STATE OF VERMONT
PRE-ASSESSMENT SCREENING AND RESIDENT REVIEW (PASRR): LEVEL 1
FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, OR RELATED CONDITION

Federal regulations require that a preadmission screening must occur **before** any person who is known to have or possibly may have a serious mental illness and/or intellectual 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 Last/First Name: _____ DOB: _____

Where is the individual currently located? _____

To which Nursing Facility is the individual seeking admission? _____

Part A – Exemption

If the individual is found to meet the conditions of this exemption, the individual may be admitted to a nursing facility without further screening.

Hospital Discharge for Short-Stays (30 days or less)

Is this individual being admitted to a nursing facility directly following an acute hospitalization for treatment of a condition that he/she was hospitalized for? (The attending physician must certify before admission that the individual is likely to require less than 30 days in the nursing facility to qualify for this exemption.)

☐ Yes

_____
(Physician's Signature Required)

If it is later decided the individual will exceed the 30 days stay, this form must be completed by the admitting nursing home in full and submitted.

Part B-Mental Illness

1. Does this individual have one of the following diagnoses? (a major mental disorder 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: _____

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2. 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? Check YES if any of the subcategories below are checked.
   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 time period, 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.

3. Has this individual had a hospitalization for 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 his/her functioning in the community?
   Yes ☐ No ☐

Does this person have a current or recent mental health provider? Please list name, program and contact information: _____

Diagnosis of Dementia
Is the individual's Primary diagnosis dementia as described in the Diagnostic and Statistical Manual of Mental Disorders?

Yes ☐ No ☐

If yes, documented evidence of the diagnosis (physician note, discharge summary, work-up, comprehensive mental status exam) must be attached.

If yes, the individual is exempt from further PASRR Mental Health evaluation, even if they have been diagnosed and treated for a mental illness.

If ALL the responses to question 1-3 in Part B are Yes, a Level II Mental Health PASRR evaluation is required. Please notify the MH PASRR Coordinator, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010 , or Fax (802) 241-0100, or call (802) 241-0090.

Part C – Intellectual Disability or Related Condition

1. Does this individual have a diagnosis of intellectual/developmental disability? Yes ☐ No ☐
   Age when diagnosis was established _____ Unknown ☐

2. Does this individual have a "related condition" (e.g. cerebral palsy, epilepsy, brain injury-resulting in significant impairment in intellectual functioning and adaptive behavior)? Yes ☐ No ☐
   Age of onset_____ Unknown ☐

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3. Does the individual have a history of intellectual/developmental disability or related condition? Yes ☐ No ☐

4. Is there presenting evidence (cognitive or behavioral) that indicated this individual may have an intellectual/developmental disability or related condition? Yes ☐ No ☐

   If yes, explain:

5. 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 response to ANY question in Part C is YES, a Level II DEVELOPMENTAL DISABILITIES PASRR is required. Notify the DDS PASRR coordinator, 280 State Drive, HC 2 South, Waterbury, VT 05671-2030 or FAX (802) 241-0410, or call (802) 289-0015

   _____

   Completed copies of this form have been distributed to:

☐ **hospital of record**
☐ **nursing facility**
☐ **individual/legal guardian(s).**

Name & Title of Person Completing Form: _____
(Please Print)

Signature of Person Completing Form: _____

Hospital/Facility Address: _____

Phone #: _____ Email: _____ Date: _____

Please mail or fax all original signed LEVEL I PASRR forms to: Department of Mental Health, Attn: MH PASRR Coordinator, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010 or Fax (802) 241-0100