maximus

AssessmentPro Level I Form – Colorado
Pre-Admission Screening and Resident Review (PASRR)

Demographics

First Name	Middle Initial	Last Name	Suffix

Mailing Address

City	State	Zip	County	Gender
				☐ Male ☐ Female ☐ Other: _____

Phone Number

Unique Identifier
☐ Social Security Number ☐ Passport ID ☐ Temporary Resident ID ☐ Driver's License/State ID
☐ Medicaid ID ☐ AssessmentPro IID Identifier Number: _____
☐ The individual doesn't have any of these IDs

Date of Birth

Marital Status
☐ Married ☐ Single
☐ Widowed ☐ Divorced

Race
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Hispanic/Latino/Spanish
☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other (specify): _____

Payment Method
☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ Private Insurance
Medicaid ID: _____ Medicare ID: _____

Current Location
☐ Community Setting ☐ Medical Facility Medical Unit
☐ Medical Facility ER/ED ☐ Medical Facility Psych Unit
☐ Psychiatric Facility ☐ Nursing Facility
☐ PACE Facility ☐ Home
☐ Other (specify): _____

Current Location Address

Admission Date

Current Location Phone Number

What has been his/her typical living situation over the past year?
☐ Home alone ☐ Home w/natural supports ☐ Home w/paid supports ☐ Assisted living
☐ Nursing facility ☐ Homeless ☐ Group home ☐ Psychiatric facility
☐ Jail/prison ☐ ICF/IID ☐ Other (specify): _____

Where does the individual say they would like to live within the next year?
☐ Home setting ☐ Assisted living ☐ Nursing facility ☐ Group home
☐ Psychiatric facility ☐ ICF/IID ☐ Other (specify): _____

What is the admitting nursing facility?

Admitting Nursing Facility Address

Reason for Screening

Is the individual a nursing facility applicant or resident?

☐ Nursing facility applicant
☐ Nursing facility resident who is not currently in an inpatient psychiatric hospital/unit at this time
- ☐ This nursing facility resident has experienced a significant change in status or has not adequately responded to PASRR recommended services and may require a Level II evaluation
  Date of Last PASRR Level II:
  ☐ No prior PASRR on record
- ☐ A previous PASRR short-term approval for nursing facility stay is expiring or has expired (e.g., Exempted Hospital Discharge, Emergency, Respite)
- ☐ This nursing facility resident has never had a PASRR Level I screen
- ☐ This nursing facility resident has never had a PASRR Level II evaluation and shows signs or symptoms that indicate she/he may have a PASRR condition

☐ Nursing facility resident who is currently hospitalized in a psychiatric hospital/unit and an evaluation is needed to ensure nursing facility readmission is appropriate

Status Change

Complete this section if you marked any nursing facility resident item in Reason for Screening above.

☐ There were no indicators of a significant status change
☐ Increased behavioral, psychiatric, or mood related symptoms

Last Name_____ First Name_____ DOB_____

- ☐ Improved medical condition such that the resident's plan of care or service recommendations may require modification
- ☐ Resident has expressed a preference for community placement
- ☐ Resident's condition is significantly different than that described in the most recent PASRR Level I or II
- ☐ Resident was not previously identified to require a Level II, though current symptoms/behaviors suggest that her/his condition may have been overlooked
- ☐ Resident was not previously identified to require a Level II, and it appears that the referral source may not have appropriately completed screening information
- ☐ Resident recently required inpatient psychiatric treatment
- ☐ Other, specify: _____

Explain your selection(s) by describing the change(s) experienced by the resident, and submit documentation to support the change(s).

_____

_____

Mental Health Diagnoses

Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past. If you are reporting a depression diagnosis, include the ICD-10 code.

Diagnosis	Current	Suspected	ICD-10 Code(s)
☐ No mental health diagnosis is known or suspected	☐	☐	
☐ Schizophrenia	☐	☐	
☐ Schizoaffective disorder	☐	☐	
☐ Major depression	☐	☐	
☐ Psychotic/delusional disorder	☐	☐	
☐ Bipolar disorder (I or II)	☐	☐	
☐ Paranoid disorder/paranoid personality disorder	☐	☐	
☐ Personality disorder	☐	☐	
☐ Anxiety disorder	☐	☐	
☐ Depression/depressive disorder (mild or situational)	☐	☐	
☐ Other mental health diagnosis (do not include dementia). Specify:	☐	☐	

Substance Related Diagnoses

Does the individual have a substance related disorder (abuse or dependency)?	☐ No (skip to Dementia/Neurocognitive Disorders) ☐ Yes (complete Substance Related Diagnoses)
Substance Used	When was the last known use?
☐ Alcohol	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Cannabis	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Phencyclidine	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Hallucinogens	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Inhalants	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Opioids	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Sedatives/anxiolytics/hypnotics	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Amphetamines	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Cocaine	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
☐ Other (specify):	☐ <7 days ☐ 7–14 days ☐ 15–30 days ☐ 31 days–3 months ☐ 4–6 months ☐ 7–12 months ☐ >12 months ☐ Unknown
Is the request for nursing facility care in any way associated with or resulting from the substance related disorder? ☐ No ☐ Yes	

Last Name_____ First Name_____ DOB_____

Dementia/Neurocognitive Disorders

Does the individual have a diagnosis of dementia/ neurocognitive disorder?	☐ No (skip to Interpersonal Behaviors) ☐ Yes (complete Dementia/Neurocognitive Disorders)
Are the deficits due to dementia/neurocognitive disorder so severe that the individual cannot live in the community because of those deficits?	☐ No ☐ Yes
Due to the dementia/ neurocognitive disorder, does the individual present with any of the following?	
Significant difficulty communicating?	☐ No ☐ Yes
Significant difficulty ambulating and/or completing routine motor tasks?	☐ No ☐ Yes
Significant difficulty recognizing familiar people or familiar objects?	☐ No ☐ Yes
Significant short-term memory impairments?	☐ No ☐ Yes
Significant long-term memory impairments?	☐ No ☐ Yes
Is corroborative testing or other information available to verify the presence or progression of the dementia, such as neurological testing, comprehensive mental status exam, or other testing?	☐ No ☐ Yes, specify ☐ Neurological testing ☐ CT Scans ☐ Mental Status Exam ☐ Other (specify):

Interpersonal Behaviors

Check any or all of the following interpersonal behaviors or symptoms experienced by this individual recently or in the past.		
Behavior or Symptom	When last experienced?	
☐ There are no known mental health behaviors which affect interpersonal interactions		
☐ Serious difficulty interacting with others	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
☐ Altercations, evictions, or unstable employment	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
☐ Excessive isolation from or avoidance of others (such as would occur with a person with severe anxiety, paranoia, depression, or fear of strangers)	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years

Concentration/Task Completion

Check any or all of the following task- or concentration-related behaviors or symptoms experienced by this individual recently or in the past.		
Behavior or Symptom	When last experienced?	
☐ There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which s/he should be physically capable of completing		
☐ Serious difficulty thinking through or completing tasks that s/he should be capable of completing	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
☐ Requires assistance thinking through or completing tasks which s/he should be capable of thinking through or completing	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
☐ Substantial errors thinking through or completing tasks	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years

Mental Health Symptoms

Check whether any of the following behaviors or symptoms have occurred for this individual recently or in the past		
Behavior or Symptom	When last experienced?	
☐ There are no known recent or current mental health symptoms		
☐ Self-injurious or self-mutilation behaviors	☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
☐ Suicidal talk	☐ Current or within past 30 days	☐ Within past 2–6 months

Last Name_____ First Name_____ DOB_____

Check whether any of the following behaviors or symptoms have occurred for this individual recently or in the past		
Behavior or Symptom	When last experienced?	
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ History of suicide attempt or gestures	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Physical violence	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Physical threats (with potential for harm)	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Physical threats (potential for harm is unknown)	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Physical threats (no potential for harm)	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Severe appetite disturbance due to depression, sadness, or other mental health condition	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Hallucinations or delusions	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Serious loss of interest in things due to depression, sadness, or other mental health condition	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Excessive tearfulness	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Excessive irritability	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Other major mental health symptoms. These may include symptoms that have emerged or worsened as a result of recent life changes as well as any ongoing symptoms. Describe symptoms:	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years

Behavioral Health Services

Has the individual received any of the following mental health services now or in the past?		
Service	When last experienced?	
☐ No		
☐ Inpatient psychiatric hospitalization	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Mental health partial hospitalization	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Residential treatment/supported housing due to mental health or substance related disorder	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Mental health crisis services	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months
	☐ Within past 25 months–5 years	☐ Greater than 5 years
☐ Other intensive mental health services	☐ Current or within past 30 days	☐ Within past 2–6 months
	☐ Within past 7–12 months	☐ Within past 13–24 months

Last Name_____ First Name_____ DOB_____

Has the individual received any of the following mental health services now or in the past?	
Service	When last experienced?
	☐ Within past 25 months–5 years ☐ Greater than 5 years

Behavioral Health Impact

Has there been legal intervention due to mental health symptoms/behaviors?	☐ No ☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Yes. Identify timeframe below. ☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
Has the individual had to move to another setting because of mental health symptoms?	☐ No ☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Yes. Identify timeframe below. ☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
Has the individual ever been homeless?	☐ No ☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Yes. Identify timeframe below. ☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years
Are there other examples where the individual's life has been seriously affected because of mental health symptoms?	☐ No ☐ Current or within past 30 days ☐ Within past 7–12 months ☐ Within past 25 months–5 years	☐ Yes. Identify timeframe below. ☐ Within past 2–6 months ☐ Within past 13–24 months ☐ Greater than 5 years

Mental Health Medications

List any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or anytime within the past six months. Attach additional pages if needed.

Medication	Dosage MG/Day	Diagnosis	Current	Discontinued
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Intellectual and/or Developmental Disabilities

Does the individual have a diagnosis of an intellectual disability?	☐ No ☐ Yes
If no known diagnosis, is the individual suspected to have an intellectual disability that has not been diagnosed?	☐ No ☐ Yes. Identify the presenting evidence below. ☐ History of special education services ☐ Communication difficulties ☐ Suspected intellectual disability ☐ Other (specify):
Has a reliable source, such as a family member, confirmed the presence of an intellectual disability prior to the age of 18?	☐ No ☐ Yes ☐ Unknown
Is there existing IQ testing for this individual?	☐ No ☐ Yes ☐ Unknown
Has the individual ever received services from an agency that serves persons with intellectual disabilities?	☐ No ☐ Yes. Identify the provider. Facility/Agency Name: Facility/Agency Phone: Case Manager Name:

Does the individual have a developmental condition or diagnosis that affects either/both intellectual and/or adaptive functioning?

☐ There is no known or suspected developmental condition or diagnosis that affects intellectual and/or adaptive functioning

☐ Anoxia at birth	☐ Arthrogryposis	☐ Autism spectrum disorder	☐ Asperger syndrome
☐ Cerebral palsy	☐ Congenital blindness	☐ Congenital deafness	☐ Childhood disintegrative disorder
☐ Down syndrome	☐ Encephalitis	☐ Epilepsy	☐ Expressive language disorder
☐ Fetal alcohol syndrome	☐ Fragile X syndrome	☐ Friedreich's ataxia	☐ Hydrocephaly
☐ Isodicentric chromosome 15 syndrome		☐ Klippel-Feil syndrome	☐ Landau-Kleffner syndrome

Last Name_____ First Name_____ DOB_____

☐ Meningitis	☐ Pervasive developmental disorder		☐ Phenylketonuria (PKU)
☐ Polio	☐ Prader-Willi syndrome	☐ Rett syndrome	☐ Seizure disorder
☐ Spina bifida or neural tube defect		☐ Traumatic brain injury (TBI)/Neurocognitive disorder due to TBI	
☐ Williams syndrome	☐ XXY syndrome	☐ Other (specify):	

Did this condition develop prior to age 22?	☐ No ☐ Yes ☐ Unknown
Due to the condition, does the individual have substantial functional limitations in any of the following areas	☐ There are no substantial functional limitations associated with the condition ☐ Mobility is impacted due to the condition ☐ Self-care skills are impacted due to the condition ☐ Self-direction/planning is affected due to the condition ☐ Learning is affected due to the condition ☐ Understanding/use of language is affected due to the condition ☐ Ability to live independently is affected due to the condition

Exemption and Categorical Decisions

Does the individual need nursing facility care for the condition treated in the hospital?	☐ No ☐ Yes
Has the individual's physician documented that s/he requires 30 days or less of NF care? (Exempted Hospital Discharge)	☐ No ☐ Yes
Has the individual's physician documented that s/he requires 60 days or less of NF care? (Convalescence Categorical)	☐ No ☐ Yes
Is the admission occurring because of an emergency?	☐ No ☐ Yes. Does the emergency meet the following criteria? ☐ There is an urgent need for nursing facility services ☐ Lower level of care is not available and/or appropriate ☐ The authorization was provided by an appropriate state employee or authorized designee (Ombudsman, APS) ☐ Nursing facility care is needed for no more than 7 calendar days ☐ None of the above apply
Does the individual have acute delirium?	☐ No ☐ Yes
Is nursing facility care being sought for temporary caregiver respite purposes?	☐ No ☐ Yes. Does the need for respite meet the following criteria? ☐ The individual requires respite care for up to 30 calendar days per certification period to provide relief to the family or caregiver ☐ The individual will be returning to the community at the conclusion of the respite stay ☐ The individual is receiving one of the following waivers: HCBS-BI, HCBS-CMHS, HCBS-CIH, HCBS-EBD, or HCBS-SLS ☐ None of the above apply
Has a physician determined that the individual's medical condition is terminal?	☐ No ☐ Yes
Does the individual have any of the following serious medical conditions?	☐ No ☐ Yes ☐ Individual is currently comatose ☐ Individual is currently ventilator dependent ☐ The individual presents with brain-stem functioning ☐ The individual has an other severe condition that warrants long-term NF care ☐ None of the above apply

Last Name_____ First Name_____ DOB_____

Guardianship & Physician Information (Required only for individuals with known or suspected Level II conditions)

Does the individual have a legal guardian? ☐ **No legal guardian.** ☐ **Yes, information is below:**

Legal Guardian Last Name_____ First Name_____ Phone:_____

Street_____ City_____ State_____ Zip_____

Primary Physician's Name: _____ Phone:_____ Fax:_____

Street_____ City_____ State_____ Zip_____

Case Management Agency

Does the individual have a Case Management Agency (CMA)? ☐ **No CMA.** ☐ **Yes, information is below:**

Case Management Agency Name_____

Case Manager (CM) Name_____

CM Phone_____ CM Email_____

Referral Source Signature

I attest that the information submitted herein is true and accurate to the best of my knowledge. I understand that misrepresentation of the individual in the screen is considered Medicaid fraud.

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax: