MARYLAND DEPARTMENT OF HEALTH
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I ID SCREEN FOR
MENTAL ILLNESS AND INTELLECTUAL DISABILITY OR RELATED CONDITIONS

Note: This form must be completed for all applicants to nursing facilities (NF) which participate in the Maryland Medical Assistance Program regardless of applicant's payment source.

Last Name_____ First Name_____ MI_____ Date of Birth_____

SSN_____ Sex M___ F___ Actual/Requested Nursing Facility Adm Date_____

Current Location of Individual_____

Address_____

City/State_____ ZIP_____

Contact Person_____ Title/Relationship_____ Tel#_____

A. EXEMPTED HOSPITAL DISCHARGE

1. Is the individual admitted to a NF directly from a hospital after receiving acute inpatient care? Yes [ ] No [ ]

2. Does the individual require NF services for the condition for which he received care in the hospital? Yes [ ] No [ ]

3. Has the attending physician certified before admission to the NF that The resident is likely to require less than 30 days NF services? Yes [ ] No [ ]

IF ALL THREE QUESTIONS ARE ANSWERED YES, FURTHER SCREENING IS NOT REQUIRED (PLEASE SIGN AND DATE BELOW). IF ANY QUESTION IS ANSWERED NO, THE REMAINDER OF THE FORM MUST BE COMPLETED AS DIRECTED.

IF THE STAY EXTENDS FOR 30 DAYS OR MORE, A NEW SCREEN AND RESIDENT REVIEW MUST BE PERFORMED WITHIN 40 DAYS OF ADMISSION.

Signature_____ Title_____ Date_____

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B. INTELLECTUAL DISABILITY (ID) AND RELATED CONDITIONS (see definitions)

1. Does the individual have a diagnosis of ID or related condition? If yes, specify diagnosis_____ Yes [ ] No [ ]

2. Is there any history of ID or related condition in the individual's past, prior to age 22? Yes [ ] No [ ]

3. Is there any presenting evidence (cognitive or behavior functions) that may indicate that the individual has ID or related conditions? Yes [ ] No [ ]

4. Is the individual being referred by, and deemed eligible for, services by an agency which serves persons with ID or related conditions? Yes [ ] No [ ]

Is the individual considered to have ID or a Related Condition? If the answer is Yes to one or more of the above, check "Yes." If the answers are No to all of the above, check "No." Yes [ ] No [ ]

Name_____

C. SERIOUS MENTAL ILLNESS (MI) (see definitions)

1. Diagnosis. Does the individual have a major mental disorder?
If yes, list diagnosis and DSM Code_____ Yes [ ] No [ ]

2. Level of Impairment. Has the disorder resulted in serious functional limitations in major life activities within the past 3 – 6 months (e.g., interpersonal functioning, concentration, persistence and pace; or adaptation to change? Yes [ ] No [ ]

3. Recent treatment. In the past 2 years, has the individual had psychiatric treatment more intensive than outpatient care more than once (e.g., partial hospitalization) or inpatient hospitalization; or 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 [ ]

Is the individual considered to have a SERIOUS MENTAL ILLNESS? If the answer is Yes to all 3 of the above, check "Yes." If the response is No to one or more of the above, check "No." Yes [ ] No [ ]

If the individual is considered to have MI or ID or a related condition, complete Part D of this form. Otherwise, skip Part D and sign below.

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (described in Part A)? Yes [ ] No [ ]

2. Does the individual have a terminal illness (life expectancy of less than six months) as certified by a physician? Yes [ ] No [ ]

3. Does the individual have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes [ ] No [ ]

4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. Yes [ ] No [ ]

5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? Yes [ ] No [ ]

If any answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach. Additionally, if questions 1, 2, or 3 are checked "Yes," or if all answers in Part D are "No," the individual must be referred to AERS for a Level II evaluation.

I certify that the above information is correct to the best of my knowledge. If the initial ID screen is positive and a Level II evaluation is required, a copy of the ID screen has been provided to the applicant/resident and legal representative.

Name_____ Title_____ Date_____

FOR POSITIVE ID SCREENS, NOT COVERED UNDER CATEGORICAL DETERMINATIONS, Check below.

___ This applicant has been cleared by the Department for nursing facility admission.
___ This resident has been assessed for a resident review.

Local AERS Office_____ Contact_____ Date_____