Instructions for PASRR Level II

A Level II must be initiated for ALL individuals that have an appropriately referred MAP 409/4095.

Provide and answer to ALL questions on the form. If a question does not apply to the individual being evaluated enter "N/A". NO QUESTION SHOULD BE LEFT BLANK

Section 1: REFERRAL INFORMATION
Date of referral – date the CMHC received a completed MAP 409/4095 (that included a current H&P) that indicated a Level II was needed.
Date assigned to PASRR staff – date the evaluation was assigned to evaluator
Region completing assessment – CMHC completing the evaluation
Name of Evaluator – name of the evaluator completing the Level II
Applicant's name – include first and last name of the individual being evaluated
SSN – full social security number for individual being evaluated
DOB – full date of birth for individual being evaluated
Gender – identify the individual's gender
Marital status – list the individual's current status (single, married, divorced, widowed….)
Spouse – name of spouse if married, otherwise type N/A
Evaluation location – check box for location of the individual at the point of interview or contact. If "other", specify
Referral source – check appropriate box for which form was received that indicated a Level II was needed
Legal guardian – check yes or no as appropriate
POA or other legal Rep – check yes or no as appropriate
Name – Name of legal guardian, POA or other legal rep if appropriate. If none, N/A.
Relationship to applicant – guardian, POA, or other legal representative relationship to the individual (please be specific). N/A if no guardian, POA, or other legal representative.
Telephone – Phone number for guardian, POA, or other legal representative
Facility requested – Full name of Nursing Facility the individual intends to, or currently, resides in
Region NF located – CMHC region where the requested NF is located (forward full evaluation and findings to this region)
Address – Nursing facility's full address
Contact person – list contact person for the requested NF
Phone – phone number for the requested NF
Name of MD to receive summary of findings – Name of admitting physician
Address – address of admitting physician
Type of referral – check the appropriate box **based on the referral information** from the MAP 409 or MAP 4095
Type of assessment – check the appropriate box based on which criteria are met
Date of NF admission – If pre-admission evaluation input "pending". If post-admission evaluation, input date of admission. If evaluation is late for any reason (whether on the NF or CMHC side), explain the reason in this section.
Information for the evaluation was obtained from the following – Complete each box. Be sure to complete person/agency and date of contact. (Federal regulations require that the individual and ANY legal representative be involved in the evaluation – If they are not included in the evaluation, you must thoroughly document why and your efforts).

Section 2: DIAGNOSIS (be sure to list Dx under the appropriate column)
Mental health – list all mental health diagnoses
Intellectual disability/related condition – list all Intellectual Disability **and** Related Condition diagnoses
Medical – list all other medical diagnosis
IQ – list all known scores, name of tool(s) used for the testing, name of evaluator that performed the testing, and date of testing.
Adaptive Behavior – list all known scores, name of tool(s) used for the testing, name of evaluator that performed the testing, and date of the testing.
Other – list any other testing done related to MI/ID/RC here, along with the known scores, name of the tool(s) used for the testing, name of the evaluator that performed the testing, and date of the testing.
Comments – enter any additional comments about the testing listed above. If there was no testing or test cannot be located, indicate this here along with your attempts to obtain.

Current history and physical shall be attached. If there has been no significant change in the individual's medical condition, a copy of a history/physical performed by a physician within the last year may be used and attached. The history and physical must reflect the individual's current condition.
If the physical was conducted by an APRN, PA, or RN, a physician's signature is required.

Section 3: Medication history
List or attach current medications and reason for use – if listing, include all information. If attaching document, input "SEE ATTACHED".
Allergies – list all known allergies
Documentation of all other medications applicant has taken in the last year – include all known. If no additional medications besides current, input "NONE".
Previous psychotropic medications – list all known previous psychotropic medication including the dosage, frequency and reason for taking.
Comment on any medication that could mask or mimic mental illness symptoms – list all known medications and how that medication could mask or mimic mental illness symptoms.
Does/has the client use(d) alcohol or other substances? Has their alcohol usage and/or substance usage resulted in the need for treatment; resulted in involvement from law enforcement; caused financial woes; or had any other negative impacts? If yes detail if currently using, or history of use and explain type, frequency, amount, and length of use and how this has affected their lives.
Does the client complain of side effects of medication, or are there visible signs of side effects – include all information about client's complaints, or signs of, side effects of medication.
Self-management of medication – check appropriate box
Comments – If client is not independent with medication management, detail what the individual's needs/limitations are. Also, include any information concerning medication that was not already addressed in this section.

The evaluation may be terminated if the evaluator finds at any time during the evaluation that the individual being evaluated -

(1) **Does not have MI or ID/RC;**
(2) **Does not have sufficient evidence to support a diagnosis of MI or ID/RC; or**
(3) **Has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder)**

(For the purposes of a PASRR evaluation, when a person has more than one diagnosis, the primary diagnosis is the one with the most pervasive symptoms or the condition that is chiefly responsible for the need for treatment. The primary diagnosis may not necessarily be listed first in a chronological listing of problems/conditions.)
If 1, 2, or 3 above is found, please complete a Response to Referral form for the facility.

Evaluator has determined…
Once the evaluator has done their due diligence in gathering basic information and documentation, they should now determine if the supporting documentation indicates the individual meets criteria to terminate the evaluation (Does NOT meet PASRR criteria). If more information is needed to make the determination, continue with the evaluation and complete all sections in full.
Mark the appropriate box to either terminate evaluation (if so go straight to section 8) or complete full evaluation (if so, continue through all sections).

Section 4: MENTAL STATUS/PSYCHIATRIC ASSESSMENT
Psychiatric hospitalization – list any prior admission to any psychiatric hospital. Include where, when, why, and for how long.
Community based treatment – list any involvement with the CMHC's, private psychiatric or mental health facilities. Include types of services, dates, reason, and outcomes.
History of engagement/success with recommended treatment – Include any history of treatments that are known. Be sure to include how the individual responded to treatment, if they complied, and whether or not treatment was successful.
Mental status assessment – answer yes or no to all questions, do not leave anything blank
Comments or additional observations – Provide additional mental health information and details that are not already addressed or clear in this section.

Section 5: ACTIVITIES OF DAILY LIVING
Rank the person's ability to perform the activities – for each activity, list the number level of functioning based on the table. Include comments with explanation for anything marked other than 1. The description of assistance should explain the individual's specific needs and/or deficits and should not simply give the definition of the associated number assigned.
Vision – check appropriate box and add any additional comments or clarifications in comment box
Hearing – check appropriate box and add any additional comments or clarifications in comment box
Language – list preferred language and indicate if English is the primary language. In the comment box, list any additional language issues, concerns or clarifications. Include in detail what the individual needs to communicate more effectively.
Physical therapy – Check yes or no if the individual currently receives, and yes or no if it is recommended
Occupational therapy – Check yes or no if the individual currently receives, and yes or no if it is recommended
Swallow study – check yes or no if the individual has received, and yes or no if it is recommended
Speech/language therapy – check yes or no if the individual currently receives, and yes or no if it is recommended
Hearing screen recommendations – check yes or no
Comments – include clarification or additional comments about these recommendations. Be specific about what the individual's needs and or deficits are as they relate to the evaluators recommendations.

Section 6: PSYCHOSOCIAL EVALUATION
Reason for placement – Provide details for the reason NF placement is being considered. What has occurred that has led to NF placement. Identify any changes in the individual's status and/or living situation that contributed to the referral for NF placement.
Is placement in NF considered temporary – check yes or no
What barriers may prevent return to community services – Be specific in types of barriers and how they may prevent the individual from returning to the community. What services or supports are needed to help the individual transition into the community?
Family/friends/support systems – list any natural supports for the individual, their relationship to the individual, and their phone number

Current functioning levels – provide details of the individual's ability to function independently, with supports, or how they are dependent on others for assistance with ADL's.

Social/behavioral
Social skills/participation – check all appropriate boxes and add any additional information concerning the individual's social functioning.
Family history and current relationships – Detail any significant family history and relationships. Include information regarding who has been, or is currently, a part of the individual's life.
Hobbies/activities – Provide details of the indivual's interests and things they enjoy doing
Emotional/behavioral regulation – check all appropriate boxes and add any additional information concerning the individual's emotional/behavioral functioning.
Legal status – Detail any charges, convictions, probation/parole, offender registries, etc.
Identify any supports/techniques used and outcomes – Detail all supports and techniques that have been used on the individual Include how the client responded. Be specific.
Give any developmental history that would provide background to factors indicating onset of, or contributing to, identified disability/diagnosis. Include things like details about developmental milestones, ability to have/maintain relationships, experiences, psychological trauma, abuse, personality, and how the individual functioned in childhood. Gather as much information that is known from the records, individual, guardian, and family. Do not make broad statements such as 'developmentally delayed' – this provides no insight to an individual's functioning. Keep in mind that everyone has a developmental history and N/A would never be an appropriate answer to this question. If history is unknown, detail why it is unknown and why further information cannot be obtained. **Things to consider about the developmental period**: Social interactions, understanding of social cues, ability to communicate effectively, emotional regulation, personal care, learning new tasks, transferring knowledge to other tasks, specific developmental delays, ability to remember things and/or store information, ability to focus on multiple areas of problems, ability to adapt to changes or challenges, ability to learn abstract concepts.

Prior ID/RC Services – check box here if no indication of ID/RC and continue to educational history.
Have supports been provided in another state – provide information on current or past out of state providers.
Current and Past ID/RC services –Check yes or no as appropriate to whether or not the individual is receiving ID services. Check yes or no as appropriate to whether or not the individual has ever received ID services.
ID/RC service providers – If the individual is receiving, or has received ID/RC services, provide information about the agencies that are/were providing services.

Educational history – check all that apply and provide details as applicable
Details – give any additional educational information including home schools, specialized schools, academic performance, disciplinary problems, excessive absences, etc…If the individual did not attend school, or dropped out, provide detailed information about why. If information is unknown, detail why it is unknown and why further information cannot be obtained.

Employment history – check all that apply and provide details as applicable
Details – give detailed information on types of employment, length of employment, barriers to employment, history of termination and reasons, etc… If the individual has never been employed, provide detailed information about why. If information is unknown, detail why it is unknown and why further information cannot be obtained.

Section 7: REVIEW OF FINDINGS
Low Intensity Medicaid level of care – check all that apply, be sure that the boxes checked correspond with the evaluation responses. An applicant must meet at least 2 criteria to meet Medicaid level of care
Community options discussed – Federal regulations require that community options be discussed with the individual/guardian to prevent institutionalization. Check whether or not you provided this information, and detail what was discussed.
Individual's strengths and weaknesses – Provide details on the capabilities of the individual based on the information gathered during the evaluation
Nursing facility care needs – describe what the individual's care needs are that can be provided by the NF. As applicable, include details about the individual's inability to participate in specialized services.
Behavioral health services to be included in the resident's treatment plan while residing in the NF – list any recommendations or current supports that need to be continued for behavioral and mental health services. Include information on how the individual can benefit from the recommendations.

Recommendations for specialized services are not just simply a list of things the individuals likes or generalized statement that apply to everyone. It is a summary of what really matters to the individual. What is important to the individual? What are their hobbies, interest and passions? Who is important and what makes a good day for them? **Remember to be specific and to provide person centered information and details.**
Important to the person – What is important to a person includes what results in feeling satisfied, content, comforted, fulfilled, and happy. You get this information from what people are saying with words and with behaviors. When words and behavior are in conflict, listen to the behavior.. Include things like: relationships, rituals and routines, rhythm or pace of life, things to do and places to go, and things to have. **Is this available in the NF?** Check yes if the NF can provide and no if they cannot. A no answer indicates specialized services are needed. **Provide details on how this can be achieved** – The evaluator should explain in detail how what is important to the individual could be obtained. For specialized services, the evaluator should focus on the individual maintaining or learning skills to increase independence and/or integration into the community.
Important for the person – These are the things that other people know about the individual that will keep them safe and healthy as well as successful in the community. Include things like: being a valued community member, issues of health, treatment of illness/medical conditions, promotion of wellness, issues of safety, environment, well-being (physical and emotional), and freedom from fear. **Is this available in the NF?** Check yes if the NF can provide and no if they cannot. A no answer indicates specialized services are needed. **Provide details on how this can be achieved** – The evaluator should explain in detail how what is important for the individual could be obtained. For specialized services, the evaluator should focus on the individual maintaining or learning skills to increase independence and/or integration into the community.

Section 8: DETERMINATIONS

Does the individual meet PASRR criteria?

YES – If the individual does meet PASRR criteria, mark "YES" and the appropriate box for the outcome of the evaluation as to whether or not the individual meets LOC, and if so whether or not the individual needs specialized services.

***NOTE**: If the evaluation was completed due to a significant change referral, and the outcome remains the same, a response to referral marking "change in condition does not affect NF LOC, SS or services of lesser intensity needs" shall be sent to the NF.*

NO – If the individual does not meet PASRR criteria, mark "NO" and the box for the reason. Then, you MUST provide details on how you reached the determination and send a response to referral to the NF.

Evaluation time frames – date of referral should match date on 1st page. Date of verbal is only for SMI determinations as applicable. The evaluator then signs, including their title and date. IF this is an SMI **or** Dual evaluation, then a QMHP must complete the evaluation or counter sign the evaluation.

Interpretation of findings – This section is required for individuals who did meet PASRR criteria. Federal regulations require that findings are explained and given to the individual and any legal representative. The individual/legal representative must sign that this has been given to them. For ID/RC evaluations, findings CANNOT be explained (and signatures obtained) until AFTER receiving a determination from DDID. CMHC staff who provided the interpretation of findings signs.

If a signature is not obtained, you must document why it was not, including your attempts to get a signature. You will

Date report sent is the date final report is sent to all appropriate parties – Individual/guardian, NF and admitting MD.

Definitions in Federal Regulations

§ 483.102 Applicability and definitions. **(b)**

(1) An individual is considered to have a **serious mental illness (MI)** if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

(i)*Diagnosis.* The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders

(ii)*Level of impairment.* The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

(A)*Interpersonal functioning.* The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

(B)*Concentration, persistence, and pace.* The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

(C)*Adaptation to change.* The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

(iii)*Recent treatment.* The treatment history indicates that the individual has experienced at least one of the following:

(A) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, 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.

(3) An individual is considered to have **intellectual disability (IID)** if he or she has -

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability

§ 435.1010 Definitions relating to institutional status.

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to -

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care. **(2)** Understanding and use of language. **(3)** Learning. **(4)** Mobility. **(5)** Self-direction. **(6)** Capacity for independent living.

Useful Information

Preferred documentation to support onset of ID/RC

- Psychological evaluation with diagnosis based on IQ testing and adaptive behavior assessment.
- Individualized Education Plan (IEP) that contains records of IQ score and assessment of adaptive functioning.
- Psychological assessment submitted during the course of guardianship proceedings;
- Medical/tx records that provide evaluation and diagnosis of the related condition and impairments related to the condition.

In the absence of the items listed above, additional documentation may be used to provide support for ID/RC.

- Treatment records in which provide review of psychological evaluations (when the evaluation itself cannot be provided) and key information from the assessment such as when the testing was done, who it was conducted by, tests and scores obtained, diagnosis given.
- Onset of ID/RC may be supported through a comprehensive developmental history (records or information from parent/guardian, other close relative who can provide first person account of individuals developmental history) that contains specific information about the onset of any medical conditions or injuries that resulted in intellectual impairment, information about the nature of those impairments (delays or regression in key developmental milestones such as speech, gross and fine motor skills, learning, etc.).
- Assessment and documentation that rules out other factors or conditions that may have contributed to diminished cognitive and adaptive functioning such as severe mental illness, chronic substance abuse, or medical conditions. This can be accomplished by documentation in which the trained professional indicates that these conditions are not present, or if documentation of ID/RC exists prior to the onset of the other conditions, or can demonstrate that the impairments are more consistent with ID/RC than other factors.

The following items are not sufficient to determine ID/RC on their own, but may be used in conjunction with other information to provide support for the presence of the condition.

- Records or reports of special education without specification of the classification of special education services that were received. Individuals may be in special education related to medical issues, behavioral health issues, specific learning disorders, etc., and it does not necessarily imply intellectual impairment.
- Failure to complete school/poor grades
- Lack of vocational history or difficulty maintaining employment
- No history of living independently, or difficulty maintaining independent housing
- Social security disability determination (without documentation that identifies reason for disability that meets criteria of ID/RC)

The following items in the individual's records may indicate that impairments are not associated with ID/RC.

- Records of medical event or injury that occurred after age 18 (ID) or 22 (RC) that are documented to have (or likely would have) caused impairments in intellectual and adaptive functioning, particularly if there is indication in the individual's history that these deficits were not present or not as severe prior to the event.
- Adaptive functioning deficits are specifically related only to physical limitations or related to symptoms of a diagnosed mental illness (such as related to depression, anxiety, psychosis, etc.), or occurring in conjunction with or following significant substance use.

Documentation should include:

- Attempts of efforts to obtain previous documentation that are not included in evaluation and why they could not be obtained, etc.
- Specific description of the individual's psychosocial history (social, cognitive, vocational, educational, psychiatric, medical history)
- Specific description of the individual's adaptive functioning deficits and types of support needed (type of supports needed, frequency and intensity of supports)
- Previous types of supports and services the individual has received
- Treatment records that demonstrate evaluation and support for any diagnosis provided.