COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Provisional Admission to a Nursing Facility

Applicant's Name_____ **Date of Facility Admission**_____

Social Security/ID Number_____ Date of Birth_____

Name of Nursing Facility_____ Medicaid Provider Number_____

Phone Number_____ Fax Number_____

Address_____

_____

Level l screen triggered Mental Illness ☐ **Yes**

Level l Screen triggered Intellectual Disability, Related Condition ☐ **Yes**

Provisional Admission means an individual is being admitted to a nursing facility for fourteen (14) days, or less, before a PASRR Level ll is required; and

1. The applicant is expected to stay in NF for Fourteen (14) days or less; and ☐ **Yes**
2. The applicant has been diagnosed with delirium; or ☐ **Yes**
3. The applicant is in need of respite for the in-home caregiver, and the applicant is expected to return to that in-home caregiver upon discharge from the nursing facility. ☐ **Yes**

Authorized Nursing Facility Staff _____ Date_____

NF Applicant or Responsible Party_____

Note: If an individual, who is admitted to a NF under the provisional admission, is later found to require more than fourteen (14) days of nursing facility services, a Level ll PASRR is required. Therefore, nursing facility staff shall refer the individual for a Level ll PASRR as soon as it is indicated that the resident requires more than fourteen (14) days of nursing facility services by transmitting a copy of the MAP 409 form to the CMHC. PASRR evaluators shall complete the level ll PASRR written evaluation report within Nine (9) working days from the date of referral.

Date Transmitted_____

_____
Signature and Title of person completing the form

Original to Remain on Chart
Copy to Medical Records