Instructions

PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613)

Please provide the required information for this PA request on the following pages. When you have completed entering the data for this PA request, select the Review Request link to view the information entered.

In accordance with Section 1919(b)(3)(f) of the Social Security Act, a nursing facility cannot admit any new resident without this preadmission identification screen. This screen is part of the Preadmission Screening/Resident Review (PASRR), and determines whether each applicant to a nursing facility has indicators for a related condition of mental illness, mental retardation, or developmental disability.

* Last Name: * First Name: MI:

* Social Security Number: nnn-nn-nnnn * Date of Birth: mm/dd/yyyy * Gender:

* Current location of applicant:

Check all that apply to the applicant/resident: :

- ☐ New admission
- ☐ Out of State resident
- ☐ Readmission to NF from psychiatric hospital
- ☐ Readmission to NF from acute hospital
- ☐ Transfer from residential to NF
- ☐ Transfer between NF's
- ☐ Other

* 1. Does the individual have a suspected mental illness, mental retardation, developmental disability or related condition? ○ Yes ○ No

* a. Does the individual have a **primary** (Axis I) diagnosis of dementia based on DSM IV criteria? ○ Yes ○ No

If Yes, check the type of dementia, due to:

- ☐ Alzheimer's Disease
- ☐ Vascular Changes
- ☐ HIV
- ☐ Head Trauma
- ☐ Huntington's Disease
- ☐ Creutzfeldt-Jakob (ABE)
- ☐ Parkinson's Disease
- ☐ Pick's Disease

* b. Is there current and accurate data found in the patient record to indicate that there is a **severe** physical illness? ○ Yes ○ No

If Yes, specify the physical illness:

- ☐ Coma
- ☐ Functioning at a brain stem level
- ☐ Congestive Heart Failure
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Ventilator dependence
- ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ☐ Delirium

b.1. If yes, is the level of impairment so severe that the individual could NOT be expected to benefit from specialized services (PASRR)? ○ Yes ○ No

* c. Does the individual have a terminal illness as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less? ○ Yes ○ No

* d. Does the individual require nursing facility services after hospital discharge and whose attending physician has certified that the nursing facility stay is likely to require less than 30 days? ○ Yes ○ No

* **If YES was answered for numbers 1a, 1b, 1c OR 1d above, proceed to next page, sign and submit to GHP.**

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* 2. Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM IV criteria? [redacted] Yes [redacted] No

If Yes, check all that apply:

- [ ] Schizophrenia, Paranoid Type
- [ ] Schizophrenia, Disorganized Type
- [ ] Schizophrenia, Catatonic Type
- [ ] Schizophrenia, Undifferentiated Type
- [ ] Schizophrenia, Residual Type
- [ ] Other Psychotic Disorder
- [ ] Depressive Disorder
- [ ] Bipolar Disorder
- [ ] Anxiety Disorder
- [ ] Somatoform Disorder

Comments :

a. Does the treatment history indicate the individual has experienced **at least ONE of the following?**

* (1) In-patient psychiatric treatment more than once in the past 2 years. [redacted] Yes [redacted] No

* (2) Within the last 2 years 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. [redacted] Yes [redacted] No

b. **Within the past 3 to 6 months** the disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has AT LEAST ONE of the following characteristics on a continuing or intermittent basis:

* (1) **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. [redacted] Yes [redacted] No

* (2) **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. [redacted] Yes [redacted] No

* (3) **Adaptation to change.** This 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. [redacted] Yes [redacted] No

* 3. The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22). [redacted] Yes [redacted] No

a. Diagnosis of any of the following disabilities MAY indicate a RELATED CONDITION: Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

The individual is a "PERSON WITH RELATED CONDITIONS" having a severe, chronic disability that meet ALL of the following conditions:

(1) It is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required by these persons.

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

(3) It is likely to continue indefinitely.

(4) It results in substantial functional limitations in THREE or more of the following areas of major life activities:

- self-care;
- understanding and use of language;
- learning;
- mobility;
- self-direction; and
- capacity for independent living.

[redacted]

PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613) - Continued

I understand that this report 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 material fact may be prosecuted under Federal or State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

Nursing Facility Information

* **Has the patient been admitted to the nursing facility?** [redacted] Yes [redacted] No

Date of Admission to Nursing Facility : mm/dd/yyyy

Name of Nursing Facility:

Physician Information

* Physician Name:
Physician License number:
* Physician Address 1:
Physician Address 2:
* State:
* Physician Signed?
[redacted]
* Office or Hospital:
* County
* Physician Phone: aaa-nnn-nnnn
* City:
* ZIP Code: nnnnn
* Date Signed: mm/dd/yyyy
[redacted]

Contact Information

* Contact First & Last Name:
* Contact Phone: aaa-nnn-nnnn
Contact Fax:
* Address:
* State:
[redacted]
* Name of Contact Facility:
* Contact Facility Type:
Contact E-mail:
* City:
* ZIP Code: nnnnn
[redacted]

If questions #2 and #3 were answered "yes," do not admit the patient to the nursing facility until GHP and PASRR Determination Unit approves the admission and gives an authorization number.

If all questions were answered "no" and there is no further evidence to indicate the possibility of mental illness, mental retardation, or other related condition, the nursing facility may admit the patient if approved.

Admission to the facility does not constitute approval for Title XIX patient status.

A copy of this form, as well as a copy of the DMA-6, must be placed in each resident's clinical record in the facility.

* denotes required field

Review Request