PASRR Significant Change/Subsequent Review
Discharge and Death Information

Use this form to indicate when an individual's mental or physical condition has changed in a manner that affects their need for nursing facility level of care, specialized services, or recommended services of lesser intensity. If the patient meets this criteria and any of the following events have occurred, please check the type of change, and contact the local Community Mental Health Center within fourteen (14) calendar days.

Section 1: General Information

First Name: MI : Last Name:

Date of Birth: Social Security #: Medicaid ID if Applicable:

Nursing Facility:

Address: City State: Zip:

Provider Number: Phone:

Section 2: Change in Diagnosis/Condition

☐ The individual has a new mental health diagnosis that caused significant difficulty in at least 1 of these areas:
Interpersonal functioning such as serious difficulty interacting with others, difficulty communicating with others, altercations, evictions, unstable employment, frequent isolation, avoids others, or fear of strangers.
Concentration, persistence and pace such as serious difficulty in focusing and concentrating, requiring assistance with completing tasks, and the inability to complete simple tasks within an established time period without assistance.
Adaption to change that shows serious difficulty adapting to changes involving work, school, family, or social interactions through agitation, self-harm, suicidal/homicidal ideation, physical violence or threats, appetite disturbances, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or intervention by mental health or judicial system.

AND

Due to the diagnosis and related impairments, required intensive psychiatric treatment (more intensive than outpatient care) or experienced an episode of significant disruption to their normal living situation for which supportive services were required to maintain functioning.

☐ The individual has a new Intellectual Disability diagnosis with reason to believe that onset was prior to age 18 with deficits in both:
Intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience; and
Adaptive functioning such as failure to meet developmental and sociocultural standards for personal independence and social responsibility and limited independent functioning in one or more activities of daily life such as – communication, social participation, and independent living; and across multiple environments, such as home, school, work, and community.

☐ The individual has a new Related Condition diagnosis such as cerebral palsy, Down Syndrome, fetal alcohol syndrome, seizure disorder, and traumatic brain injury with reason to believe that onset prior to age 22.
AND
This diagnosis results in substantial functional limitations in 3 or more of the following areas of major life activities that requires treatment or services similar to those required by persons with an intellectual disability: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

☐ The PASRR SMI/ID/RC resident has a medical condition which has greatly **declined.**

☐ The PASRR SMI/ID/RC resident has a medical condition which has greatly **improved.**

If there is a box in section 2 checked, then describe the Significant Change and its effect on the Nursing Facility Resident:

Section 3: Transfer/Discharge/Death

☐ The individual is transferring to another Nursing Facility. Date of Transfer

Name of Receiving Facility

Location of Receiving Facility

☐ The individual has been discharged. Date of discharge

Discharged to:
(be specific to type of setting, i.e. Supports for Community Living Waiver, Group or Foster Care Home, Psychiatric Support Facility, out of state NF)

☐ The individual is deceased. Date of Death

Section 4: Designation

Was any box in section 2 or 3 checked?

☐ Yes. The NF must submit this form to their local CMHC for a PASRR Level II evaluation; or to notify them of a PASRR individuals transfer, discharge, or death.

☐ No, there was a change to the individual's condition (as described below), however, this change did not meet the criteria to require a referral for a PASRR Level II evaluation.

Section 5: Signatures

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate, and complete.

Signature Title Date Telephone Number

Facility Name Medicaid Provider Number

Original – Nursing facility record
COPY TO CMHC