**STATE OF VERMONT**

**PRE-ASSESSMENT SCREENING AND RESIDENT REVIEW (PASRR): LEVEL I**

**FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, OR RELATED CONDITION**

Federal regulations require that a pre-admission screening be completed **before** any person who is known to have, or possibly may have, a serious mental illness and/or intellectual/developmental disability, or related condition, is admitted to a Medicaid participating nursing facility (NF), **regardless of the source of payment for the NF services, and regardless of the individual’s known diagnoses.**

Individual’s Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is the individual currently located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To which Nursing Facility is the individual seeking admission? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Serious Mental Illness**

1. Does this individual have one of the following diagnoses? (A serious mental illness diagnosable under the Diagnostic and Statistical Manual of Mental Disorders)

Schizophrenia

Mood Disorder (Depression, Bipolar Disorder)

Delusional Disorder (Paranoid Disorder)

Personality Disorder

Somatoform Disorder

Psychotic Disorder (Schizoaffective Disorder; Atypical Psychosis; Schizophreniform Disorder; Brief Reactive Psychosis)

Anxiety Disorder (Panic Disorder; Phobia; Obsessive-Compulsive Disorder; Post-Traumatic Stress Disorders; Severe Anxiety)

Substance Use Disorder

None

Other mental disorder that may lead to chronic disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this individual had a disability or significant impairment in major life functions in the past 6 months due to a psychiatric disorder or substance use disorder? If Yes, check one or more of the subcategories below.

Yes  No

**Interpersonal Functioning:** This individual has serious difficulty interacting appropriately and communicating effectively with other people; may have a history of evictions or altercation with others, fear of others, avoidance of interpersonal relationships and social isolation, and unstable employment.

**Completing Tasks:** This individual has serious difficulty sustaining focused attention, completing tasks, difficulties with concentration, inability to complete simple tasks within an established timeframe, makes frequent errors, or requires assistance to complete tasks.

**Adapting to Change:** This individual has serious difficulty in adapting to typical changes in work, school, family, or social interactions; may have excessive irritability or agitation, exacerbated signs and symptoms associated with the illness checked above, withdrawal from situations, self-injurious behaviors, self-mutilation, suicidal behavior, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest in hobbies or activities, and sustained tearfulness.

1. Has this individual had a hospitalization for treatment of a psychiatric condition or substance use disorder within the past 3 years? Or, has this individual required intensive psychiatric treatment (partial hospitalization/day treatment, crisis bed, in-home supportive services) to maintain their functioning in the community?

Yes  No

**Diagnosis of Dementia**

Is this individual’s Primary diagnosis dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders?

Yes  No

If Yes, the individual is exempt from a PASRR Level II Mental Health evaluation.

**If ALL of the responses under serious mental illness are Yes, a Level II Mental Health PASRR evaluation is required.**

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**Intellectual/Developmental Disability or Related Condition**

1. Does this individual have a diagnosis of intellectual/developmental disability prior to the age of 18?

Yes  No

1. Does the individual have a history of intellectual/developmental disability prior to the age of 18 or related condition prior to the age of 22?

Yes  No

If Yes, provide historical information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does this individual have a diagnosis of a “related condition” prior to the age of 22? (e.g. cerebral palsy, epilepsy, brain injury-resulting in significant impairment in intellectual functioning and adaptive behavior)

Yes  No

1. Is there presenting evidence (cognitive or behavioral) that indicated this individual may have an intellectual/developmental disability prior to the age of 18 or related condition prior to the age of 22?

Yes  No

If Yes, provide evidence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Was this individual referred by or receiving services from an agency that serves individuals with intellectual/developmental disabilities and/or related conditions?

Yes  No

If Yes, name of agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If ANY of the responses under intellectual/developmental disability or related condition are Yes, a Level II Developmental Disabilities PASRR evaluation is required.**

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**Please be sure to send completed copies of this form to the hospital of record, nursing facility, and individual/legal guardian(s).**

Name of Person Completing Form: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Nursing Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_