria for MR/RC?
MR Decision: [ ] **Y** [ ] **N**

Name and Professional Title of Person Completing Form: _____ **Date Completed:** _____

FHSC-18 Aug-03

STOP HERE IF NO INDICATORS OF MI, MR OR RC

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STOP HERE - IF NO INDICATORS OF MI, MR OR RC
OTHERWISE CONTINUE

SECTION III: DEMENTIA (complete for both MI & MR/RC)

A. Does the individual have a primary diagnosis of Dementia or Alzheimer's Disease?
_____ Y _____ N (specify)_____
B. Does the individual have any other organic disorders?
_____ Y _____ N (specify)_____
C. Is there evidence of undiagnosed Dementia or other organic mental disorders?
Y N disoriented to time Y N disoriented to situation
Y N disoriented to place Y N pervasive, significant confusion
Y N severe ST memory deficit Y N paranoid ideation
D. Is there evidence of affective symptoms which might be confused with Dementia?
Y N frequent tearfulness Y N severe sleep disturbance
Y N frequent anxiety Y N severe appetite disturbance
E. Can the requstor provide any corroborative information to affirm that the dementing condition exists and is the primary diagnosis?
_____ Dementia work-up _____ Thorough mental status exam
____ Medical/functional history prior to onset of dementia
_____ Other_____

STOP - If Dementia is primary to MI.
CONTINUE - for all MR/RC or non-primary dementia with MI.

FHSC USE ONLY: Meets dementia criteria? ☐ **Y** ☐ **N**

SECTION IV: EXEMPTED HOSPITAL DISCHARGE (EHD)*

A. Does the individual meet all of the following criteria?
_____ Admission to a NF directly from a hospital after receiving ***acute in-patient care*** at the hospital; and
_____ Requires NF services for the condition he/she received care in the hospital; and
_____ The attending physician has certified prior to NF admission that the individual will require less than 30 days NF services. (Submit copy)

*** Individuals meeting all above criteria are exempt from PASRR II screening for 30 days. The receiving facility must submit a Level I by the 25th day to request PASRR Level II, when it is apparent the stay will exceed 30 days.**

FHSC USE ONLY:
Meets EHD criteria? ☐ **Y** ☐ **N**
Limitation Date: _____

PASRR LEVEL II CATEGORICAL DETERMINATIONS

SECTION V: Time-Limited* CATEGORICAL DETERMINATIONS

IIE. The following categories indicate the individual requires NF services and does not require specialized services for the time specified.
A. _____ **Convalescent care** from an acute physical illness which required hospitalization and does not meet all criteria for an EHD.
B. _____ **Emergency protective service** situation for MI or MR/RC individual - placement in NF not to exceed 7 days.
C. _____ **Delirium** precludes the ability to accurately diagnose. Facility must obtain PASRR Level II as soon as the delirium clears.
D. _____ **Respite** is needed for in-home caregivers to whom the MI, MR/RC individual will return.

***If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the limitation date listed below for resident's whose stay is anticipated to exceed that date.**

FHSC USE ONLY: Meets IIE Categorical Determination Criteria?
A. ☐ **Y** ☐ **N**
B. Appropriate for NF ☐ **Y** ☐ **N**
Limited to: _____
Note: Limitations for Convalescent care = 45 days, Emergency Protective Services = 7 days, Delirium = 30 days, and Respite = 30 days.

SECTION VI: OTHER CATEGORICAL DETERMINATIONS *(non-limited)*

IIF. _____ **Terminal Illness:** Physician has certified life expectancy of less than 6 months. (Submit copy of certification).
IIG. _____ **Severe Physical Illness** limited to: Coma, Ventilator Dependence, functioning at a brain stem level or a diagnosis of Parkinson's, Chronic Obstructive Pulmonary Disease, Huntington's disease, Amyotrophic lateral sclerosis or congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

FHSC USE ONLY:
Meets Other Categorical Determination criteria?
☐ **Y** ☐ **N**

SECTION VII: REQUESTING PROVIDER TO COMPLETE

Mailing Information (required if indicators of MI, MR/RC):
Legal representative's name and address:

Primary physician's name and address:

☐ Additional supporting documentation is attached/submitted.
☐ Physician's certification stating a less than 30 day nursing facility stay is needed to justify EHD is attached/submiited.
☐ Physician's certification for a less than six (6) month life expectancy for terminal illness is attached/submitted.

Date Form Completed:
Name and Professional Title of Person Completing form:

FHSC OFFICE USE ONLY:
SUMMARY and DETERMINATION

☐ **Has indicators of MI, MR/RC** ☐ **No indicators of MI, MR/RC**

Level I Identification Determination:
_____ **IA - Exempted Hospital Discharge**
_____ **IA - Qualifies for Categorical Determination**
_____ **IA - Requires PASRR Level II Individual Evaluation**
_____ **IB - Has Dementia, Alzheimer's, Organic Brain Syndrome**
_____ **IC - Not MI, MR/RC or Demented**

PASRR Level II Categorical Determination:
☐ **PAS (applicant to NF)** ☐ **RR (resident in NF)**
_____ **IIE - Time Limited Approval Limitation Date:** _____
_____ **IIF - Terminal Illness**
_____ **IIG - Severe Physical Illness**

Referral Needed for PASRR Level II Individual Evaluation:
_____ **Referred for MI** **Date Referred:** _____
_____ **Referred for MR/RC** **Date Referred:** _____
_____ **Dual Referral MI and MR/RC** **Date:** _____

_____
Date Completed **FHSC Reviewer's Name/Signature**