

Ohio Department of Medicaid
PREADMISSION SCREENING/RESIDENT REVIEW (PAS/RR) IDENTIFICATION SCREEN

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT

Last Name	First Name	MI
Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female	Date of Birth (mm/dd/yyyy)	Social Security Number
Medicaid Recipient <input type="checkbox"/> Yes <input type="checkbox"/> Managed Care <input type="checkbox"/> Pending <input type="checkbox"/> No		
Medicaid Number (12 digits) if applicable		Managed Care Plan Name (If applicable)
<input type="checkbox"/> YES <input type="checkbox"/> NO Does applicant/resident have additional health care insurance with another company? If so, name of insurance company		

Living arrangement/options at the time of the request for PASRR: (Check one below)

<p>Independent Living Option</p> <input type="checkbox"/> Own/Leases Home/Apartment-Lives Alone <input type="checkbox"/> Own Home/Apartment Lives with Others (Friends/Family) <input type="checkbox"/> Home Owned/Leased by Individual <input type="checkbox"/> Living with Family <input type="checkbox"/> Homeless	<p>Institutional Setting</p> <input type="checkbox"/> ICF/MR <input type="checkbox"/> Private Psychiatric Hospital Name <input type="checkbox"/> Regional Psychiatric Hospital Name <input type="checkbox"/> Prison <input type="checkbox"/> Nursing Facility	<p>Community-Based Residence</p> <input type="checkbox"/> Group Home (Non ICF/MR) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other (please specify)
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SECTION B: REASONS FOR SCREENING

(Indicate using **ONE** of the boxes below)

Preadmission Screening Codes (If seeking admission into nursing facility)

- 1 – Ohio resident seeking nursing facility admission.
- 2 – Individual residing in a state other than Ohio, seeking nursing facility admission.

INSTRUCTIONS: IF #1 OR #2 ABOVE IS SELECTED, GO TO SECTION C.

Resident Review Codes (If seeking to remain in nursing facility)

Resident's Date of Admission

- 3 - Expired Time Limit for Hospital Exemption: (Check one)
 - a) seeking approval for an unspecified period of time
 - b) seeking approval for a specified period of time
 (please complete Section G (1) and (2) in addition to the remainder of this form)
 - c) seeking an extension to an approved RR for a specified period of time
 (please complete Section G (3) and (4) in addition to the remainder of this form)

Name	SSN
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4 - Expired Time Limit for Emergency Admission (*Check one*)

a) seeking approval for an unspecified period of time

b) seeking approval for a specified period of time

(please complete Section G (1) and (2) in addition to the remainder of this form)

c) seeking an extension to an approved RR for a specified period of time

(please complete Section G (3) and (4) in addition to the remainder of this form)

5 - Expired Time Limit for Respite Admission

a) seeking approval for an unspecified period of time

b) seeking approval for a specified period of time

(please complete Section G (1) and (2) in addition to the remainder of this form)

c) seeking an extension to an approved RR for a specified period of time

(please complete Section G (3) and (4) in addition to the remainder of this form)

6 - NF Transfer, No Previous PASRR Records

7 - Significant Change in Condition (*Check either a, b, or c to identify the change in condition*)

a) Decline

b) Improvement

c) Admission to psychiatric unit

If admission to psychiatric unit, provide hospital name and phone number below.

Hospital Name

Phone #

(Check either d, e, or f to identify length of stay being sought)

d) Seeking approval for an unspecified period of time

e) Seeking approval for a specified period of time

(please complete Section G (1) and (2) in addition to the remainder of this form)

f) Seeking an extension to an approved RR for a specified period of time

(please complete Section G (3) and (4) in addition to the remainder of this form)

Please provide details regarding the Significant Change

Name	SSN
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SECTION C: MEDICAL DIAGNOSIS

<input type="checkbox"/> YES <input type="checkbox"/> NO	1) Does the individual have a documented diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-IV TR (or most recent version)?
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If this is a Resident Review, please complete the remainder of this section. Check NA if this request is a PAS.

<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	2) Please indicate current diagnosis if different from diagnosis submitted at admission. Diagnosis
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Please list below the top six medical diagnosis at time of admission if different from the resident review request.

Diagnosis 1	Diagnosis 2	Diagnosis 3
Diagnosis 4	Diagnosis 5	Diagnosis 6

SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS
All questions in Section D must be completed.

<input type="checkbox"/> YES <input type="checkbox"/> NO	1) Does the individual have a diagnosis of any of the mental disorders listed below? <i>(Check all that apply)</i>
<input type="checkbox"/> a) Schizophrenia <input type="checkbox"/> b) Mood Disorder <input type="checkbox"/> c) Delusional (Paranoid) Disorder <input type="checkbox"/> d) Panic or Other Severe Anxiety Disorder <input type="checkbox"/> e) Somatoform Disorder	<input type="checkbox"/> f) Personality Disorder <input type="checkbox"/> g) Other Psychotic Disorder <input type="checkbox"/> h) Another Mental Disorder Other Than MR that may lead to a chronic disability. If so, describe

<input type="checkbox"/> YES <input type="checkbox"/> NO	2) Within the past two (2) years, DUE TO MENTAL DISORDER, has the individual utilized psychiatric services more than once?
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Indicate the number of times the individual utilized each service over the last 2 years. If service was not utilized, enter "0"

	Ongoing case management from mental health agency? ("1" if continuously receiving over 2 years. If not, "0").
	Emergency mental health services?
	Number of admissions to the inpatient hospital settings for psychiatric reasons?
	Number of admissions to partial hospitalization treatment programs for psychiatric reasons?
	Number of admissions to Residential Care Facilities (RCFs) providing mental health services by a mental health agency?
	TOTAL SCORE

Name	SSN
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If total score equals 2 or more, answer YES to Question D (2). Regardless of score answer Question D (2)(b).

OR

- YES NO b) Within the past two (2) years, **DUE TO THE MENTAL DISORDER** has the individual had a disruption to his/her usual living arrangement (e.g., arrest, eviction, inter or intra-agency transfer, non-hospital locked seclusion)?

If YES, answer YES to Question D(2).

- YES NO 3) Within the past 6 months, **DUE TO THE MENTAL DISORDER**, has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis?

(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> a) Maintaining Personal Hygiene | <input type="checkbox"/> g) Performing Household Chores |
| <input type="checkbox"/> b) Dressing Self | <input type="checkbox"/> h) Going Shopping |
| <input type="checkbox"/> c) Walking/Getting Around | <input type="checkbox"/> i) Using Available Transportation |
| <input type="checkbox"/> d) Maintaining Adequate Diet | <input type="checkbox"/> j) Managing Available Funds |
| <input type="checkbox"/> e) Preparing/Obtaining Own Meals | <input type="checkbox"/> k) Securing Necessary Support Services |
| <input type="checkbox"/> f) Maintaining Prescribed Medication Regimen | <input type="checkbox"/> l) Verbalizing Needs |

- YES NO 4) Within the past 2 years, has the individual received SSI or SSDI due to a mental impairment?

- YES NO 5) Does the individual have indications of Serious Mental Illness?

NOTE: The individual has indications of Serious Mental Illness if the individual answered YES to AT LEAST two questions of D(1), D(2), or D(3) - OR - YES to D(4).

SECTION E: INDICATIONS OF MR OR RELATED CONDITION

- YES NO 1) Does the individual have a diagnosis of mental retardation (mild, moderate, severe or profound) as described in the AAMR manual "Mental Retardation: Definition, Classifications and Systems of Support" (2002 or more recent version)?

If YES, go to Question E (3) and answer Questions E 3 through E7

- YES NO 2) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR?

If NO, go to Question E(6). If YES, please specify AND answer Questions E3 through E7. Specify

- YES NO 3) Did the disability manifest before the individual's 22nd birthday?

- YES NO 4) Is the disability likely to continue indefinitely?

- YES NO 5) Did the disability result in functional limitations, prior to age 22, in 3 or more of the following major life activities.

(Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> a) Self Care | <input type="checkbox"/> d) Capacity for Independent Living | <input type="checkbox"/> f) Understanding and Use of Language |
| <input type="checkbox"/> b) Economic Self-Sufficiency | <input type="checkbox"/> e) Mobility | <input type="checkbox"/> g) Learning |
| <input type="checkbox"/> c) Self Direction | | |

- YES NO 6) Does the individual currently receive services from a County Board of DD?

Name	SSN
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YES NO 7) Does the individual have indications of MR or related condition?

NOTE: The individual has indications of MR or related condition if the individual received a

- **Yes to Question E (1); OR**
- **Yes to all of the following in this Section: Questions, 2, 3, 4 AND 5; OR**
- **Yes to Question E (6)**

SECTION F: RETURN TO COMMUNITY LIVING REFERRAL

YES NO 1) Did you share with the individual the service and support alternatives to the nursing facility admission (for PAS) or continuation of the nursing facility stay (for RR)?

If service and support alternatives are not appropriate due to care needs, please explain why alternatives are not appropriate at this time.

YES NO 2) Does this individual expect to return to live in the community either following the short term stay in the nursing facility or at some point in the future?

YES NO 3) Do you believe that this individual could benefit from talking to someone about returning to the community following the short term stay in the nursing facility (for PAS) or during the continued stay in the nursing facility (for RR)?

YES NO 4) Was this individual employed prior to the nursing facility placement?
Occupation, if applicable

YES NO 5) Does the individual need assistance obtaining and/or returning to employment upon return to a community setting?

6) What challenges or barriers do you believe could impede this individual's return to the community?

Check all that apply and provide a brief description

- | | |
|--|--|
| <input type="checkbox"/> a) Care needs are likely greater than community capacity | <input type="checkbox"/> e) Affordable housing limited |
| <input type="checkbox"/> b) Limited or no family/friend support available | <input type="checkbox"/> f) Accessible housing limited |
| <input type="checkbox"/> c) Guardian/Family likely to not support community living | <input type="checkbox"/> g) Limited income to support community living |
| <input type="checkbox"/> d) Lost housing during NF stay | <input type="checkbox"/> h) Other, please describe below |

Brief Description

Name	SSN
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Does the Individual Need Help Returning to Community Living?

If the individual already has, or is likely to have prior to discharge from the facility, a combined stay in the hospital/nursing facility/ICF-MR facility of 90 days or longer and could benefit from community transition assistance, a referral to the HOME Choice Transition Program is recommended. Please visit <http://medicaid.ohio.gov/FOROHIOANS/Programs.aspx#1078414-home-choice> to submit an application or call 1-888-221-1560 for more information regarding program benefits and application procedures.

Application submitted on _____ (mm/dd/yyyy)

Ohio's twelve area agencies on aging offer free long-term care consultations. As requested, a consultant (most often a nurse or social worker) will meet with the individual and their family for a free evaluation of the current situation and future options. The consultant will explain services available, discuss eligibility requirements and financial resources required and help determine needs and wishes. Call toll-free 1-866-243-5678 to be connected to the area agency on aging serving your community.

SECTION G: REQUEST FOR RESIDENT REVIEW APPROVAL FOR A SPECIFIED PERIOD
Complete only when seeking a Resident Review for a Specified Period of Time

Initial Request

1) If seeking a resident review approval for a specified period of time, how much time is needed?
 a) Number of Days

2) Reason for Initial Request:

a) Individual requires more rehabilitation related to the recent hospital stay. *Describe*

OR

b) More time is needed to ensure a safe and orderly discharge due to: *(Check all that apply)*

i) Accessible housing barrier. *Describe*

ii) Affordable housing barrier. *Describe*

iii) Service and support limitations in the community. *Describe*

iv) Lack of sufficient income. *Describe*

v) Other. *Describe*

NOTE: If requesting a resident review due to time needed for a safe and orderly discharge, the NF shall attach a written discharge plan consistent with OAC 5101:3-3-15.2.

Request for an Extension to a Specified Period Approval

Resident's Date of Admission

1) If seeking a resident review approval extension, how much time is needed? a) Number of Days

Name	SSN
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2) Reason for Extension Request:

a) Individual requires more rehabilitation following the recent hospital stay. *Describe*

- **OR** -

b) More time is needed to ensure a safe and orderly discharge due to: *(Check all that apply)*

i) Accessible housing barrier. *Describe*

ii) Affordable housing barrier. *Describe*

iii) Service and support limitations in the community. *Describe*

iv) Lack of sufficient income. *Describe*

v) Other. *Describe*

NOTE: If requesting an extension to a resident review due to time needed for a safe and orderly discharge, the NF shall attach a written discharge plan consistent with OAC 5101:3-3-15.2.

SECTION H: MAILING ADDRESSES

Please place an 'x' in the box next to the address and phone number of the person to be contacted for a Level 2 PAS/RR evaluation by ODMH and/or DODD.

1) What address should be used for mailing results of the PAS/RR evaluation to the applicant/resident?

In Care Of

Street Address

City	State	Zip	Ohio County of Residence <i>(First 4 letters)</i>
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Telephone No.

2) Please provide the following information about the individual's attending physician.

Last Name	First Name
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Street Address

City	State	Zip	Telephone No.
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3) If the individual has a guardian or legal representative (e.g. Power of Attorney), please provide the following information about the guardian/legal representative:

Last Name	First Name
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Street Address

City	State	Zip	Telephone No.
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Fax Number	Email Address
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Name	SSN
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4) If the individual is an applicant to or resident of a nursing facility, please provide the name and address of the nursing facility:

Name of Nursing Facility			
Street Address			
City	State	Zip	Ohio County of Residence (<i>First 4 letters</i>)
Telephone No.			

5) If the individual is being discharged from a hospital, and the submitter is not employed by the discharging hospital, please provide the name of a contact person and the name and address of the discharging hospital:

Last Name		First Name	
Street Address			
City	State	Zip	Telephone No.

SECTION I: SUBMITTER INFORMATION/CERTIFICATION

In order to process the screen, the submitter must provide his/her name and address and sign below. Complete the form fully and with accuracy. Incomplete forms may be returned with a request for further information. ***The nursing facility may not admit or retain individuals with indications of Serious Mental Illness and/or MR or a related condition without further review by ODMH and/or DODD (OAC rules 5101:3-3-15.1 and 5101:3-3-15.2).***

Last Name		First Name	
Street Address		City	State
Zip Code	County	Telephone No.	

I understand that this screening information may be relied upon in the payment of claims that will be from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

Signature	Title	Date (<i>mm/dd/yyyy</i>)
Employer		

Name	SSN
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Additional Instructions and Documentation Requirements

Please complete electronically and print all sections of the form unless otherwise specified. For any RR-ID, a copy of the screen must be placed in the resident's chart at the nursing facility. The screen should accompany the resident in the event of transfer to another nursing facility.

Section A: Include date of birth and social security number and specify whether the applicant/resident is a Medicaid recipient including whether the applicant/resident is enrolled on a managed care plan.

Section B: Check the box that corresponds with the request. If Code #7 is checked, please identify what has changed.

Section C: If the diagnosis at the Resident Review request is different than the admitting diagnosis under the preadmission screen or hospital exemption, please attach supporting documentation of the admission diagnosis and the resident review diagnosis.

Section E: When requesting a preadmission screen or a resident review, please assess the individual's potential to return to a community setting and indicate whether a referral has been made to the HOME Choice Transition Program or for a Long Term Care Consultation.

Section G:

For resident review approvals for a specified period of time.

*The nursing facility is required to submit the following documentation:

*For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.

*For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.

For extensions of resident review approvals for a specified period of time.

*Please note the number of the extension request in the space provided.

*The nursing facility is required to submit the following documentation:

*For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.

*For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review extension request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.

Go to website: <http://mha.ohio.gov/Default.aspx?tabid=126>