Pre-Admission Screening and Resident Review (PASRR)

Response to Referral

Intended/Current Nursing Facility:

Individual Referred:

Date of Birth:

Type of Referral (Level I or Significant Change):

Date referral received from the Nursing Facility:

CMHC region completing:

The evaluator has gathered all available information and documentation, and reviewed the referral and the current history and physical (including medications). Based on a review of all records, the evaluator found that at this time the individual:

[ ]  Did not meet criteria for a Serious Mental Illness because: (Mark all that apply)

 [ ]  The diagnosis is not a major behavioral health diagnosis

 [ ]  The individual has no significant impairment in functioning related to their behavioral health diagnosis

[ ]  The individual has no history of treatment for their behavioral health diagnosis within the last 2 years

[ ]  Did not meet criteria for an Intellectual Disability because: (Mark all that apply)

 [ ]  The individual’s history does not indicate an intellectual disability

 [ ]  There is no evidence to validate a diagnosis of an intellectual disability

[ ]  Did not meet criteria for a Related Condition because: (Mark all that apply)

 [ ]  The individual’s history does not indicate a related condition

 [ ]  There is no evidence to validate the condition meets the criteria for a related condition

[ ]  Has a primary diagnosis of Dementia (including Alzheimer’s disease or a related disorder).

[ ]  Change in condition does not affect nursing facility level of care, specialized service or services of lesser intensity needs.

Due to the above noted reason, the PASRR process stops here. The nursing facility is required to contact the PRO for the Medicaid level of care determination.

**Signature of Evaluator: \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

For all SMI determinations, a QMHP signature is required. If the evaluator is not a QMHP, a counter signature by a QMHP is required.

**Counter Signature: \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

*\*All referrals, information and documentation to support this determination shall be maintained by the CMHC following retention rules.*