Ohio Department of Medicaid

PREADMISSION SCREENING/RESIDENT REVIEW (PAS/RR) IDENTIFICATION SCREEN

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT

LAST NAME	FIRST NAME	MI

SEX	DATE OF BIRTH *(MM/DD/YYYY)*	SOCIAL SECURITY NUMBER
☐ M = Male ☐ F = Female		

MEDICAID RECIPIENT

☐ YES ☐ MANAGED CARE ☐ PENDING ☐ NO

MEDICAID NUMBER *(12 digits – if applicable)*	MANAGED CARE PLAN NAME *(If applicable)*

☐ YES ☐ NO Does applicant/resident have additional health care insurance with another company?
If so, name of insurance company:

Living arrangement/options at the time of the request for PAS/RR: *(Check one below)*

INDEPENDENT LIVING OPTION	INSTITUTIONAL SETTING	COMMUNITY-BASED RESIDENCE
☐ Own/Leases Home/Apartment – Lives Alone	☐ ICF/IID	☐ Group Home (Non ICF/IID)
☐ Own Home/Apartment – Lives with Others (Friends/Family)	☐ Private Psychiatric Hospital (Hospital Name:)	☐ Assisted Living
☐ Home Owned/Leased by Individual	☐ Regional Psychiatric Hospital (Hospital Name:)	☐ Other *(please specify)*
☐ Living with Family	☐ Prison	
☐ Homeless	☐ Nursing Facility	

SECTION B: REASONS FOR SCREENING *(Indicate using **ONE** of the boxes below)*

Preadmission Screening Codes: *(If seeking admission into nursing facility)*

☐ **1 – Ohio resident seeking nursing facility admission**

☐ **2 – Individual residing in a state other than Ohio, seeking nursing facility admission.**

INSTRUCTIONS: IF #1 OR #2 ABOVE IS SELECTED, GO TO SECTION C.

Resident Review Codes: *(If seeking to remain in nursing facility)* **Resident's Date of Admission:**

☐ **3 – Expired Time Limit for Hospital Exemption:** *(Check one)*

- ☐ a) seeking approval for an unspecified period of time
- ☐ b) seeking approval for a specified period of time
  (please complete Section G (1) and (2) in addition to the remainder of the form)
- ☐ c) seeking an extension to an approved RR for a specified period of time
  (please complete Section G (3) and (4) in addition to the remainder of the form)

☐ **4 – Expired Time Limit for Emergency Admission:** *(Check one)*

- ☐ a) seeking approval for an unspecified period of time
- ☐ b) seeking approval for a specified period of time
  (please complete Section G (1) and (2) in addition to the remainder of the form)
- ☐ c) seeking an extension to an approved RR for a specified period of time
  (please complete Section G (3) and (4) in addition to the remainder of the form)

☐ **5 – Expired Time Limit for Respite Admission:** *(Check one)*

- ☐ a) seeking approval for an unspecified period of time
- ☐ b) seeking approval for a specified period of time
  (please complete Section G (1) and (2) in addition to the remainder of the form)
- ☐ c) seeking an extension to an approved RR for a specified period of time
  (please complete Section G (3) and (4) in addition to the remainder of the form)

☐ **6 – NF Transfer, No Previous PAS/RR Records**

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☐ **7 – Significant Change in Condition** ***(Check either a, b, or c to identify the change in condition)***

- ☐ a) Decline
- ☐ b) Improvement
- ☐ c) Admission to psychiatric unit

If admission to psychiatric unit provide hospital name and phone number below.

Hospital Name: **Phone #:**

(Check either d, e, or f to identify length of stay being sought)

- ☐ d) seeking approval for an unspecified period of time
- ☐ e) seeking approval for a specified period of time
  (please complete Section G (1) and (2) in addition to the remainder of the form)
- ☐ f) seeking an extension to an approved RR for a specified period of time
  (please complete Section G (3) and (4) in addition to the remainder of the form)

Please provide details regarding the Significant Change:

SECTION C: MEDICAL DIAGNOSIS

☐ YES ☐ NO 1) Does the individual have a documented diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-5 (or most recent version)?

If this is a Resident Review, please complete the remainder of this section. Check NA if this request is a PAS.

☐ YES ☐ NO ☐ NA 2) Please indicate current diagnosis if different from diagnosis submitted at admission.
Diagnosis:

Please list below the top six medical diagnosis at time of admission if different from the resident review request.

Diagnosis 1:	**Diagnosis 2:**	**Diagnosis 3:**
Diagnosis 4:	**Diagnosis 5:**	**Diagnosis 6:**

SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS
All questions in Section D must be completed.

☐ YES ☐ NO 1) Does the individual have a diagnosis of any of the mental disorders listed below?
(Check all that apply)

- ☐ a) Schizophrenia
- ☐ b) Mood Disorder
- ☐ c) Delusional (Paranoid) Disorder
- ☐ d) Panic or Other Severe Anxiety Disorder
- ☐ e) Somatoform Disorder
- ☐ f) Personality Disorder
- ☐ g) Other Psychotic Disorder
- ☐ h) Another mental disorder other than DD that may lead to a chronic disability.
  If so, describe:

☐ YES ☐ NO 2) Within the past two (2) years, DUE TO MENTAL DISORDER, has the individual utilized psychiatric services more than once?

Indicate the number of times the individual utilized each service over the last 2 years. If service was not utilized, enter "0"

	Ongoing case management from mental health agency? ("1" if continuously receiving over 2 years. If not, "O")
	Emergency mental health services?
	Number of admissions to the inpatient hospital settings for psychiatric reasons?
	Number of admissions to partial hospitalization treatment programs for psychiatric reasons?
	Number of admissions to Residential Care Facilities (RCFs) providing mental health services by a mental health agency?
	TOTAL SCORE

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If total score equals 2 or more, answer YES to Question D (2). Regardless of score answer Question D (2)(b).

OR

☐ YES ☐ NO b) Within the past two (2) years, DUE TO MENTAL DISORDER, has the individual had a disruption to his/her usual living arrangements (e.g., arrest, eviction, inter or intra-agency transfer, non-hospital locked seclusion)?

If YES, answer YES to Question D (2).

☐ YES ☐ NO 3) Within the past six (6) months, DUE TO MENTAL DISORDER, has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis? *(Check all that apply)*

☐ a) Maintaining Personal Hygiene
☐ b) Dressing Self
☐ c) Walking/Getting Around
☐ d) Maintaining Adequate Diet
☐ e) Preparing/Obtaining Own Meals
☐ f) Maintaining Prescribed Medication Regimen
☐ g) Performing Household Chores
☐ h) Going Shopping
☐ i) Using Available Transportation
☐ j) Managing Available Funds
☐ k) Securing Necessary Support Services
☐ l) Verbalizing Needs

☐ YES ☐ NO 4) Within the past two (2) years, has the individual received SSI or SSDI due to a mental impairment?

☐ YES ☐ NO 5) Does the individual have indications of Serious Mental Illness?

NOTE: The individual has indications of Serious Mental Illness if the individual answered YES to AT LEAST two questions of D(1) , D(2) or D(3) OR YES TO D(4)

SECTION E: INDICATIONS OF DD OR RELATED CONDITION

☐ YES ☐ NO 1) Does the individual have a diagnosis of developmental disability (mild, moderate, severe or profound) as described in the AAIDD manual "Intellectual Disability: Definition, Classification and Systems of Supports" (2009 or more recent version)?

If YES, go to Question E (3) and answer Questions E 3 through E7

☐ YES ☐ NO 2) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to DD because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with DD and requires treatment or services similar to those required for persons with DD?

If NO, go to Question E(6). If YES, please specify AND answer Questions E3 through E7. Specify:

☐ YES ☐ NO 3) Did the disability manifest before the individual's 22nd birthday?

☐ YES ☐ NO 4) Is the disability likely to continue indefinitely?

☐ YES ☐ NO 5) Did the disability result in functional limitations, prior to age 22, in 3 or more of the following major life activities. *(Check all that apply)*

☐ a) Self Care
☐ b) Economic Self-Sufficiency
☐ c) Self Direction
☐ d) Capacity for Independent Living
☐ e) Mobility
☐ f) Understanding and Use of Language
☐ g) Learning

☐ YES ☐ NO 6) Does the individual currently receive services from a County Board of DD?

☐ YES ☐ NO 7) Does the individual have indications of DD or related condition?

NOTE: The individual has indications of DD or related condition if the individual received a

- **Yes to Question E(1); OR**
- **Yes to all of the following in this Section: Questions: 2, 3, 4 AND 5; OR**
- **Yes to Question E(6)**

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SECTION F: RETURN TO COMMUNITY LIVING REFERRAL

☐ YES ☐ NO 1) Did you share with the individual the service and support alternatives to the nursing facility admission (for PAS) or continuation of the nursing facility stay (for RR)?

If service and support alternatives are not appropriate due to care needs, please explain why alternatives are not appropriate at this time:

☐ YES ☐ NO 2) Does this individual expect to return to live in the community either following the short term stay in the nursing facility or at some point in the future?

☐ YES ☐ NO 3) Do you believe that this individual could benefit from talking to someone about returning to the community following the short term stay in the nursing facility (for PAS) or during the continued stay in the nursing facility (for RR)?

☐ YES ☐ NO 4) Was this individual employed prior to the nursing facility placement?
Occupation, if applicable:

☐ YES ☐ NO 5) Does the individual need assistance obtaining and/or returning to employment upon return to a community setting?

6) What challenges or barriers do you believe could impede this individual's return to the community?
Check all that apply and provide a brief description

☐ a) Care needs are likely greater than community capacity
☐ b) Limited or no family/friend support available
☐ c) Guardian/Family likely to not support community living
☐ d) Lost housing during nursing facility stay
☐ e) Affordable housing limited
☐ f) Accessible housing limited
☐ g) Limited income to support community living
☐ h) Other, please describe below

Brief Description:

Does the Individual Need Help Returning to Community Living?

If the individual already has, or is likely to have prior to discharge from the facility, a combined stay in the hospital/ nursing facility/ICF-IID facility of 90 days or longer and could benefit from community transition assistance, a referral to the HOME Choice Transition Program is recommended. Please visit www.medicaid.ohio.gov/homechoice to submit an application or call 1-888-221-1560 for more information regarding program benefits and application procedures.

Application submitted on *(mm/dd/yyyy)*

Ohio's twelve area agencies on aging offer free long-term care consultations. As requested, a consultant (most often a nurse or social worker) will meet with the individual and their family for a free evaluation of the current situation and future options. The consultant will explain services available, discuss eligibility requirements and financial resources required and help determine needs and wishes. Call toll-free 1-866-243-5678 to be connected to the area agency on aging serving your community.

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SECTION G: REQUEST FOR RESIDENT REVIEW APPROVAL FOR A SPECIFIED PERIOD

Complete only when seeking a Resident Review for a Specified Period of Time

Initial Request

1) If seeking a resident review approval for a specified period of time, how much time is needed?

   a) Number of Days:

2) Reason for Initial Request:

☐ a) Individual requires more rehabilitation related to the recent hospital stay.
Describe:

–OR–

☐ b) More time is needed to ensure a safe and orderly discharge due to: *(Check all that apply)*

- ☐ i) Accessible housing barrier. *Describe:*
- ☐ ii) Affordable housing barrier. *Describe:*
- ☐ iii) Service and support limitations in the community. *Describe:*
- ☐ iv) Lack of sufficient income. *Describe:*
- ☐ v) Other. *Describe:*

NOTE: If requesting a resident review due to time needed for a safe and orderly discharge, the nursing facility shall attach a written discharge plan consistent with OAC 5160-3-15.2.

Request for an Extension to a Specified Period Approval

Resident's Date of Admission:

1) If seeking a resident review approval extension, how much time is needed?

   a) Number of Days:

2) Reason for Extension Request:

☐ a) Individual requires more rehabilitation following the recent hospital stay.
Describe:

–OR–

☐ b) More time is needed to ensure a safe and orderly discharge due to: *(Check all that apply)*

- ☐ i) Accessible housing barrier. *Describe:*
- ☐ ii) Affordable housing barrier. *Describe:*
- ☐ iii) Service and support limitations in the community. *Describe:*
- ☐ iv) Lack of sufficient income. *Describe:*
- ☐ v) Other. *Describe:*

NOTE: If requesting a resident review due to time needed for a safe and orderly discharge, the nursing facility shall attach a written discharge plan consistent with OAC 5160-3-15.2.

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SECTION H: MAILING ADDRESSES

Please place an "X" in the box next to the address and phone number of the person to be contacted for a Level 2 PAS/RR evaluation by OhioMHAS and/or DODD.

☐ **1) What address should be used for mailing results of the PAS/RR evaluation to the applicant/resident?**

In Care of			
Street Address	**City**	**State**	**Zip**
Telephone No.	**Ohio County of Residence** *(First 4 letters)*		

☐ **2) Please provide the following information about the individual's attending physician.**

Last Name	First Name		
Street Address			
City	**State**	**Zip**	**Telephone No.**

☐ **3) If the individual has a guardian or legal representative (e.g. Power of Attorney), please provide the following information about the guardian/legal representative.**

Last Name	First Name		
Street Address			
City	**State**	**Zip**	**Telephone No.**
Fax Number	**Email Address**		

☐ **4) If the individual is an applicant to or resident of a nursing facility, please provide the name and address of the nursing facility.**

Name of Nursing Facility			
Street Address	**City**	**State**	**Zip**
Telephone No.	**Ohio County of Residence** *(First 4 letters)*		

☐ **5) If the individual is being discharged from a hospital, and the submitter is not employed by the discharging hospital, please provide the name of a contact person and the name of the discharging hospital.**

Last Name	First Name		
Street Address			
City	**State**	**Zip**	**Telephone No.**

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SECTION I: SUBMITTER INFORMATION/CERTIFICATION			
In order to process the screen, the submitter must provide his/her name and address and sign below. Complete the form fully and with accuracy. Incomplete forms may be returned with a request for further information. ***The nursing facility may not admit or retain individuals with indications of Serious Mental Illness and/or DD or a related condition without further review by OhioMHAS and/or DODD (OAC rules 5160-3-15.1 and 5160-3-15.2).***			
Last Name	First Name		
Street Address	City	State	Zip
Telephone No.	County		

I understand that this screening information 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 a material fact may be prosecuted under Federal and State laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.		
Signature	Title	Date *(mm/dd/yyyy)*
Employer		

ADDITIONAL INSTRUCTIONS AND DOCUMENTATION REQUIREMENTS

Please complete electronically and print all sections of the form unless otherwise specified. For any RR-ID, a copy of the screen must be placed in the resident's chart at the nursing facility. The screen should accompany the resident in the event of transfer to another nursing facility.

Section A: Include date of birth and social security number and specify whether the applicant/resident is a Medicaid recipient including whether the applicant/resident is enrolled on a managed care plan.

Section B: Check the box that corresponds with the request. If Code #7 is checked, please identify what has changed.

Section C: If the diagnosis at the Resident Review request is different than the admitting diagnosis under the preadmission screen or hospital exemption, please attach supporting documentation of the admission diagnosis and the resident review diagnosis.

Section F: When requesting a preadmission screen or a resident review, please assess the individual's potential to return to a community setting and indicate whether a referral has been made to the HOME Choice Transition Program or for a Long Term Care Consultation.

Section G:

For resident review approvals for a specified period of time.

- The nursing facility is required to submit the following documentation:
- For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.
- For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.

For extensions of resident review approvals for a specified period of time.

- Please note the number of the extension request in the space provided.
- The nursing facility is required to submit the following documentation:
- For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.
- For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review extension request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.

Go to website: http://mha.ohio.gov/Default.aspx?tabid=126