

PASRR (Level II) Cover Sheet
Comprehensive Evaluation

For Behavioral Health and Developmental and Intellectual Disabilities

Date of Referral: _____ Date Assigned to PASRR: Staff: _____

Name of Center Completing Assessment: _____

Applicant Identifying Data

Applicant's Name: _____ Social Security Number: _____

Birth Date: _____ Sex: ___ Race: _____ Marital Status: ___ Spouse: _____

Address: _____

Evaluation Location: Home Relative's Home Personal Care, Mini, or Family Care
 State Hospital ICF/MR Staff Residence (SCL, group home)
 Hospital Hospital Psychiatric Unit Nursing Facility
 Psychiatric Hospital Other

Legal Guardian: Yes No

If yes, please provide name and telephone number: _____

Are any ADA accommodations needed? Yes No

If yes, specify: _____

Referral Information

Referral Source: MAP 409 Telephone Contact: Subsequent Review (form or phone)

Name: _____

Relationship to Applicant: _____ Telephone Number: _____

Facility Requested: _____

(if known) Address: _____

Contact Person: _____ Telephone Number: _____

MD to receive summary of findings: Name: _____

Address: _____

Type of Referral: (Check One)

Mental Illness Mental Retardation Dual Diagnosis
Related Condition MI Portion Only
MR Portion Only

Type of Assessment: (Check One)

Pre-admission

New Nursing Facility Applicant
(Did Not Meet Readmission Status)

Initial Resident Review

Hospital Exemption _____
 Provisional Admission _____
 Delirium _____
 Respite _____
 New to PASRR _____

Subsequent Review

Significant Changes in Condition _____

Give Date of Nursing Facility Admission _____

Information for this evaluation was obtained from the following:

(Identify person / agency and date of contact.)

Applicant (If applicant was unable to significantly contribute to the interview, please identify reason): _____

Family Members / Legal Representative: _____

Other Agencies: _____

Record / Document Review: _____

This evaluation may be typed or hand-written legibly in ink.

Name: _____ Region: _____

Evaluated or Reviewed by (include name, title and date) _____

Part C: Independent/Instrumental activities of daily living/ Services receiving or indicated

In final determination process, an individual may meet base level of care, but still not require nursing facility admission, particularly if needs identified can feasibly be met in an alternate setting with supports.

ACTIVITIES OF DAILY LIVING (toileting, dressing, grooming/bathing eating)

If assistance is required, indicate the type by checking appropriate option or provide a description in the comments section; most categories will require comments for full elaboration.

Rate **pre-morbid** functioning assistance required of each category by assigning the appropriate numerical value; **Pre-morbid means best baseline functional capacity/prior to current illness or current level.**

1. Independent (no or little assistance required) 2. Minimal (limited hands-on or verbal cues) 3. Moderate (assist of 1)
 4. Maximum (assist of 2/much hands-on)

A comment section is provided for each component.

TOILETING		Pre-morbid Numerical Rating:	DRESSING		Pre-morbid Numerical Rating:
<input type="checkbox"/>	Independent/changes own incontinence briefs	Comments:	<input type="checkbox"/>	Independent	Comments:
<input type="checkbox"/>	Totally dependent		<input type="checkbox"/>	Totally dependent	
<input type="checkbox"/>	Assistance required (one person each time)		<input type="checkbox"/>	Assistance required	
<input type="checkbox"/>	Bedpan		<input type="checkbox"/>	Stand-by verbal prompts	
<input type="checkbox"/>	Peri-care		<input type="checkbox"/>	Hands on each time	
<input type="checkbox"/>	Ostomy				
<input type="checkbox"/>	Catheter				
<input type="checkbox"/>	Other				
GROOMING		Pre-morbid Numerical Rating:	EATING		Pre-morbid Numerical Rating:
<input type="checkbox"/>	Independent	Comments:	<input type="checkbox"/>	Independent	Comments:
<input type="checkbox"/>	Totally dependent		<input type="checkbox"/>	Totally dependent	
<input type="checkbox"/>	Assistance required		<input type="checkbox"/>	Device	
<input type="checkbox"/>	Stand-by verbal		(feeding tube/IV)		
<input type="checkbox"/>	Help in/out tub or shower		<input type="checkbox"/>	NPO	
<input type="checkbox"/>	Hands on each time		<input type="checkbox"/>	Tray set up	
<input type="checkbox"/>	Other		<input type="checkbox"/>	Assistance required	
				<input type="checkbox"/>	
			<input type="checkbox"/>	Physical assistance moving food from plate to mouth	
			<input type="checkbox"/>	Continuous need for verbal instructions	
			<input type="checkbox"/>	Chokes / Swallow study indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			If already performed, please attach		

Name:		Region:	
Evaluated or Reviewed by (include name, title and date)			
SENSIORMOTOR/MOBILITY		Pre-morbid Numerical Rating:	
Ambulation			
<input type="checkbox"/>	Independent	Comments:	
<input type="checkbox"/>	Independent with aid		
<input type="checkbox"/>	Needs assistance		
<input type="checkbox"/>	Totally Dependent/Non-mobile (complete transfer)		
<input type="checkbox"/>	Physical Assistance mobilizing wheelchair, walker, or device		
<input type="checkbox"/>	Physical assistance with transfers		
<input type="checkbox"/>	Physical assistance with bed-positioning		
<input type="checkbox"/>	Stand-by assistance of one for mobilization		
<input type="checkbox"/>	Other		
		Services Received or Identified:	
<input type="checkbox"/>	Receives Physical Therapy	<input type="checkbox"/> Receives Occupational Therapy <input type="checkbox"/> Occupational Therapy Evaluation Indicated	
<input type="checkbox"/>	Physical Therapy Evaluation Indicated		
<input type="checkbox"/>	Restorative Nursing Program		
<input type="checkbox"/>	Needs evaluation for customized wheelchair and/or adaptive equipment		
SPEECH/LANGUAGE		Pre-morbid Numerical Rating:	
Describe the individual's reaction the interview:			
<input type="checkbox"/>	Adequate Verbal Communication/Easily Understood	Comments:	
<input type="checkbox"/>	Inadequate Verbal Communication		
<input type="checkbox"/>	Communication Device Needed		
<input type="checkbox"/>	Hearing Aide Needed		
<input type="checkbox"/>	None Due to Poorly Responsive State		
<input type="checkbox"/>	Other		
Receptive			
<input type="checkbox"/>	Adequate Verbal Reception		
<input type="checkbox"/>	Inadequate Receptive Communication		
<input type="checkbox"/>	Some Receptive Communication; Understands Simple Commands		
<input type="checkbox"/>	Limited Receptive Communication		
<input type="checkbox"/>	None Due to Poorly Responsive State		
<input type="checkbox"/>	Other		
		Services Received or Identified	
<input type="checkbox"/>	Receives Speech Therapy		
<input type="checkbox"/>	Speech Therapy Evaluation Indicated		
<input type="checkbox"/>	Habilitative Speech Therapy Indicated		

Name:		Region:	
Evaluated or Reviewed by: (include name, title and date)			
SOCIAL DEVELOPMENT		Pre-morbid Numerical Rating	Maladaptive Behaviors
<input type="checkbox"/>	Adequate Social Skills	Specify Maladaptive Behaviors	
<input type="checkbox"/>	Inadequate Social Skills		
<input type="checkbox"/>	Withdrawn/Avoidant of Contact	Comments:	
<input type="checkbox"/>	Limited Contact Due to Social Deprivation		
<input type="checkbox"/>	Responds Inappropriately To Situation		
<input type="checkbox"/>	Depression		
<input type="checkbox"/>	Loneliness		
<input type="checkbox"/>	Anxiety		
<input type="checkbox"/>	Self-Injurious Behavior		
<input type="checkbox"/>	Physically Combative	<input type="checkbox"/> By History	<input type="checkbox"/> Other
		<input type="checkbox"/> Currently	
<input type="checkbox"/>	Verbally Abusive	<input type="checkbox"/> Repetitive Verbalizations	<input type="checkbox"/> Threats to Others
		<input type="checkbox"/> Delusions/Hallucinations	<input type="checkbox"/> Other
Services Received or Identified:			
<input type="checkbox"/>	NF Can Meet Socialization Needs		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		
ACADEMIC/EDUCATIONAL		(Pre-morbid functioning does not apply)	
<input type="checkbox"/>	No Educational Needs Identified	Comments:	
<input type="checkbox"/>	High School Graduate		
<input type="checkbox"/>	High School Graduate, Special Education		
<input type="checkbox"/>	Attended 1-8		
<input type="checkbox"/>	No Formal Schooling		
<input type="checkbox"/>	Other		
Services Received or Identified:			
<input type="checkbox"/>	NF Can Meet Academic Needs		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		
FUNCTIONAL LEARNING/ INDEPENDENT LIVING SKILLS		Pre-morbid Numerical Rating:	
<input type="checkbox"/>	Functionally Independent	Comments:	
<input type="checkbox"/>	Functionally Independent With Supervision		
<input type="checkbox"/>	Completely Dependent For All IADL's		
<input type="checkbox"/>	Requires Assistance With IADL's		
<input type="checkbox"/>	Finances		
<input type="checkbox"/>	Meals		
<input type="checkbox"/>	Transportation		
<input type="checkbox"/>	Other		
Services Received or Identified:			
<input type="checkbox"/>	NF Can Meet Functional Needs		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		

Name:		Region:	
Evaluated or Reviewed by (include name, title and date)			
VOCATIONAL		Pre-morbid Numerical Rating:	
<input type="checkbox"/>	Retirement Age/doesn't wish to work	Comments:	
<input type="checkbox"/>	No Vocational Skills/No Potential		
<input type="checkbox"/>	Worked With Minimal Supervision		
<input type="checkbox"/>	Has Never Worked		
<input type="checkbox"/>	Desires To Work		
<input type="checkbox"/>	Capable of Work In Supervised Setting		
<input type="checkbox"/>	Other		
Services Received or Identified:			Comments:
<input type="checkbox"/>	NF Can Meet Vocational Needs		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		
TREATMENT HISTORY		Pre-morbid rating does not apply	
<input type="checkbox"/>	Has attended MR/DD programs	List region of treatment _____	Comments:
<input type="checkbox"/>	Is currently attending MR/DD programs		
<input type="checkbox"/>	Is an SCL recipient/ Is placement considered temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, case manager should request extensions		
<input type="checkbox"/>	Has a history of treatment for MI diagnosis		
<input type="checkbox"/>	Has received MR/DD treatment in another state		
Current Medical Supports Received:			
Recommendation For Additional Medical Supports:			
Services Received or Identified:			Comments:
<input type="checkbox"/>	Doesn't meet criteria for requiring MR/DD services		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		
AFFECTIVE DEVELOPMENT		Pre-morbid Numerical Rating	
<input type="checkbox"/>	Has legal guardian	Comments:	
<input type="checkbox"/>	Independent with decisions		
<input type="checkbox"/>	Needs minimal assistance with decision making		
<input type="checkbox"/>	Family or significant others assist with decisions		
<input type="checkbox"/>	Needs maximum assistance with decisions		
<input type="checkbox"/>	Other		
Services Received or Identified:			
<input type="checkbox"/>	NF can meet needs related to decisions/needs		
<input type="checkbox"/>	Evaluation By MR/DD Staff Indicated		

SUPPORTS CURRENTLY NEEDED TO ASSIST WITH ACTIVITY

Activities of Daily Living		Instrumental Activities of Daily Living			
Eating		Meal Preparation		Laundry	
Dressing		Light Housekeeping		Shopping	
Bathing		Heavy Housework		Mobility	
Toileting		Money Management		Travel	
Grooming		Nutritional Habits			
Ambulation		Health Monitoring & Medication Management			
Transfer					
Comments:					

PHYSICAL EXAMINATION SUPPLEMENT

PASRR/2/MR

Name: _____

Social Security Number: _____

Comprehensive Medical History / Physical Examination

A physician, registered nurse or a physician assistant must perform the examination. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's medical condition. Cite document(s) referred to here: _____

Medical History

1. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
2. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
3. Allergies or Drug/Food Sensitivities	4. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

Review of Body Systems - Assess all variables and explain all abnormal findings.

Vital signs:	T:	P:	R:	B/P:	HT:	WT:
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General Appearance and Behavior:
Skin:
Head:
Face (include Eyes, Ears, Nose):
Mouth, Throat, Neck:
Cardiovascular:
Pulmonary:

PHYSICAL EXAMINATION SUPPLEMENT

PASRR/2/MR

Name: _____
Social Security _____

Breast:
Gastrointestinal:
Genitourinary:
Rectal:
Musculoskeletal:
Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

Abnormal Findings - In case of abnormal findings, which are the basis for the individual's nursing home placement, include recommendations for additional information.

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IV. Summary of Major Medical/Physical Needs.

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Signature and Professional Title (RN, RNP, or PA) if not performed by a physician	Date
Physician Signature (A physician must sign here in order to complete the form)	Date

PASRR/2/MR	
Name:	Social Security #

SUMMARY

•	Current Medical Issues
•	Medications
•	Activities of Daily Living
•	Psychosocial History <i>Please describe the response of the applicant/resident to your interview;</i>
•	Nursing Facility Needs (Give chronological history of nursing facility admission)

Recommendations

New Applicant

- Does applicant meet Medicaid admission criteria?
Yes No
- Does applicant meet admission criteria, but services could be provided in an alternate setting?
Yes No

NF Resident

- Resident no longer meets Medicaid criteria for continued stay. Does 30 month option apply?
 Yes No
- Resident meets base Medicaid criteria, but needs could be met in an alternate setting. Does 30 month option apply? Yes No
- Resident is appropriate for nursing facility, and requires specialized services.
- Resident is appropriate for nursing facility, and does not require specialized services.

Name: _____	Region: _____
Evaluated or Reviewed by (include name, title and date) _____	

DISPOSITION/SPECIALIZED SERVICES CRITERIA

A specialized services recommendation is based on the person's developmental strengths and weaknesses and to what extent the person's status compares with each of the following characteristics: The *inability* to:

1. Take care of most personal care needs;
2. Understand simple commands;
3. Communicate basic needs and wants;
4. Be employed at a productive wage level without systematic long-term supervision or support;
5. Learn new skills without aggressive and consistent training;
6. Apply skills learned in a training situation to other environments or place without direct aggressive and consistent training;
7. Demonstrate behavior appropriate to the time, situation, or place without direct supervision;
8. Make decisions requiring informal consent without extreme difficulty; OR

Demonstrates severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and / or

Has other skill deficits or specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.

The responsibility of the PASRR evaluator is to use his/her expertise as a QMPR to recognize strengths and weaknesses as identified in this evaluation, and make recommendations based upon the above criteria. The final determination rests with the DMHMRS PASRR Review Committee. Once the final determination has been made, the PASRR Coordinator, Specialized Services Coordinator, and Regional Liaison will be notified by Committee correspondence; and a person-centered planning process will be initiated to assure the person receives identified services. Regional Liaisons also monitor for compliance with Specialized Services recommendations. The Committee determination letters from the Division of DID will provide additional instructions.

Specialized Services (Active Treatment) Recommended: yes no

Residence of more than 30 months: yes no

Signature of Evaluator: _____

Title: _____ Date: _____

Counter Signature: _____

Title: _____ Date: _____

Counter Signature: _____

Title: _____ Date: _____

Name _____

Social Security Number _____

has had a Level II PASRR evaluation for MR Developmental Disability,

as mandated by OBRA 1987. The above criteria have been assessed and a determination has been made regarding the need for nursing facility care and specialized services for the above condition. The PASRR Review Committee made the following determinations on _____, _____.

Date Year

- meets base Medicaid level of care, but total care needs can be met in alternate setting with supportive services.
- meets Medicaid level of care and does not require specialized services. Total care needs can be met in the nursing facility.
- meets Medicaid level of care, but requires additional or specialized services in the nursing facility.
- does not meet Medicaid base level of care; may not be admitted to a nursing facility.
- no longer meets Medicaid level of care; must be discharged from nursing facility.
(Does 30 month option apply?) Yes No

INTERPRETATION OF PASRR FINDINGS: The Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of this evaluation be interpreted and explained to the individual and, where applicable, to a legal representative designated under state law.

The findings of this evaluation have been explained to (check one):

- Individual
- Legal representative
- Other (Specify)

I understand that my signature does not mean that I consent to or agree with the findings, but only that the evaluation has been received by me and the first-level hearing rights have been explained to me should I disagree with the determination and wish to appeal.

NOTE: If signature was not obtained, please document steps taken to obtain signature and note the date that the Interpretation of Findings were sent to the individual / representative.

Individual / Representative

Relationship (if appropriate)

Mental Health/Mental Retardation Board Staff _____

Title _____

Date _____