OHIO DEPARTMENT OF MEDICAID

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) IDENTIFICATION SCREEN

This form must be submitted electronically. Manual submission of this form requires authorization from the local PASSPORT Administrative Agency (PAA). The fields marked with an (*) are required.

Clear Form

SCREENING TYPE

☐ (1) Preadmission Screening (PAS) ☐ (a) Community ☐ (b) Out of State PAS ☐ (c) Categorical Request *(choose type in section C below)*	☐ (2) Resident Review (RR) (a) Significant Change in Condition *(supporting documentation required)* ☐ Decline ☐ Improvement ☐ NF Readmission from a Psychiatric Facility/Unit Hospital name _____ Phone Number _____ (b) ☐ Expiring Hospital Exemption (c) ☐ Expiring Emergency Admission (d) ☐ Expiring Respite Stay (e) ☐ NF to NF Transfer- No PASRR Records (f) ☐ Extension Request for a Specified Period Approval

SECTION A: INDIVIDUAL'S BASIC INFORMATION

Last Name*	First Name*		MI
Permanent Street Address*	City*	State*	Zip*
County of Residence*	Primary Telephone	Secondary Telephone	
Gender* ☐ Male ☐ Female	Date of Birth* *(mm/dd/yyyy)*	Social Security Number*	
Are you a Medicaid Recipient? ☐ Yes ☐ No	Medicaid Number	Managed Care? ☐ Yes ☐ No	Name of Managed Care Organization

Where is the recipient currently located? ***Select one***

☐ Home/Apartment ☐ Hospital ☐ Nursing Facility ☐ ICF/IID ☐ Private Psychiatric Unit/Facility

☐ Regional Psychiatric Unit/Facility ☐ Homeless ☐ Assisted Living/Residential Care Facility

☐ Residential Facility ☐ Incarcerated ☐ Other: _____

SECTION B: ADMITTING NURSING FACILITY

Name*	Admission Date*		Medicaid Provider Number*	
Address*	City*	State*	Zip Code*	County*

Individual Last Name	Individual First Name

SECTION C: CATEGORICAL DETERMINATION AND EXTENSION REQUESTS - *Supporting documentation required.* Choose only **ONE** option**.**

☐ **Categorical Determination**

☐ (1) Emergency NF stay in situations requiring protective services as defined in OAC 5101:2-20-01
~ ***Time Limit = 7 days***

☐ (2) Respite NF stay to provide respite to in-home caregivers to whom the individual is expected to return
~ ***Time Limit = 14 days***

☐ **Extension Request**

(1) Number of Days? _____ *(up to 90 days)*

(2) Reason for Extension Request? *Describe:* _____

SECTION D: MEDICAL DIAGNOSIS

(1) Does the individual have a diagnosis of dementia?* ☐ No ☐ Yes ☐ Unknown

If "Yes" or "Unknown", please attach documentation related to symptoms, treatment, or a diagnosis of dementia.

(2) Please list current diagnoses below: * *(if none, indicate none)*

SECTION E: INDICATIONS OF SERIOUS MENTAL ILLNESS - *All questions in Section E must be completed*

1) Does the individual have a diagnosis(es) of any of the mental disorders listed below?* ☐ No ☐ Yes ☐ Unknown

Check all that apply.

☐ Schizophrenia
☐ Mood Disorder(s)
☐ Delusional Disorder(s)
☐ Panic or other Severe Anxiety Disorder(s)
☐ Somatic Symptom Disorder(s)
☐ Personality Disorder(s)
☐ Other Psychotic Disorder(s)
☐ Another mental disorder that may lead to a chronic disability
If so, describe: _____

2) Does the individual have a diagnosis(es) of a substance use related disorder?* ☐ No ☐ Yes ☐ Unknown

If Yes, specify diagnosis(es): Last reported usage: _____

3) Within the last **TWO** (2) years, has the individual utilized psychiatric services listed below more than once **DUE TO THE MENTAL DISORDER**?* **Complete information below before responding** ☐ No ☐ Yes ☐ Unknown

Indicate the number of times the individual utilized each service over the past 2 years. <u>If the total score below is greater than 1 answer yes in the question above.</u>

_____ Ongoing case management from a mental health agency
_____ Emergency mental health services
_____ Inpatient psychiatric hospitalization
_____ Partial hospitalization treatment program for psychiatric reasons
_____ Admission to residential facility for mental health services provided by mental health agency

__0__ **TOTAL**

Individuals Last Name	Individuals First Name

4) Within the last **TWO** (2) years, has the individual had a disruption in his/her usual living arrangement *(i.e. arrest, eviction, inter or intra-agency transfer, non-hospital locked seclusion)* **DUE TO THE MENTAL DISORDER**?* ☐ No ☐ Yes ☐ Unknown

5) Within the past **SIX** (6) months**,** has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis **DUE TO THE MENTAL DISORDER**?* ☐ No ☐ Yes ☐ Unknown

***Check all that apply*.**

- ☐ Maintaining Personal Hygiene
- ☐ Maintaining Adequate Diet
- ☐ Performing Household Chores
- ☐ Using Available Transportation
- ☐ Managing Available Funds
- ☐ Dressing Self
- ☐ Walking/Getting Around
- ☐ Maintaining Prescribed Medication Regimen
- ☐ Going Shopping
- ☐ Securing Necessary Support Services
- ☐ Verbalizing Needs
- ☐ Preparing/Obtaining Meals

6) In the past SIX (6) months, has the individual been prescribed any psychotropic medications? * ☐ No ☐ Yes ☐ Unknown

Check all that apply.

- ☐ Anti-psychotics *(i.e., Haldol, Loxitane, Thorazine, Mellaril, Moban, Zyprexa, Risperdal, Clozaril, etc.)*
- ☐ Anti-depressants *(i.e., Celexa, Paxil, Remeron, Serzone, Wellbutrin, Zoloft, etc.)*
- ☐ Anti-anxiety *(i.e., Ativan, Buspar, Valium, Xanax, etc.)*
- ☐ Mood Stabilizers *(i.e., Depakote, Lithium Carbonate, Lithobid, Tegretol, etc.)*
- ☐ Other ***(please specify):***

The individual has indications of Serious Mental Illness (SMI) if any of the following are true:

Answered yes OR unknown to AT LEAST two questions of E(1), E(3) through E(5) OR
Is currently admitted in an inpatient psychiatric unit/facility

Does the individual have indications of Serious Mental Illness? ☐ No ☐ Yes

SECTION F: INDICATIONS OF INTELLECTUAL & DEVELOPMENTAL DISABILITY OR RELATED CONDITION

1) Does the individual have a physical or mental disability, or related condition, that is **not solely caused by mental illness?*** ☐ No ☐ Yes ***(select all that apply below)*** ☐ Unknown

- ☐ Autism
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Traumatic Brain Injury
- ☐ Blindness
- ☐ Deafness
- ☐ Intellectual Disability
- ☐ Other ***(specify condition)***_____

2) Did the condition manifest before the individual's 22nd birthday?* ☐ No ☐ Yes ☐ Unknown

3) Is the condition likely to continue indefinitely?* ☐ No ☐ Yes ☐ Unknown

4) Does the individual have indications of substantial functional impairments in any of the major life activity areas *(self-care, language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency)*?* ☐ No ☐ Yes ☐ Unknown

5) Does the individual currently receive, or have they previously received, services from a County Board of DD?* ☐ No ☐ Yes ☐ Unknown

The individual has indications of DD/ID or related condition if any of the following are true:

Answered yes OR unknown to two or more questions F(1) through F(4) OR
Answered yes OR unknown to question F(5)

Does the individual have indications of DD? ☐ No ☐ Yes

Individuals Last Name	Individuals First Name

SECTION G: LEGAL GUARDIAN / POWER OF ATTORNEY INFORMATION - *(supporting documentation required)*

1) Does the individual have a court appointed legal guardian? ☐ No ☐ Yes *(If yes, fill in name and address below.)*			
2) Does the individual have a legal representative *(e.g. Power of Attorney)*? ☐ No ☐ Yes *(If yes, fill in name and address below)*			
Last Name *		First Name *	
Street Address *	City*	State*	Zip Code*
Email (optional)		Phone Number*	

SECTION H: ATTENDING PHYSICIAN INFORMATION

Last Name		First Name		
Street Address	City	State	Zip Code	Phone Number

SUBMITTER INFORMATION/CERTIFICATION

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 shall not admit or retain individuals with indications of Serious Mental Illness and/or Developmental Disabilities or a related condition without further review by Ohio Department of Mental Health and Addiction Services and/or Ohio Department of Developmental Disabilities in accordance with Ohio Administrative Code rules 5160-3-15.1 and 5160-3-15.2.

Last Name *		First Name *	
Facility/Organization Name *		Email Address *	
Street Address	City	State	Zip Code
County*	Telephone Number *	Fax Number *	

I understand this screening information may be relied upon for the payment of claims 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 to the best of my knowledge the foregoing information is true, accurate and complete. This form must be signed and dated to be valid.

_____ _____

Signature **Date (mm/dd/yyyy)**

_____ _____

Employer **Title**