Instructions for PASRR Level II updated 1/2018

Please complete all questions on form. If question doesn't apply to the individual being evaluated enter "N/A". No question should be left blank.

PART 1: REFERRAL INFORMATION
Date of referral – date the agency was notified Level II was needed
Date assigned to PASRR staff – date of assignment
KLOCS Application # - application number in KLOCS as applicable
Name of Center completing form – CMHC doing evaluation
Name of Evaluator – Evaluator completing the Level II
Applicant's name – include first and last name
SSN – full social security number for applicant
DOB – full date of birth for applicant
Gender – list the gender of the individual
Marital status – current status (single, married, divorced, widowed….)
Spouse – name of spouse if married, otherwise type N/A
Evaluation location – check box for location of the individual at the point of interview or contact
Referral source – check appropriate box for notification that Level II was needed
Legal guardian – yes or no as appropriate
POA or other legal Rep – yes or no as appropriate
Name – Name of legal guardian, POA or other legal rep if yes to #13 or #14, otherwise N/A
Relationship to applicant – in reference to #15, please be specific. N/A in no to #13 and #14.
Telephone – in reference to #15, please list phone number
Facility requested – Full name of Nursing Facility
Address – Nursing facility full address
Contact person – contact person at NF
Phone – phone number of NF
Name of MD to receive summary of findings – list MD if applicable, otherwise N/A
Address – address of MD if applicable, otherwise N/A
Type of referral – check appropriate box based on the information from the MAP 409 or MAP 4095
Type of assessment – check appropriate box based on individual's situation
Date of nursing facility admission – If the individual was admitted to NF prior to Level II, please input date of admission, otherwise 'pending'. Please also list the reason the referral was sent to DDID after day 7, if applicable.
Information for the evaluation was obtained from the following – answer each box as appropriate, otherwise N/A. (Federal regulations require that the individual and ANY legal representative be involved in the evaluation – If they are not included in the evaluation, you must thoroughly document why and your efforts.)
PART 2: DIAGNOSIS AND TESTING
Mental/Behavioral Health – list all mental health diagnoses
Intellectual disability/related condition – list all ID/RC diagnoses
Medical – list all other medical diagnosis' (if a long list, please list a few and then can say 'see attached ___'
IQ – list score, name of tool used for test, name of evaluator and date of test.
Adaptive Behavior – list score, name of tool used for test, name of evaluator and date of test.
Other – any other testing done for MI/ID/RC list here
Comments – enter any additional comments about the testing's listed, or about why no testing's have been done.

Current history and physical should be attached. If there has been no significant change in the individual's medical condition, a copy of a history/physical performed by a physician, APRN, or PA within the last year may be used and attached. The history and physical must reflect the individual's current condition. If the physical is conducted by an APRN, or PA, a physician must review and concur with the conclusions.

PART 3: Medication history
Current medication list has been uploaded to KLOCS or attached (PCP, pharmacy, NF, SCL provider): – please answer yes or no and if no, please explain **Does the current medication list include the reason for each medication?** – please answer yes or no and if no, please provide an explanation for any medication prescribed for any reason other than it's generally approved use
Allergies – list all known
Previous psychotropic medications – list all known
Documentation of all other medications applicant has taken in the last year – please include all, if none besides current then type NONE
Comment on any medication that could mask or mimic mental illness symptoms – list all known and how
Does the client use alcohol or non-prescription drugs – explain type and history of alcohol or non-prescription drug use
Does the client complain of side effects of medication, or are there visible signs of side effects – include all information about side effects
Self-management of medication – check appropriate box
Comments – please include any information concerning medication that was not already addressed in this section
PART 4: MENTAL STATUS/PSYCHIATRIC ASSESSMENT
Psychiatric hospitalization – list any prior admission to any psychiatric hospital. Include where, when, why, and for how long.
Community based treatment – list any involvement with CMHC's, private psychiatric or mental health facilities. Include types of services, dates, reason, and outcomes.
History of engagement/success with recommended treatment – Include any known information with details
Mental status assessment – answer yes or no to all questions
Comments or additional observations – please give any follow ups to the mental status section and/or any additional mental health issues or needs noted that were not already addressed. Explain in this section if a section could not be completed.
PART 5: ACTIVITIES OF DAILY LIVING
Rank the person's ability to perform the activities – for each activity, list the number level of functioning based on the table. Include comments with explanation for all marked with 2, 3, 4, or 5.
Vision – check appropriate box and add any additional comments or clarifications in comment box
Hearing – check appropriate box and add any additional comments or clarifications in comment box
Language – list preferred language, indicate if English is the primary language and if no, please indicate if an interpreter was used and if not why not. In comment box list any additional language issues, concerns or clarifications.
Physical therapy – answer yes or no if they currently receive, and yes or no if it is recommended
Occupational therapy – answer yes or no if they currently receive, and yes or no if it is recommended
Swallow study – answer yes or no if they have received, and yes or no if it is recommended
Speech/language therapy – answer yes or no if they currently receive, and yes or no if it is recommended
Hearing screen recommendations – yes or no
Comments – include clarification or additional comments about these recommendations
PART 6: PSYCHOSOCIAL EVALUATION
Reason for placement – list reason NF placement is being considered, what has occurred that has led to NF placement.
Is placement in nursing facility considered temporary – yes or no
What barriers may prevent the return to Community Services – please list the barriers to returning to the community and what services and supports would be needed to return to the community.
Family/friends/support system – list any natural supports for the individual, relationships and phone numbers
Current functioning levels – list clients ability to function independently, with supports, or how they are dependent on others
Social skills/participation – check appropriate box and add any additional comments
Family history and current relationships – list any significant family history and relationships
Hobbies/activities – list clients' interests and things they enjoy doing

Emotional/behavioral regulation – check appropriate box and add comments related to the box checked
Identify any supports/techniques used and outcomes – list all supports and techniques, along with the outcomes. Please be specific.
Legal status – list any charges, convictions, probation/parole, offender registries
Give any developmental history that would provide insight to behaviors or diagnosis – include the individual providing the information and their relationship with the individual. This includes things like developmental milestones, ability to have and maintain relationships, psychological trauma, abuse, personality, and how the individual functioned in childhood.
ID/RC Service History – if there is no indication of ID or RC please check the box
Have supports been provided in another State, Region? – yes or no and if yes please provide info on where, when and what.
Currently Receives ID Services – yes or no and mark the appropriate service box and list agencies that are providing services
If not, did they receive ID Services in the past: yes or no and if yes please mark the appropriate service box and list agencies that provided the services
Educational history – check all that apply
Details – please provide details related to the items checked above and give any additional educational history including home school, specialized schools, academic performance, disciplinary problems, excessive absences, etc…
Employment history – check all that apply
Details – please provide details related to the items checked above and give detailed information on types of employment, length of employment, barriers to employment, history of termination and reasons, etc…

PART 7: REVIEW OF FINDINGS
Community options discussed with individual/guardian: please check yes or no and provide details of what information was provided; only provide information relevant to the applicant
Individual's strengths and weaknesses – Provide details on the capabilities of the individual based on the information gathered during the evaluation
Nursing facility care needs – describe what the individual's needs are that can be provided by a NF
Behavioral health services to be included in the resident's treatment plan while residing in the NF – list any recommendations, or current supports that need to be continued for behavioral and mental health services. Include information on how patient can benefit from the recommendations.
Important to the person – it is important to ask the individual what is important to them. Include only what the person says, has said, or indicated with their words or behaviors those things they consider important for a comfortable and satisfying life
Important for the person – Include things that should be considered in regards to health, safety, and prevention of regression or loss of skills which could become a barrier to community based services
SECTION 8: Determination
Does the individual meet PASRR criteria – please select the appropriate box
AND: (must mark one) – does the applicant require NF services or are NF services not least restrictive
AND: (must mark one) – requires additional or specialized services in the NF or does not require additional or specialized services in the NF
NO – the individual <u>does not</u> meet PASRR criteria because: (must mark one) **** A response to referral must be completed*** – please mark the appropriate box and provide details on why you determined the applicant does not meet PASRR criteria
Evaluation signatures – date of referral should match date on 1st page. Always sign, include title and date. Ensure counter signature is included if required.
Interpretation of findings – it is required by federal regulations that findings are explained and given to individual and any legal representative. They must sign that this has been given to them. If a signature is not obtains, you must document why it wasn't including your attempts to get a signature and then sign as a witness to this including title and date.

Definitions in Federal Regulations

§ 483.102 Applicability and definitions. **(b)**

(1) An individual is considered to have a **serious mental illness (MI)** if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

(i)*Diagnosis.* The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders

(ii)*Level of impairment.* The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has 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, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

(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; and

(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.

(iii)*Recent treatment.* The treatment history indicates 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 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, 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.

(3) An individual is considered to have **intellectual disability (IID)** if he or she has -

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability

§ 435.1010 Definitions relating to institutional status.

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to -

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:
(1) Self-care. **(2)** Understanding and use of language. **(3)** Learning. **(4)** Mobility. **(5)** Self-direction. **(6)** Capacity for independent living.

Useful Information

Intellectual Disability diagnosis requires intellectual impairment and deficits in adaptive functioning with onset prior to the age of 18.

Related condition requires severe, chronic disability closely related to intellectual disability which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability that requires similar supports. The condition must have manifested prior to the age of 22.

Preferred documentation to support onset of ID/RC

- Psychological evaluation with diagnosis based on IQ testing and adaptive behavior assessment.
- Individualized Education Plan (IEP) that contains records of IQ score and assessment of adaptive functioning.
- Psychological assessment submitted during the course of guardianship proceedings;
- Medical/tx records that provide evaluation and diagnosis of the related condition and impairments related to the condition.

In the absence of the items listed above, additional documentation may be used to provide support for ID/RC.

- Treatment records in which provide review of psychological evaluations (when the evaluation itself cannot be provided) and key information from the assessment such as when the testing was done, who it was conducted by, tests and scores obtained, diagnosis given.
- Onset of ID/RC may be supported through a comprehensive developmental history (records or information from parent/guardian, other close relative who can provide first person account of individuals developmental history) that contains specific information about the onset of any medical conditions or injuries that resulted in intellectual impairment, information about the nature of those impairments (delays or regression in key developmental milestones such as speech, gross and fine motor skills, learning, etc).
- Assessment and documentation that rules out other factors or conditions that may have contributed to diminished cognitive and adaptive functioning such as severe mental illness, chronic substance abuse, or medical conditions. This can be accomplished by documentation in which the trained professional indicates that these conditions are not present, or if documentation of ID/RC exists prior to the onset of the other conditions, or can demonstrate that the impairments are more consistent with ID/RC than other factors.

The following items are not sufficient to determine ID/RC on their own, but may be used in conjunction with other information to provide support for the presence of the condition.

- Records or reports of special education without specification of the classification of special education services that were received. Individuals may be in special education related to medical issues, behavioral health issues, specific learning disorders, etc., and it does not necessarily imply intellectual impairment.
- Failure to complete school/poor grades
- Lack of vocational history or difficulty maintaining employment
- No history of living independently, or difficulty maintaining independent housing
- Social security disability determination (without documentation that identifies reason for disability that meets criteria of ID/RC)

The following items in the individual's records may indicate that impairments are not associated with ID/RC.

- Records of medical event or injury that occurred after age 18 (ID) or 22 (RC) that are documented to have (or likely would have) caused impairments in intellectual and adaptive functioning, particularly if there is indication in the individual's history that these deficits were not present or not as severe prior to the event.
- Adaptive functioning deficits are specifically related only to physical limitations or related to symptoms of a diagnosed mental illness (such as related to depression, anxiety, psychosis, etc), or occurring in conjunction with or following significant substance use.

Documentation should include:

- Attempts of efforts to obtain previous documentation that are not included in evaluation and why they could not be obtained, etc.
- Specific description of the individual's psychosocial history (social, cognitive, vocational, educational, psychiatric, medical history)
- Specific description of the individual's adaptive functioning deficits and types of support needed (type of supports needed, frequency and intensity of supports)
- Previous types of supports and services the individual has received
- Treatment records that demonstrate evaluation and support for any diagnosis provided.