



**Pre-Admission Screening and Resident Review (PASRR) Level I**

To ensure an individual is placed in a long term care facility appropriately and receives needed services, federal regulations, 42 CFR 483.100 - 483.138 require a Pre-Admission Screening and Resident Review (PASRR) Level I screening for individuals who have or may have a diagnosis of mental illness, intellectual disabilities, and/or related conditions. The PASRR Level I Screening is required for all applicants to long term care Medicaid certified facilities, regardless of the individual's payment source, and for long term care Medicaid certified facility residents who have had a significant change in condition or diagnosis (resident review). All information requested on this form is required.

Submit complete form, with all required signatures and attachments, by direct secure messaging (DSM) to: **DSDS.LTCAuthorizations@direct.dhss.akhie.com**

**Name of Individual**  
(Last, First, MI)

<b>Name of Individual</b> (Last, First, MI)
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DOB	Medicaid # (if applicable)	Address (Street, City, Zip)	Telephone Number

Name of Representative	Address (Street, City, Zip)	Telephone Number	Type of Representative

Current Location	Admitting Facility & ID #	Address (Street, City, Zip)	Telephone Number	Email	Contact Name/Title

If multiple facilities are being considered, please identify these here (*Facility ID # and Name*):

Applicant	Resident
<input type="checkbox"/> New Admission. Proposed/Actual Date: _____  <input type="checkbox"/> Inter-facility Transfer (from one facility to another)	<input type="checkbox"/> Significant Change (Resident Review) <ul style="list-style-type: none"> <li><input type="checkbox"/> Condition improvement- LOC from SNF to ICF</li> <li><input type="checkbox"/> Condition decline- LOC from ICF to SNF</li> <li><input type="checkbox"/> New diagnosis</li> </ul>

<b>Exempted Hospital Discharge</b> (does not require PASRR Level II evaluation)	<input type="checkbox"/> Individual being admitted to LTC facility for less than 30 days, as certified by physician
<b>Primary Dementia/Mental Illness</b> (does not require PASRR Level II evaluation)	<input type="checkbox"/> Primary dementia in combination with mental illness as certified by physician

<b>Name of Individual:</b>	<b>Admitting Facility ID#:</b>
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<b>PASRR Categorical Determinations</b> (certain circumstances that are time-limited that only require an abbreviated PASRR Level II evaluation report)	<input type="checkbox"/> Individual has a primary diagnosis of dementia, Alzheimer’s disease or related disorder in combination with diagnosis of intellectual disability or related condition. (Further evaluation may be required for validation of diagnosis) <input type="checkbox"/> Individual admitted directly to LTC facility from hospital for convalescent care for an acute physical illness and is likely to require less than 90 days of NF services <input type="checkbox"/> Terminal illness, as certified by physician (life expectancy of less than six months) <input type="checkbox"/> Severe physical illness resulting in level of impairment so severe that individual needs LTC services but cannot be expected to benefit from specialized services.
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Identify primary/secondary diagnosis, applicable code, and age of onset	Primary Diagnosis and Code (ICD-10)	Secondary Diagnosis and Code (ICD-10)	Date of Onset
<b>Mental Illness</b>			
<b>Intellectual Disability</b>			
<b>Related Condition</b>			
The individual has been referred for or has received services/treatment for mental illness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
The individual has been referred for or has received services/treatment for intellectual disability or related condition		<input type="checkbox"/> Yes	<input type="checkbox"/> No
The individual has a history or other indication of substance abuse disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any known or suspected diagnosis of mental illness, intellectual disability, substance abuse disorder, or related condition		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Physician’s Name:</b>		<b>Date:</b>	
<b>Physician’s Signature:</b>			

<b>Functional and Adaptive Needs</b> (Check all that apply)			
<b>Communication/Language</b>	<input type="checkbox"/> unable to communicate basic needs <input type="checkbox"/> does not understand directions	<input type="checkbox"/> does not participate in conversation <input type="checkbox"/> incoherent/bizarre speech content	
<b>Challenges with Practical Skills</b>	<input type="checkbox"/> occupation skills <input type="checkbox"/> safety <input type="checkbox"/> schedule/routines <input type="checkbox"/> mobility/ travel/transportation	<input type="checkbox"/> use of money <input type="checkbox"/> healthcare and self-care <input type="checkbox"/> use of telephone	
<b>Challenges with Conceptual Skills</b>	<input type="checkbox"/> language and literacy <input type="checkbox"/> limitations in reasoning <input type="checkbox"/> learning, problem-solving	<input type="checkbox"/> time & number concepts <input type="checkbox"/> self- direction	
<b>Completion of Tasks/Activities</b>	<input type="checkbox"/> difficulty completing <input type="checkbox"/> makes mistakes/errors with tasks <input type="checkbox"/> needs assistance to complete	<input type="checkbox"/> slow pace to completion <input type="checkbox"/> lacks persistence <input type="checkbox"/> difficulty concentrating	
<b>Harmful to Self or Others</b>	<input type="checkbox"/> head bangs <input type="checkbox"/> hits, bites, or scratches self <input type="checkbox"/> threatens physical violence	<input type="checkbox"/> causes physical pain to others <input type="checkbox"/> threatens physical violence <input type="checkbox"/> suicidal ideation/attempt	
<b>Unusual Activities</b>	<input type="checkbox"/> talks to self <input type="checkbox"/> makes faces or odd noises	<input type="checkbox"/> stares at objects or into space <input type="checkbox"/> hallucinations or delusions	

<b>Name of Individual:</b>	<b>Admitting Facility ID#:</b>
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<b>Disruptive Behavior</b>	<input type="checkbox"/> challenging/combative <input type="checkbox"/> interferes with others <input type="checkbox"/> excessive irritability	<input type="checkbox"/> yells or screams <input type="checkbox"/> uncooperative <input type="checkbox"/> overly demanding
<b>Socially Inappropriate Behaviors</b>	<input type="checkbox"/> spits at others <input type="checkbox"/> verbally abusive <input type="checkbox"/> inability to follow rules <input type="checkbox"/> history of altercation	<input type="checkbox"/> social isolation <input type="checkbox"/> challenges with independent living <input type="checkbox"/> inappropriately touches self or others
<b>Withdrawn Behavior</b>	<input type="checkbox"/> difficulty interacting with others <input type="checkbox"/> sad or worried	<input type="checkbox"/> uninterested in activities <input type="checkbox"/> anxious or fearful
<b>Destructive to Property</b>	<input type="checkbox"/> defaces or breaks objects <input type="checkbox"/> tears or cuts materials	<input type="checkbox"/> attempts to burn objects
<b>Has Experienced Restrictive Interventions</b>	<input type="checkbox"/> interpersonal skills <input type="checkbox"/> restraints	<input type="checkbox"/> medication to control behavior
<b>Challenges with Social Skills</b>	<input type="checkbox"/> seclusion <input type="checkbox"/> social responsibility <input type="checkbox"/> self-esteem	<input type="checkbox"/> social problem-solving <input type="checkbox"/> vulnerable to manipulation by others

<b>Check all that were reviewed during PASRR Level I Screening</b>	<input type="checkbox"/> H&P (required) <input type="checkbox"/> Plan of Care <input type="checkbox"/> Current psychological evaluation (if applicable) <input type="checkbox"/> Other (specify):
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**Signatures and Contact Information**

*The State is responsible for the final determination regarding PASRR. If review of the Level I PASRR Screening indicates a need for a PASRR Level II evaluation, the State may require additional documentation, will complete the evaluation and make a determination regarding appropriate placement within 7-9 business days, and will notify all parties of the outcome.*

Name of person Completing this PASRR Level I Screening	Date	Telephone Number	Email

<b>Signature:</b>
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Name of Individual:	Admitting Facility ID#:
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**State of Alaska use only - Preadmission Screening and Resident Review Determination**

Date Received:	Date Reviewed:	Date of Determination:
Date of Admission:		
Name of SDS Reviewer:		Contact Information:
Applicable Category	<p><i>Based on the information reviewed by SDS, the following determination is made. If admission or continued placement for this individual is approved, all services as identified by the PASRR Level II evaluation must be provided, by collaborative effort with the state, to meet the individual's nursing and disability-specific needs. A copy of the PASRR evaluation report will be provided for inclusion in the medical record; the recommendations made in that report must be incorporated into the plan of care. A notice has been provided to the individual and/or his/her representative of the need for a Level II evaluation if applicable, and a summary of the PASRR Level II evaluation report.</i></p>	
Negative Screen	<input type="checkbox"/> PASRR Level I screening does <b>not</b> indicate need for Level II PASRR evaluation. Applicant may be admitted to the LTC facility.	
Exempted Hospital Discharge	<input type="checkbox"/> Placement in facility for 30 days or less, as certified by physician. If the individual stays beyond the 30 days, an individualized PASRR Level II evaluation must be completed by the state on or before the 40 <sup>th</sup> day. The facility shall notify SDS on day 25 that it anticipates the resident will need services more than 30 days. <b>Day 25 is:</b>	
Primary Dementia/Mental Illness	<input type="checkbox"/> Primary dementia in combination with mental illness. May be admitted to the LTC facility.	
PASRR Categorical Determinations (certain circumstances that are time-limited that require an abbreviated PASRR Level II evaluation report)	<input type="checkbox"/> Convalescent care for a period of 90 days or less, as certified by the physician. If the individual stays beyond the 90 days, an individualized PASRR Level II evaluation must be completed. The facility shall notify SDS on day 85 that it anticipates the resident will need services more than 90 days. <b>Day 85 is:</b>	
	<input type="checkbox"/> Primary dementia in combination with a diagnosis of intellectual disability or related condition applies. A Level II evaluation may be required, if there is a substantial change in condition.	
	<input type="checkbox"/> Terminal illness, as certified by attending physician. A Level II evaluation may be required, if there is a substantial change in condition.	
	<input type="checkbox"/> Severe physical illness. A Level II evaluation may be required, if there is a substantial change in condition.	
Resident Review	<input type="checkbox"/> May be considered appropriate for continued placement in the LTC facility, without specialized services for disability-specific needs.	
	<input type="checkbox"/> May not continue to reside in LTC facility. Alternative placement and services are developed by the state in cooperation with the facility. Payment continues until transfer completed.	
Level II PASRR Evaluation needed	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Related condition	Date referred for Level II evaluation:  Date Level II report received: