

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL I SCREEN**

- Please print and complete all questions.
- This form must be completed for all applicants **PRIOR TO** nursing facility admission in accordance with Federal PASRR Regulations 42 CFR § 483.106.
- **All Positive Level I Screens are to be faxed to the appropriate agencies including OCCO (Office of Community Choice Options) and also to DDD (Division of Developmental Disabilities) and/or DMHAS (Division of Mental Health and Addiction Services), as applicable.**
- **All 30-Day Exempted Hospital Discharge Screens are to be faxed to OCCO and DDD and/or DMHAS, as applicable.**
- For first time identification of MI (Mental Illness) and/or ID/DD/RC (Intellectual Disability/Developmental Disability/Related Condition), the Level I Screener must provide written notice to the applicant and/or their legal representative that MI and/or ID/DD/RC is suspected or known and that a referral is being made to DMHAS and/or DDD for a PASRR Level II Evaluation. The referral notice for a PASRR Level II Evaluation Letter (LTC-29) can be downloaded from the New Jersey Department of Human Services' Division of Aging Services forms webpage at <http://www.state.nj.us/humanservices/doas/home/forms.html>.
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

SECTION I – DEMOGRAPHICS AND OCCO PAS STATUS

Name of Applicant (<i>Last Name, First Name</i>)		Social Security Number
Current Location Address	County of Current Location	Date of Birth
Current Location Setting <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Home/Apartment <input type="checkbox"/> Residential Health Care Facility <input type="checkbox"/> Group Home/Boarding Home <input type="checkbox"/> Psychiatric Hospital/Unit <input type="checkbox"/> Assisted Living Residence <input type="checkbox"/> Other (Specify): _____		
OCCO PAS Status <input type="checkbox"/> Current PAS on File, PAS Date: _____ <input type="checkbox"/> Referred to OCCO for PAS, Referral Date: _____ <input type="checkbox"/> Private Pay <input type="checkbox"/> Other (Specify): _____		

SECTION II – MENTAL ILLNESS SCREEN

1. Does the individual have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? Yes No
 Specify Diagnosis(es) based on DSM-5 or current ICD criteria and include any current substance-related disorder diagnosis(es):

2. Has the individual had a significant impairment in functioning related to a suspected or known diagnosis of mental illness (record YES if ANY of the three subcategories below are checked)? Yes No
Check all that apply:

a. **Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, 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, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

c. **Adaptation to change.** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

3. Within the last 2 years has the individual (record YES if EITHER/BOTH of the two subcategories below are checked): Yes No

a. experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or integrated Case Management Services); and/or

b. due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

If yes, explain and provide dates:

**PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL – CONTINUED**

Name of Applicant (<i>Last Name, First Name</i>)	Social Security Number
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SECTION II SCREENING OUTCOME for MI Screen Questions 1 through 3 (check one outcome only)

<input type="checkbox"/> Positive Screen MI	If ALL Questions 1 through 3 are answered YES , screen is Positive for MI. Continue on to Section III to determine if MI Primary Dementia Exclusion applies.
<input type="checkbox"/> Negative Screen MI	If Questions 1 through 3 are answered with <u>any combination of NO</u> , screen is Negative for MI. Skip to Section IV for ID/DD/RC Screen.

SECTION III – MENTAL ILLNESS PRIMARY DEMENTIA EXCLUSION

(complete this section only if Section II Screening Outcome is Positive for Screen for MI)

4. The Mental Illness Primary Dementia Exclusion applies to individuals who have a confirmed diagnosis of dementia and that the dementia diagnosis is documented as primary or more progressed than a co-occurring mental illness.

- a. Does the individual has a diagnosis of dementia (including Alzheimer’s Disease or related disorder) based on criteria in the DSM-5 or current version of the ICD? Yes No
Specify DSM-5 or ICD Codes(s): _____
- b. Were any of the following criteria used to establish the basis for a Dementia diagnosis? Record Yes if any or all of the following criteria apply and are checked off: Yes No
 Mental Status Exam Neurological Exam History and Symptoms
 Other Diagnostics (specify): _____
- c. Has the Physician **documented** dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis (explain how dementia as primary/more progressed was documented and verified)? Yes No:

SECTION III SCREENING OUTCOME for MI Primary Dementia Exclusion Question 4 (check one outcome only)

<input type="checkbox"/> YES – MI Primary Dementia Exclusion	If ALL responses to Questions 4a-4c are YES , outcome is YES for the MI Primary Dementia Exclusion. Continue on to Section IV for ID/DD/RC Screen.
<input type="checkbox"/> NO – MI Primary Dementia Exclusion	If ANY responses to Questions 4a-4c are NO , outcome is NO for the MI Primary Dementia Exclusion. Continue on to Section IV for ID/DD/RC Screen.

SECTION IV – INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY/RELATED CONDITIONS SCREEN

5. Intellectual Disability (ID) is a significantly decreased level of intellectual functioning measured by a standardized, reliable test of intellectual functioning and encompasses a wide range of conditions and levels of impairment with concurrent impairments in adaptive functioning. The ID must have manifested prior to the age of 18.

Does the individual have a current diagnosis or a history of Intellectual disability (mild, moderate, severe or profound) and/or is there any presenting evidence (cognitive or behavior characteristics) that may indicate the person has an intellectual disability with date of onset prior to age 18? Yes No
If yes, explain: _____

6. Related Conditions (RCs) are severe, chronic developmental disabilities, but not forms of intellectual disabilities, that produce similar functional impairments and require similar treatment or services. RCs must have manifested prior to the age of 22.

Does the individual have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction, learning, understanding/use of language, capacity for independent living (e.g., autism, seizure disorder, cerebral palsy, spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf or closed head injury)? Yes No
If yes, explain: _____

7. Does the individual currently receive services or previously received services paid through the Division of Developmental Disabilities (e.g., day habilitation, group home, case management, Community Care Waiver, Real Life Choices, Family Support of Self Determination) or other agency? Yes No

8. Was a referral made from an agency that serves individuals with ID/DD/RC past? Yes No
If yes, referred from what agency? _____

SECTION IV SCREENING OUTCOME for ID/DD/RC Screen Questions 5 through 8 (check one outcome only)

<input type="checkbox"/> Positive Screen ID/DD/RC	If ANY responses to Questions 5 through 8 are YES , screen is Positive for ID/DD/RC
<input type="checkbox"/> Negative Screen ID/DD/RC	If ALL responses to Questions 5 through 8 are No , screen is Negative for ID/DD/RC

**PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL – CONTINUED**

Name of Applicant (<i>Last Name, First Name</i>)	Social Security Number
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SECTION V – PASRR LEVEL I SCREENING OUTCOME AND REFERRAL, IF INDICATED

STEP 1. Determine Screening Outcomes for Sections II, III and IV (check ONE response for EACH Section):

<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Section II – MI Screen
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Section III – MI Primary Dementia Exclusion NOTE: check N/A if Section III was skipped due to Negative MI Screen
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Section IV – ID/DD/RC Screen

STEP 2. Determine Final Level I Screening Outcome (check ONE final screening outcome only):

<input type="checkbox"/>	Negative Screen	If Step 1 Section II Negative Section III N/A Section IV Negative	Admit to NF
<input type="checkbox"/>	Negative Screen	If Step 1 Section II Positive Section III Yes Section IV Negative	Admit to NF
<input type="checkbox"/>	Positive Screen MI Only	If Step 1 Section II Positive Section III No Section IV Negative	Refer to DMHAS (unless eligible for 30-Day Exempted Hospital Discharge, see Section VII)
<input type="checkbox"/>	Positive Screen ID/DD/RC only	If Step 1 Section II Negative Section III N/A Section IV Positive	Refer to DDD (unless eligible for 30-Day Exempted Hospital Discharge, see Section VII)
<input type="checkbox"/>	Positive Screen MI and ID/DD/RC	If Step 1 Section II Positive Section III No Section IV Positive	Refer to both DMHAS and DDD (unless eligible for 30-Day Exempted Hospital Discharge, see Section VII)

- ✓ Positive screening outcomes require referral to the applicable agency(ies) – DMHAS and/or DDD – prior to NF admission unless requesting a 30-Day Exempted Hospital Discharge (see Section VII).
- ✓ Complete Section VI if requesting a Categorical Determination for individuals with positive screens.
- ✓ When screening outcome is positive, also forward a copy of this form to the OCCO Regional Office serving your area (see page 5).

SECTION VI – CATEGORICAL DETERMINATION FOR LEVEL I POSITIVE SCREENS

If the Level I Screener is requesting an abbreviated Categorical Determination based on any one of the following four categories? Record Yes if any one of the following four categories apply and are checked off Yes No
Place a check in the box for the appropriate condition or circumstance:

- Terminal Illness Severe Physical Illness Respite Care Protective Service (APS)

DMHAS: Visit DMHAS website for Categorical Determination Form <http://www.state.nj.us/humanservices/dmhs/home/forms.html>.
DDD: Contact DDD Regional Office serving your area (see Page 5).

SECTION VII – 30-DAY EXEMPTED HOSPITAL DISCHARGE FOR LEVEL I POSITIVE SCREENS

30-Day Exempted Hospital Discharge applies only to INITIAL nursing facility admission NOT resident review, nursing facility readmission or inter-facility transfer. Complete this section for all Positive Screens meeting the following criteria.

EXEMPTED HOSPITAL DISCHARGE – An individual may be admitted to a skilled nursing facility directly from the hospital after receiving inpatient care (non-psychiatric) at the hospital if:

- ✓ the individual requires skilled nursing facility services for the condition for which he/she received care in the hospital **AND**
- ✓ the attending hospital physician certifies before the NF admission that the individual is likely to require less than 30 days skilled nursing facility care.

Is the individual eligible for the 30-Day Exempted Hospital Discharge? Yes No

Fax this completed form to OCCO and to DMHAS and/or DDD, as applicable, then the individual can be discharged to the nursing facility.

Name of Physician (Print) _____	Signature of Physician _____	Date _____
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**PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL – CONTINUED**

Name of Applicant (<i>Last Name, First Name</i>)	Social Security Number
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NURSING FACILITIES PLEASE NOTE THE FOLLOWING IMPORTANT INFORMATION ABOUT 30-DAY EXEMPTED HOSPITAL DISCHARGES:

- If the individual requires care beyond the initial 30-day period, the nursing facility must notify DMHAS and/or DDD, as applicable, prior to the individual's 30th day in the NF, and must provide a written explanation of the reason for the continued stay including the anticipated length of stay.
- Federal regulations require that the PASRR Level II Evaluation and Determination be completed prior to the individual's 40th day in the NF.
- Admission under the above exemption does not relieve the nursing facility of its responsibility to ensure that specialized services are provided to an individual who has mental health or ID/DD/RC needs and who would benefit from those services.
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT FOR NF SERVICES DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

For first time identification of MI/ID/DD, the Level I screener must provide written notice to the Nursing Facility applicant or legal representative that MI and/or ID/DD/RC is suspected or known, and that a referral is being made to DMHAS and/or DDD for Level II Evaluation. The Referral Notice for a Level II Evaluation Letter (LTC-29) can be downloaded from the New Jersey Department of Human Services' Division of Aging Services forms webpage <http://www.state.nj.us/humanservices/dmhs/home/forms.html>.

**SECTION VIII – PASRR LEVEL I SCREENING OUTCOME AND
CERTIFICATION OF SCREENING PROFESSIONAL COMPLETING LEVEL I FORM**

<p>Outcome of Level I Screen (check <u>ONE</u> Negative or Positive screening outcome)</p> <p><input type="checkbox"/> Negative Screen</p> <p><input type="checkbox"/> Positive Screen referring for Level II Evaluation prior to NF admission (check one of the following boxes)</p> <p style="padding-left: 20px;"><input type="checkbox"/> MI <input type="checkbox"/> ID/DD/RC <input type="checkbox"/> MI & ID/DD/RC</p> <p><input type="checkbox"/> Positive Screen 30-Day Exempted Hospital Discharge (check one of the following boxes)</p> <p style="padding-left: 20px;"><input type="checkbox"/> MI <input type="checkbox"/> ID/DD/RC <input type="checkbox"/> MI & ID/DD/RC</p> <p>Attending hospital physician must certify Section VII. Fax completed form to OCCO, DMHAS and/or DDD, as applicable, then the individual can be discharged to the nursing facility.</p> <p><input type="checkbox"/> Positive Screen Requesting Categorical Determination referring for Level II Evaluation prior to NF admission (check one of the following boxes)</p> <p style="padding-left: 20px;"><input type="checkbox"/> MI <input type="checkbox"/> ID/DD/RC <input type="checkbox"/> MI & ID/DD/RC</p>	<p>Name of Provider/Agency/Program</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Name of Screening Professional Completing Form (print)	Title of Screening Professional
_____	_____

Screening Professional Phone No.	Screening Professional Fax No.
_____	_____

Signature of Screening Professional Completing Form	Date
_____	_____

REMEMBER: ALL POSITIVE PASRR LEVEL I SCREENS INCLUDING 30-DAY EXEMPTED HOSPITAL DISCHARGES MUST BE FAXED TO OCCO AND ALSO TO DMHAS AND/OR DDD, AS APPLICABLE. THANK YOU.

**PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL – CONTINUED**

Name of Applicant (<i>Last Name, First Name</i>)		Social Security Number
SECTION IX – REQUIRED CONTACT INFORMATION FOR ALL POSTIVE LEVEL I SCREENS		
1. Name of Referring Entity (screening professional's affiliation such as agency, hospital, NF, other healthcare provider, MCO, etc.): Address / Street: Town / Zip Code:		Phone Number: Fax Number:
2. Consumer's Residing Address / Street (consumer's primary residence): Address / Street: Town / Zip Code:		Phone Number:
3. Name of Legal Representative (Last Name, First Name): Address / Street: Town / Zip Code:		Phone Number:
4. Name of Family Member (if available and consumer or legal representative agrees to family contact/notification): Address / Street: Town / Zip Code:		Phone Number:
5. Name of Attending Physician: Address / Street: Town / Zip Code:		Phone Number: Fax Number:
SECTION X – CONTACT INFORMATION		
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS) DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) DIVISION OF AGING SERVICES (DOAS) – OFFICE OF COMMUNITY OPTIONS (OCCO)		
Division of Mental Health and Addiction Services (DMHAS)	Division of Aging Services (DoAS) Office of Community Options (OCCO) Regional Offices	Division of Developmental Disabilities (DDD) Regional Offices
<u>Statewide PASRR Coordinator for Mental Health:</u> Phone 609-777-0482 or 609-777-0725; Fax 609-341-2307	<u>Northern Regional Office of Community Choice Options (NRO):</u> Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren Counties Phone 732-777-4650; Fax 732-777-4681 <u>Southern Regional Office of Community Choice Options (SRO):</u> Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem Counties Phone 609-704-6050; Fax 609-704-6055	<u>Territory 1:</u> Bergen, Essex, Hudson, Morris, Passaic and Sussex Counties Phone 973-693-5080; Fax 973-648-3999 <u>Territory 2:</u> Middlesex, Monmouth, Ocean, Somerset and Union Counties Phone 732-863-4500; Fax 732-863-4409 <u>Territory 3:</u> Burlington, Camden, Hunterdon, Mercer and Warren Counties Phone 609-292-1922; Fax 609-292-2629 <u>Territory 4:</u> Atlantic, Cape May, Cumberland, Gloucester and Salem Counties Phone 609-476-5200; Fax 609-909-0656