Preadmission Screening and Resident Review (PASRR)

Resident Review (RR) - Evaluation Request Form

Instructions

A. Acronyms and abbreviations:

a. AHCA – Agency for Health Care Administration
b. CARES – Florida Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services Program
c. CFR – Code of Federal Regulations
d. CMAT – Children's Multidisciplinary Assessment Team
e. DOH – Florida Department of Health
f. DOEA – Florida Department of Elder Affairs
g. F.A.C. – Florida Administrative Code
h. HIPAA – Health Insurance Portability and Accountability Act
i. ID – Intellectual Disability or Related Conditions
j. MI – Mental Illness
k. MID – Medicaid Identification Number
l. MM/DD/YYYY – Month, Day, Year
m. N/A – Not Applicable
n. NF – Medicaid-certified Nursing Facility
o. PASRR – Preadmission Screening and Resident Review
p. RR – Resident Review
q. SMI – Serious Mental Illness

B. Instructions

The Resident Review – Evaluation Request, AHCA MedServ Form 004 Part A1, March 2017, must be fully and accurately completed, and distributed in accordance with Rule 59G-1.040, F.A.C. Incomplete submissions will not be accepted, and may prohibit Florida Medicaid payment for nursing facility services. Information inserted manually must be legible. Any illegible information will result in the RR Evaluation Request being deemed unacceptable.

The Resident Review – Evaluation Request, AHCA MedServ Form 004 Part A1, March 2017, is to assist an NF to request an RR for a resident who has experienced a significant change in condition, as defined in Rule 59G-1.040, F.A.C.

The NF must notify the State authority for SMI or ID of the necessity for the RR evaluation and determination in accordance with 42 United States Code 1396r. The Resident-Review – Evaluation Request Form 004 Part A1, March 2017, must be completed and sent with all accompanying documents to the designated Level I screening agencies, CARES or DOH, as appropriate. The Level I screening agency will forward the request to the appropriate State authority.

Page 1

Fill in the blanks with the individual's demographics, name and contact information of the legal representative, insurance information, etc. Do not leave any area blank; check the appropriate box that applies.

Section I

Fill in the blanks for the individual's current NF location. Continue to provide information as requested.

Section II

Fill in the date the significant change was first identified, using the DD/MM/YYYY format.

Page 2

Fill in the individual's name and date of birth at the top of this page, and each continuing page.

Check the box(es) for information indicating a decline or an improvement in the individual's status. Continue to check the box(es) describing the reason for identifying a decline or improvement, as applicable. For dates, use the MM/DD/YYYY format. Fill in areas that require further information as applicable.

Add any additional information that may assist the state SMI or ID authority in evaluating the resident.

Section III: Attestation of Requestor

Fill in the attestation information using the name of the staff person completing the form and other information requested.

Page 3, Section IV: Completion of Evaluation Request

Check the appropriate agency box for distribution of the completed Resident Review-Evaluation Request Form 004, Part A1, March 2017, according to the resident's age and fill in the date the information is being sent to CARES or DOH, as applicable. Use the MM/DD/YYYY format for the date.

Check the box(es) for all documentation that will accompany the request. Fill in any other information that is not listed.

Check the box(es) indicating the notice to the individual and the individual's representative as applicable.

Request the resident's signature for consent, or indicate the reason the individual is unable or unwilling to sign the form.

Ensure all distributions of the PASRR Resident Review – Evaluation Request form and required documents maintain HIPAA compliance.

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

RESIDENT REVIEW (RR) – EVALUATION REQUEST

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

_____ _____-___-_____
Name Social Security Number*

☐ Male ☐ Female _____ ___/___/_____
Age Date of Birth

_____ ____-_____-_____
Legal Guardian Name, Address, City, State Zip (if applicable) Phone Number

Pay Source: ☐ Private Pay ☐ Medicaid ☐Medicare ☐Private Insurance

_____
Medicaid Number

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN 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.

Section I: Current Location

☐ NF _____ ___-____-_____ _____
Name, Address, City, State, Zip Phone Number NF License Number

____/____/_____ ____/_____/_____ ____/____/_____
NF Admission Date Date of Level I PASRR Date of most current Level II PASRR or RR (if applicable)

Previous Level II PASRR Determination: ☐ SMI ☐ ID ☐ SMI and ID ☐ N/A

Section II: Significant Change

Date of Onset _____/_____/_____

_____ _____

Individual's Name Date of Birth

Describe significant changes in the resident's condition.

☐ **Decline in Resident's Status (check all that apply):**

☐ Increase in behavioral, psychiatric, or mood-related symptoms.
☐ Behavioral, psychiatric, or mood-related symptoms that have not responded adequately to ongoing treatment.
☐ Sudden increase or decrease in weight.
Current weight _____ Date ___/___/_____
Prior weight _____ Date ___/___/_____
Reason for change: _____
_____
☐ Change in behavior, psychiatric, or mood suggestive of a suspicion of SMI (where dementia is not the primary diagnosis).
☐ Will not resolve itself without intervention by staff or the implementation of standard disease-related clinical interventions and/or modification of care plan.
☐ In more than one area of resident's health status (check all that apply):
☐ Behavior change not due to a medical condition.
☐ Adaption to change.
☐ Medical condition exacerbating current SMI/ID symptomatology.
☐ Other conditions or additional information
(Please use the space below to explain, if necessary)
_____
_____

☐ **Improvement in Resident's Status (check all that apply):**

☐ Decrease in behavioral, psychiatric, or mood-related symptoms.
☐ Behavioral, psychiatric, or mood-related symptoms that have responded adequately to ongoing treatment.
☐ Improvement in medical condition requiring interdisciplinary review and/or modifications in the plan of care.
☐ Improvement in more than one area of resident's health status. Areas affected:
_____
_____
_____ _____
☐ Has required implementation and/or modification in care plan. Specifically:
_____
_____
_____
☐ No longer requires specialized services.

Section III: Attestation of Requestor

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

_____ _____

Name Signature

_____

Credentials

_____ _____ _____

Date Phone Fax

_____

Place of Employment

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

Section IV: Completion of Evaluation Request

Resident Review Request for Level II Evaluation Distributed to:

☐ Local DOH** office, under the age of 21 years Date: ___/___/_____

☐ Local CARES*** office, age 21 years or older Date: ___/___/_____

Documentation included (Check all that apply):

☐ Completed Resident Review – Evaluation Request, AHCA MedServ Form 004 Part A1,March 2017

☐ Level I PASRR screen, AHCA MedServ Form 004 Part A, March 2017

☐ Level II PASRR evaluation and determination or most recent Resident Review, as applicable

☐ Most recent Minimum Data Set

☐ Case Notes

☐ Record of treatment

☐ Medication Administration Record

☐ Psychiatric or psychological evaluation, if available

☐ Other: _____

_____

Notice of referral for Resident Review evaluation distributed to (including how to obtain the evaluation):

☐ Individual

☐ Representative

_____

Consent for Resident Review

In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history.

I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

Signature Date

If an individual is unwilling, or unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

_____

**Department of Health

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