PASRR LEVEL I SCREEN USER GUIDE

DETERMINATION FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY,
AND OTHER RELATED CONDITIONS

PASRR Overview and FAQ

APPLICANT NAME: ***The consumer's name should appear at the top of each page of the form***

1. SUBMITTING HOSPITAL/AGENCY INFORMATION	
HOSPITAL/AGENCY NAME	Clearly print the name of the facility where the consumer is located when the screen is filled out, not the expected placement.
DATE	Clearly print the current date.
FAX NUMBER	Clearly print the number to which the Level I Determination Letter should be faxed.
PHONE NUMBER	Clearly print the phone number at which the person filling out the form can be reached if GHS has questions or needs more information.
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM	Clearly print the name and title/licensure of the person completing the screen. Per the DHHS PASRR manual, the Level I Screen may be completed by hospital discharge planners, licensed social workers, registered professional nurses, psychologists, physicians and professional NF staff. **The screen must be completed and signed by the same person.**
2. CONSUMER INFORMATION If the form does not include all identifying information, the screen cannot be processed.	
LAST NAME, FIRST NAME, MIDDLE INITIAL	Clearly print the consumer's full name in the format designated.
DATE OF BIRTH	Clearly print the consumer's date of birth.
SOCIAL SECURITY NUMBER	Clearly print the consumer's Social Security number.
MAINECARE NUMBER	Clearly print the consumer's MaineCare ID number, if applicable.
MEDICARE NUMBER	Clearly print the consumer's Medicare ID number, if applicable.
OTHER PAYER SOURCE	Clearly print the consumer's additional payer names and ID numbers, if applicable.
HOME STREET ADDRESS	Clearly print the consumer's home address street name.
TOWN, STATE, ZIP CODE	Clearly print the consumer's home town, state, and zip code.
PHONE	Clearly print the consumer's home telephone number.
3. EMERGENCY CONTACT INFORMATION	
NAME	Clearly print the name of the consumer's emergency contact.
RELATIONSHIP	Clearly print the type of relationship between the consumer and their emergency contact (e.g. parent, sibling, POA, etc.)
GUARDIAN Y ☐ N ☐	Indicate whether the consumer's emergency contact has guardianship.
POA Y ☐ N ☐	Indicate whether the consumer's emergency contact has Power of Attorney.
MAILING ADDRESS	Clearly print the contact's mailing address street name.
TOWN, STATE, ZIP CODE	Clearly print the contact's mailing address town, state, and zip code.
PHONE	Clearly print the contact's telephone number.
4. ANTICIPATED OR CURRENT NURSING FACILITY	
FACILITY NAME (IF UNKNOWN ENTER "TBD")	The admitting NF does not need to be identified before completing the Level I screen. If unknown, enter "TBD"
PHONE	Clearly print the facility's telephone number.
FACILITY STREET ADDRESS	Clearly print the facility's street address.
TOWN, STATE, ZIP CODE	Clearly print the facility's street address town, state, and zip code.
ESTIMATED NUMBER OF DAYS IN FACILITY	Clearly print the estimated number of days to be spent in the facility.
REASON FOR STAY ☐ SHORT-TERM REHAB, SKILLED CARE, RESPITE	Indicate the reason for stay. Remember that Level of Care (LOC) precedes PASRR:

CARE) Y ☐ N ☐ INTENSIVE COMMUNITY SUPPORTS (CASE MANAGEMENT SERVICES/CI/ACT)	management services, increased monitoring, etc.) would have been indicated.

7. NEXT STEPS

ANY "YES" RESPONSE FOR QUESTIONS (6.1), (6.5) OR (6.6) MEETS PASRR CRITERIA FOR THE PRESENCE OF MENTAL ILLNESS OR THAT THE PRESENCE OF MENTAL ILLNESS IS SUSPECTED. FAX THIS ENTIRE FORM TO MAXIMUS ASCEND. MAXIMUS ASCEND WILL DETERMINE WHETHER A LEVEL II IS NECESSARY.

IF THE RESPONSES TO THE ABOVE QUESTIONS ARE ALL `NO' AND THERE IS NO MENTAL ILLNESS DIAGNOSIS, OR ONLY A DEMENTIA DIAGNOSIS, FAX THIS FORM TO THE NURSING FACILITY PRIOR TO DISCHARGE AND NOT TO GHS. **PASRR SCREENING MATERIAL IS TO BE KEPT IN THE CONSUMER'S ACTIVE FILE AND MAY BE SUBJECT TO AUDIT.**	If this screen is submitted, it will receive one of the following automatic fax responses: "As this Screen was submitted with no mental health diagnosis and all responses to the questions in 6 thru 10 are 'no', no review is needed. Please send this Screen to the facility upon the patient's discharge so the facility can keep a copy in the resident's chart. No determination letter will be issued from KEPRO." "As this Screen was submitted with a dementia diagnosis and no mental health diagnosis and all responses to the questions in 6 thru 10 are 'no', no review is needed. Please send this Screen to the facility upon the patient's discharge so the facility can keep a copy in the resident's chart. No determination letter will be issued from KEPRO."

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8. INTELLECTUAL DISABILITY (ID)	
An applicant is considered to have an intellectual disability (ID), autism or a pervasive developmental disorder (PDD) if the criteria listed below are met **OR** the individual has previously been found eligible for services based on a diagnosis of an ID, autism or a PDD by DHHS. Documentation is not necessary to support the criterion as long as the individual is suspected to meet the criterion based on observations and knowledge about the individual.	
8.1 HAS THIS INDIVIDUAL EVER BEEN DIAGNOSED WITH OR IS THERE A SUSPICION OF AN INTELLECTUAL DISABILITY, AUTISM OR A PDD? Y ☐ N ☐ IF YES, PLEASE SPECIFY:	Indicate whether the consumer has been diagnosed with an intellectual disability, autism, or a PDD. If yes, specify.
ANSWER ALL OF THE QUESTIONS ON THE REST OF THE PAGE EVEN IF THE RESPONSE ABOVE IS "NO"	
8.2 THE INDIVIDUAL HAS IMPAIRMENTS IN ADAPTIVE BEHAVIOR THAT SHOW A SIGNIFICANT LIMITATION IN MEETING THE STANDARDS OF THE FOLLOWING FOR HIS/HER AGE AND CULTURAL GROUP: • MATURATION • LEARNING • PERSONAL INDEPENDENCE • SOCIAL RESPONSIBILITY Y ☐ N ☐	Indicate whether the consumer has impairments in adaptive behavior that show significant limitation in meeting the standards for his/her age and cultural group. Does the individual have presenting evidence of ID that has not been diagnosed?
8.3 THE INDIVIDUAL HAS IMPAIRMENTS IN ADAPTIVE BEHAVIOR THAT SHOW SUBSTANTIAL FUNCTIONAL LIMITATION IN 3 OR MORE OF THE FOLLOWING AREAS OF MAJOR LIFE ACTIVITIES, **WHICH ARE NOT RELATED TO THE NORMAL AGING PROCESS**. CHECK ALL AREAS OF SUBSTANTIAL FUNCTIONAL LIMITATION WHICH WERE PRESENT **PRIOR TO AGE 18** AND WERE DIRECTLY THE RESULT OF THE ID. ☐ SELF-CARE ☐ UNDERSTANDING/USE OF LANGUAGE ☐ LEARNING ☐ MOBILITY ☐ SELF-DIRECTION ☐ CAPACITY FOR INDEPENDENT LIVING ☐ WERE **3 OR MORE LIMITATIONS** WERE NOTED?	Rosa's Law changed references in federal law to 'mental retardation' to references to an 'intellectual disability', and changed references to a 'mentally retarded individual' to references to 'an individual with an intellectual disability'. ID only applies to individuals with a diagnosis or suspicion of ID. It does not apply to dementia, mental illness, or medical conditions that are not related conditions to intellectual disability (e.g. hip fractures, pneumonia, etc.) One of the key challenges is to confirm that lowered cognitive levels occurred during the developmental period and are not a result of other medical issues, e.g. stroke, TIA, or accidents/injuries experienced during adulthood. Federal law requires PASRR evaluation if the consumer is known to have or suspected of having ID, even when testing or documentation is not available to confirm conclusively the diagnosis.
8.4 **SERVICES:** HAS THE INDIVIDUAL RECEIVED SERVICES FROM A DEVELOPMENTAL SERVICES AGENCY IN THE PAST OR BEEN FOUND ELIGIBLE FOR SERVICES BY DHHS BASED ON A DIAGNOSIS OF AN ID, AUTISM OR A PDD? Y ☐ N ☐	It is the obligation of the person completing the PASRR Screen to fill in each response as accurately as possible. If the clinical record does not clearly state the answers to the questions on the Screen, the hospital staff or nursing facility must ask the consumer and/or guardian or POA and document the response.
IF YES, PLEASE IDENTIFY DHHS REGION & CASEWORKER:	Clearly print the DHHS region and Caseworker's name. Include contact information if available.
8.5 **FACILITIES:** HAS THE INDIVIDUAL EVER BEEN A RESIDENT OF A DEVELOPMENTAL DISABILITY FACILITY OR ICF/IID? Y ☐ N ☐ IF YES, PLEASE IDENTIFY FACILITY:	Indicate whether the consumer has ever been a resident of Pineland, a resident of a Residential Care facility for individuals with a developmental disability or an ICF/IID (Intermediate Care Facility for Individuals with an Intellectual Disability). If yes, clearly print the name of the facility. Include contact information if available.

9. NEXT STEPS	
	WERE **ANY** OF THE RESPONSES ABOVE "YES"? ANY "YES" RESPONSE FOR QUESTIONS (8.1, 8.2 AND 8.3) OR (8.4) OR (8.5) MEETS PASRR CRITERIA FOR DIAGNOSIS OR SUSPICION OF ID, AUTISM OR PDD. FAX THIS ENTIRE FORM TO KEPRO. KEPRO WILL DETERMINE WHETHER A LEVEL II IS NECESSARY..
	IF THE RESPONSES TO THE ABOVE QUESTIONS ARE ALL `NO' AND THERE IS NO MENTAL ILLNESS DIAGNOSIS, OR ONLY A DEMENTIA DIAGNOSIS, FAX THIS FORM TO THE NURSING FACILITY PRIOR TO DISCHARGE AND NOT TO MAXIMUS ASCEND. **PASRR SCREENING MATERIAL MAY BE SUBJECT TO AUDIT.**

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10. OTHER RELATED CONDITIONS (ORC)

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: is attributed to epilepsy or cerebral palsy; 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 mentally retarded persons, and requires treatment or services similar to those required for these persons; and it is manifested before the person reaches age 22; and it is likely to continue indefinitely; and it results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

10.1 HAS THE INDIVIDUAL BEEN DIAGNOSED WITH OR SUSPECTED OF HAVING ONE OR BOTH OF THE FOLLOWING CONDITIONS? Y ☐ N ☐ CEREBRAL PALSY Y ☐ N ☐ EPILEPSY	Indicate whether the consumer has been diagnosed with or is suspected of having cerebral palsy and/or epilepsy.
10.2 DOES THE INDIVIDUAL HAVE ANY OTHER CONDITION, OTHER THAN A SERIOUS MENTAL ILLNESS THAT: • Is closely related to an intellectual disability (ID) • Results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an ID • Requires treatment or services similar to those required for individuals with an ID Y ☐ N ☐ IF YES, PLEASE SPECIFY:	Although federal definition of ORC includes disability related to Cerebral Palsy and Epilepsy, it does not exclude any diagnosis or condition categorically except for serious mental illness (SMI). It does not apply to dementia, intellectual disability, or medical conditions that are not related conditions, (e.g. hip fractures, pneumonia, etc.) Examples of related conditions include, but are not limited to: Traumatic Brain Injury, Fetal Alcohol Syndrome, Muscular Dystrophy, Down Syndrome, Stroke, TIA, Spina Bifida, Seizure Disorder, etc.

IF ALL OF THE QUESTIONS ABOVE RESULTED IN "NO" STOP HERE AND GO TO SECTION 11 ON THIS PAGE.

If more than one condition is "YES", answer the remaining questions on this page for each condition.
One ORC form may be submitted with separate responses for each condition.

10.3 DID THE ORC MANIFEST BEFORE THE INDIVIDUAL REACHED THE AGE OF 22? Y ☐ N ☐	Indicate whether the ORC manifested before age 22.
10.4 IS THE ORC LIKELY TO CONTINUE INDEFINITELY? Y ☐ N ☐	Indicate whether the ORC is likely to continue indefinitely.
10.5 CHECK ALL AREAS OF SUBSTANTIAL FUNCTIONAL LIMITATION WHICH WERE PRESENT **PRIOR TO AGE 22 AND WERE DIRECTLY THE RESULT OF THE ORC.** ☐ SELF-CARE ☐ UNDERSTANDING/USE OF LANGUAGE ☐ LEARNING ☐ MOBILITY ☐ SELF-DIRECTION ☐ CAPACITY FOR INDEPENDENT LIVING	Indicate all areas of substantial functional limitation which were a direct result of the ORC and were present before age 22. It is the obligation of the person completing the PASRR Screen to fill in each response as accurately as possible. If the clinical record does not clearly state the answers to the questions on the Screen, the hospital staff or nursing facility must ask the consumer and/or guardian or POA and document the response.
10.6 ☐ WERE **3 OR MORE LIMITATIONS** NOTED?	Indicate whether 3 or more or 2 or less limitations were noted in the previous section regarding substantial functional limitation(s) directly resulting from the ORC prior to the age of 22.

11. NEXT STEPS

WERE **ANY** OF THE RESPONSES ABOVE "YES"? ANY "YES" RESPONSE FOR QUESTIONS (10.1) OR (10.2) AND (10.3, 10.4, 10.6) MEETS PASRR CRITERIA FOR THE DIAGNOSIS OF ORC. FAX THIS ENTIRE FORM TO MAXIMUS ASCEND. MAXIMUS ASCEND WILL DETERMINE WHETHER A LEVEL II IS NECESSARY.

IF THE RESPONSES TO THE ABOVE QUESTIONS ARE ALL `NO' AND THERE IS NO MENTAL ILLNESS DIAGNOSIS, OR ONLY A DEMENTIA DIAGNOSIS, FAX THIS FORM TO THE NURSING FACILITY PRIOR TO DISCHARGE AND NOT TO KEPRO.

12. ATTESTATION	
I ATTEST THAT I HAVE SPOKEN DIRECTLY WITH THE APPLICANT AND/OR GUARDIAN OR POA WHILE FILLING OUT THIS FORM.	Facilities must perform due diligence to gather basic information sufficient to indicate on the Screen whether or not a suspicion of a PASRR condition may be present; this information may be found in the record and/or obtained through query of the consumer or the consumer's medical designee. PASRR is a person-centered process that promotes quality of life and placement success. The consumer and/or legal representative must be involved in the process. These individuals may assist in identifying previously unreported MI/ID/ORC. The State of Maine DHHS requires that the person filling out the form sign to attest that they have spoken directly with the consumer and/or guardian or POA as part of gathering information necessary to complete this form. **PLEASE SUBMIT ALL PAGES, INCLUDING THE SIGNED ATTESTATION.** **Keep all PASRR Screening materials in the consumer's Active file as PASRR screens may be subject to audit.**

If you need further assistance with complete the Level I Screen form or have general questions about PASRR, please call MAXIMUS Ascend at 833-525-5784.

Maine ASA Fax #: 844-356-7500