COMMOMWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
Pre-Admission Screening and Resident Review

Notification of Intent to Refer for the Level II PASRR Evaluation

Name of Individual being referred _____

Date of Birth _____ Social Security Number_____

Home Address (if not in a Facility)
_____

Date of any Previous Level II referrals, and location of evaluation
Date_____Location_____

Name of Nursing Facility_____

Medicaid Provider Number_____

Facility Address _____

Phone Number_____

Date Admitted to Nursing Facility_____

Responsible Party_____

Address _____
Phone Number_____

Date Level I PASRR
Completed_____

This is the written notification to inform the individual and the responsible party, that the Level I PASRR indicated a Diagnosis of:

(Please check appropriate box)

☐ Mental Illness, or
☐ Intellectual Disability, or
☐ A Related Condition

The individual is being referred to the Community Mental Health Center for a Level II PASRR. The Level II PASRR is an evaluation and determination of the need for nursing facility services, and if so, whether specialized services is needed.

Authorized Nursing Facility Staff _____ Date _____

Print Authorized Nursing Facility Staff Name_____

Original copy to Individual/responsible Party

Copy Community Mental Health Center, and Medical Records

Kentucky UNBRIDLED SPIRIT