State of Florida Agency for Health Care Administration
Pre-Admission Screen and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)
Use for Medicaid Certified Nursing Facility (NF) Only

______________________________	______________	__________
Name of Individual Being Evaluated (print)	Social Security Number*	Date of Birth

☐ Male ☐ Female Age ________

______________________________	______________	__________
Present Location of Individual Being Evaluated	Street Address, City	State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other__________

____
Individual's or Residency Phone Number

______________________________	______________	__________
Legal Representative's Name (if applicable)	Street Address, City	State, Zip

Representative's Phone Number ______________

______________________________	__________________
Medicaid Number if Applicable	Screening Date (mm/dd/yyyy)

____
Other Health Insurance Name and Number if Applicable

☐ Private Pay

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER? Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

Name of Individual Being Evaluated ______________________ Date of Birth ______________

Section I: PASRR Screen Decision-Making

A. SMI or suspected SMI (check all that apply):

☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Dissociative Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ Psychotic Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Somatic Symptom Disorder
☐ Other (specify):
____
____

☐ Substance Abuse

B. ID or suspected ID (check all that apply):

☐ Autism
☐ Cerebral Palsy
☐ Down Syndrome
☐ Epilepsy
☐ Intellectual disability with an IQ lower than 70 (specify) ______________________
☐ Prader-Willi Syndrome
☐ Spina Bifida
☐ Other (specify): ______________________
____
____
____
____

If known:
Age of onset for ID? ______Years
Age of onset for any related condition? ______Years

Finding is based on: (check all that apply)

☐ Documented History
☐ Medications
☐ Behavioral Observations
☐ Individual, Legal Guardian or Family Report
☐ Other (specify):
____
____

Additional Information:

____
____
____
____
____

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication within the past 3 to 6 months the individual has a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been fired. ☐Yes ☐No

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, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Within the last two years, due to the mental illness, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

NOTES ON SECTIONS I AND II:

- A Level II evaluation must be completed if any box in Section I.A is checked and there is a YES checked in Section II.1, II.2, or II.3.
- A Level II evaluation must be completed if any box in Section I.B is checked and (1) the intellectual disability manifested prior to 18 years of age or a related condition manifested before age 22, and (2) the condition is likely to continue indefinitely, resulting in functional limitations in three or more of the following: self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living.
- A Level II evaluation must be completed if Section II.4 is checked YES.
- If the Level I screening is completed by a physician, a Level II evaluation is not required if the individual is found to have:
  - A primary diagnosis of dementia, including Alzheimer's Disease or a related disorder; or
  - A non-primary diagnosis of dementia unless the primary diagnosis is a serious mental illness (42 CFR 483.102(b)(1)(i)(B).

Section III: PASRR Screen Provisional Determination

☐ **Not a provisional admission**

☐ **Provisional admission (choose one of the following):**

If a provisional admission is indicated, the individual may enter an NF without a Level II evaluation/determination if the Level I screen indicated a suspicion of SMI and/or ID. However, a Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to the Florida Department of Elder Affair's CARES program for adults and the Florida Department of Health for children (age less than 21 years) within the time frames indicated in this section.

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): ___________

Name of Individual Being Evaluated ________________ Date of Birth ________________

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14 day time limit, on or before (date): _________

☐ The individual is being admitted under the 30-day hospital discharge exemption (attach Form 3008 and physician signature required below). If the individual's stay exceeds 30 days, the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _______________.

An attending physician's signature is required for those individuals admitted under this 30-day hospital discharge exemption.

ATTENDING PHYSICIAN'S SIGNATURE ________________ DATE ________________

Section IV: PASRR Screen Completion

Individual may be admitted to an NF (check one of the following):

☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.

☐ Provisional admission

Individual may not be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):

☐ SMI

☐ ID

☐ SMI and ID

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener's Name (Printed) ________________ **Signature** ________________

Credentials ________________ **Date** ________ **Phone** ________________

Place of Employment ________________ **Fax** ________________

*************************Incomplete forms will not be accepted************************

Completed Level I screen **distributed to**:	Notice of referral for Level II, if applicable, **distributed to** (including information on how to obtain the evaluation):
☐ Local DOH** office, under the age of 21years Date: ________________ ☐ Local CARES*** office, age 21years or older Date: ________________ ☐ Nursing Facility Date: ________________ ☐ Discharging Hospital (if applicable): Date: ________________	☐ Individual/Representative Date: ________________ ☐ Other:________________________ Date:________________

If the individual requires a Level II evaluation, submit the completed Level I screen, documented informed consent, completed AHCA 3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation to CARES or DOH.

****Department of Health**

***** Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services**