ALLEGHENY COUNTY
AREA AGENCY ON AGING
INSTRUCTIONS FOR LEVEL OF CARE ASSESSMENT

The Assessment application packet must be completed and received before an appointment can occur. Your application is for an Assessment to determine a level of care so that you can choose from available Long-Term-Services and Supports. These services and supports can occur in the community (at home), or in a facility (such as a Nursing Home). Additional information is provided at the bottom of the page if you would like to apply for services in the home.

The Assessment application packet includes several forms that must be completed and returned to the Area Agency on Aging (AAA) office.

Please complete the enclosed forms:

1. **Assessment Registration Form**. Please complete the referral form as thoroughly as possible. It is important that the residential address be where the consumer is now living. This is where the assessment visit will occur.

2. **MA 51 Medical Evaluation Form.** ONLY A LICENSED PHYSICIAN MAY COMPLETE THIS FORM. The physician's signature must be present in the designated area.

3. **OPTIONS Release Form.** This gives your permission for the Area Agency on Aging to collect necessary information to complete the Assessment, for example, from your PCP. An original signature is needed by the individual receiving the Assessment, or an individual on that person's behalf.

4. **PASRR-ID.** This is a tool used to screen for the need of specialized services for individuals who are involved in systems to address Mental Health, Intellectual Disability, or Other Related Conditions. Please complete to the best of your ability,and prepare to provide documentation of treatment history for those conditions. The completed assessment is subject to review by a State Program office for Level of Care eligibility, as well as suitability for Specialized Services.

The above forms must be completed in order to schedule an Assessment. When they are complete, forward the forms by mail or electronically to:

ASSESSMENT UNIT
Allegheny County DHS/Area Agency on Aging
2100 Wharton Street, Second Floor
Pittsburgh, PA 15203

Email: aaa-asmt-nh@alleghenycounty.us

When the Assessment Unit receives your application, we will contact you to schedule the assessment visit. The assessment will then determine your Level of Care eligibility for programs or services.

FOR APPLICATION FOR LONG TERM SERVICES AND SUPPORTS IN THE HOME:

Contact the Independent Enrollment Broker (IEB). The IEB oversees and will explain the enrollment and eligibility process, which will include a Level of Care Assessment. Please call 1-877-550-4227.

8/5/19

Allegheny County DHS/AAA Assessment Registration Form 7/1/19

Personal

Prefix ☐ Mr. ☐ Mrs. ☐ Ms.

First Name _____

Middle Initial _____

Last Name _____

Suffix ☐ Jr. ☐ Sr.

Maiden Name _____

Marital Status ☐ Divorced ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

Gender ☐ Female ☐ Male

Birth Date |__|__| - |__|__| - |__|__|__|__|

SSN |__|__|__| - |__|__| - |__|__|__|__|

Ethnicity

Ethnic Group ☐ American Indian / Native Alaskan ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian

Hispanic/Latino ☐ Yes ☐ No

Residential Address

Street 1 _____

Street 2 _____

Town, State _____

ZIP Code |__|__|__|__|__|

Municipality _____

County _____

Mailing Address (if different than Residential)

Street 1 _____

Street 2 _____

Town, State _____

ZIP Code |__|__|__|__|__|

Phone Number/Email

Home Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Mobile Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Email _____

Emergency Contact/MA Representative

Name _____

Relationship _____

Street 1 _____

Street 2 _____

Town, State _____

ZIP Code |__|__|__|__|__|

Home Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Mobile Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Referral Source

Name _____

Agency/Facility _____

Address _____

Town, State _____

Zip _____

Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Fax # |__|__|__| - |__|__|__| - |__|__|__|__|

Email _____

PCP/Attending Physician

Name _____

Address _____

Town, State _____

Zip _____

Phone # |__|__|__| - |__|__|__| - |__|__|__|__|

Fax # |__|__|__| - |__|__|__| - |__|__|__|__|

OFFICE USE ONLY

Assessor's Signature _____

Date of Intake _____

Date of Assessment _____

FED Level of Care ☐ NFCE ☐ NFI

Agree? ☐ Yes ☐ No

Case Type _____

Level II Cases ONLY

☐ MH ☐ ID ☐ ORC

☐ Exceptional Admit

☐ Valid Y/N

INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.

9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.

10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.

11. **Essential Vital Signs.** Self-explanatory.

12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**

13. **Vacating of building.** How much assistance does the patient require to vacate the building?

14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?

15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.

16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.

17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.

18. **Prognosis.** Indicate patient's prognosis based on current medical condition.

19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/ID Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to ID individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. **The physician must sign and date the MA-51. A licensed physician must sign the MA-51.** It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT]).

Questions 21 and 22 are completed by Aging Well or the appropriate Department of Human Services program office. These questions are used by the Department to certify the individual's medical eligibility for services.

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE

5. AGE	6. SEX	7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code)
01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) _____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE _____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

	PRIMARY (Principal)
	SECONDARY
	TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE
☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) _____

17. PHYSICIAN ORDERS
Medications _____
_____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A. **PHYSICIAN'S RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/ID Care Services to be provided at home or in an intermediate care facility for the intellectually disabled
☐ ICF/IDRC Care Services to be provided at home or in an intermediate care facility for consumers with IDRCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) _____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**
ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE _____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21 **MEDICALLY ELIGIBLE** ☐ Yes ☐ No

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE _____

ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE

Name _____ SS# (last 4 digits): _____

PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW (PASRR) IDENTIFICATION LEVEL I FORM (Revised 3/1/2024)

This process applies to all nursing facility (NF) applicants, regardless of payer source. All current NF residents must have the appropriate form(s) on their record. The Preadmission Screening Resident Review (PASRR) Level I identification form and PASRR Level II evaluation form, if necessary, must be completed **prior to** admission as per Federal PASRR Regulations 42 CFR § 483.106.

NOTE: FAILURE TO TIMELY COMPLETE THE PASRR PROCESS WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR § 483.122.

Section I – DEMOGRAPHICS

DATE THE FORM IS COMPLETED: _____ SOCIAL SECURITY NUMBER (all 9 digits): _____ – _____ – _____

APPLICANT/RESIDENT NAME - LAST, FIRST:

_____

Communication

Does the applicant/resident require assistance with communication, such as an interpreter or other accommodation, to participate in or understand the PASRR process? ☐ NO ☐ YES

Section II – NEUROCOGNITIVE DISORDER (NCD)/DEMENTIA

For NCD (i.e. Alzheimer's disease, Traumatic Brain Injury, Huntington's, etc.), the primary clinical deficit is in cognitive function, and it represents a decline from a previously attained level of functioning. NCD can affect memory, attention, learning, language, perception and social cognition. They interfere significantly with a person's everyday independence in Major NCD, but not so in Minor NCD.

1. Does the individual have a diagnosis of a Mild or Major NCD?

   ☐ NO – Skip to Section III ☐ YES

   Date of Diagnosis (if known): _____

2. Has the psychiatrist/physician indicated the level of NCD?

   ☐ NO ☐ YES – indicate the level: ☐ Mild ☐ Major

3. Is there corroborative testing or other information available to verify the presence or progression of the NCD?

   ☐ NO ☐ YES – indicate what testing or other information:

   _____

   ☐ NCD/Dementia Work up ☐ Comprehensive Mental Status Exam

   ☐ Other (Specify):

   _____

NOTE: A DIAGNOSIS OF MILD NCD WILL NOT AUTOMATICALLY EXCLUDE AN INDIVIDUAL FROM A PASRR LEVEL II EVALUATION.

Name _____ SS# (last 4 digits): _____

Section III – MENTAL HEALTH (MH)

Serious Mental Illness diagnoses may include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Psychotic Disorder, Personality Disorder, Panic or Other Severe Anxiety Disorder, Somatic Symptom Disorder, Bipolar Disorder, Depressive Disorder, or another mental disorder that may lead to chronic disability.

III-A – RELATED QUESTIONS

1. Diagnosis

Does the individual have a mental health condition or suspected mental health condition, other than Dementia, that may lead to a chronic disability?

List Mental Health Diagnosis(es): _____

2. Substance related disorder

a. Does the individual have a diagnosis of a substance related disorder, documented by a physician, within the last two years?

☐ NO ☐ YES

b. List the substance(s): _____

c. Is the need for NF placement associated with this diagnosis?

☐ NO ☐ YES ☐ UNKNOWN

III-B – RECENT TREATMENTS/HISTORY: The treatment history for the mental disorder indicates that the individual has experienced **at least one** of the following:

A "YES" TO ANY QUESTION IN SECTION III-B WILL REQUIRE A PASRR LEVEL II EVALUATION BE COMPLETED.

1. Mental Health Services (check all that apply):

a. Treatment in an acute psychiatric hospital at least once in the past 2 years:

☐ NO

☐ YES – Indicate name of hospital and date(s): _____

b. Treatment in a partial psychiatric program (Day Treatment Program) at least once in the past 2 years:

☐ NO

☐ YES – Indicate name of program and date(s): _____

c. Any admission to a state hospital:

☐ NO

☐ YES – Indicate name of hospital and date(s): _____

d. One stay in a Long-Term Structured Residence (LTSR) in the past 2 years:

A LTSR is a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR. Admission may occur voluntarily.

☐ NO

☐ YES – Indicate name of LTSR and date(s): _____

e. Electroconvulsive Therapy (ECT) for the Mental Health Condition within the past 2 years:

☐ NO ☐ YES – Date(s): _____

f. Does the individual receive community MH services or supports that may need to be continued if admitted to the NF?

☐ NO ☐ YES

g. Does the individual have a Mental Health Case Manager (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment (ACT))? ***Note:** This does NOT include psychiatrist, therapist or other mental health practitioners that provide mental health treatment.

☐ NO ☐ YES

Indicate Name, Agency, and Telephone Number of Mental Health Case Manager:

_____

2. Significant Life disruption due to a Mental Health Condition

Experienced an episode of significant disruption (may or may not have resulted in a 302 commitment) due to a Mental Health Condition within the past 2 years:

a. Suicide attempt or ideation with a plan:

☐ NO ☐ YES – List Date(s) and Explain: _____

_____

b. Legal/law intervention: ☐ NO ☐ YES – Explain: _____

_____

c. Loss of housing/Life change(s): ☐ NO ☐ YES – Explain: _____

_____

d. Other: ☐ NO ☐ YES – Explain: _____

_____

III-C – LEVEL OF IMPAIRMENT: The mental disorder has resulted in functional limitations in major life activities that are not 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 CHECK IN ANY BOX IN SECTION III-C WILL REQUIRE A PASRR LEVEL II EVALUATION BE COMPLETED.

☐. **1. Interpersonal functioning -** The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.

☐. **2. 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, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

☐**. 3. Adaptation to change -** The individual has serious difficulty 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.

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR THE OFFICE OF LONG-TERM LIVING (OLTL) FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NF) AND FORWARDED TO THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (OMHSAS) PROGRAM OFFICE FOR FINAL DETERMINATION IF THE INDIVIDUAL HAS A "YES" IN ANY OF SECTION III-B AND/OR III-C AS A RESULT OF A CONFIRMED OR SUSPECTED MENTAL HEALTH CONDITION.

Name _____ SS# (last 4 digits): _____

Section IV– INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY (ID/DD)

An individual is considered to have evidence of an intellectual disability/developmental disability if they have a diagnosis of ID/DD and/or have received services from an ID/DD agency in the past.

IV-A – Does the individual have current evidence of an ID/DD or ID/DD diagnosis (mild, moderate, severe or profound)?

☐ NO – Skip to **IV-C** ☐ YES – List diagnosis(es) or evidence: _____

_____

IV-B – Did this condition occur **prior to age 18?** ☐ NO ☐ YES ☐ CANNOT DETERMINE

IV-C – Is there a history of a severe, chronic disability that is attributable to a condition other than a mental health condition that could result in impairment of functioning in general intellectual and adaptive behavior?

☐ NO – Skip to Section IV-D ☐ YES – Check below, all that applied **prior to age 18:**

☐ **Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.

☐ **Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.

☐ **Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

☐ **Mobility:** An individual that is impaired in their use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.

☐ **Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.

☐ **Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

IV-D – Has the individual ever been registered with their county for ID/DD services and/or received services from an ID/DD provider agency within Pennsylvania or in another state? ☐ NO ☐ YES ☐ UNKNOWN

If yes, indicate county name/agency and state if different than Pennsylvania _____

Name of Support Coordinator (if known) _____

IV-E – Was the individual referred for placement by an agency that serves individuals with ID/DD? ☐ NO ☐ YES

IV-F – Has the individual ever been a resident of a state facility for ID including a state operated ICF/ID or center?

☐ NO

☐ YES – Indicate the name of the facility and the date(s): _____

☐ UNKNOWN

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NF) AND FORWARDED TO THE OFFICE OF DEVELOPMENTAL PROGRAMS (ODP) PROGRAM OFFICE FOR FINAL DETERMINATION IF:

- **THE INDIVIDUAL HAS EVIDENCE OF AN ID OR AN ID/DD DIAGNOSIS AND HAS A "YES" OR "CANNOT DETERMINE" IN IV-B AND A "YES" IN IV-C WITH AT LEAST ONE FUNCTIONAL LIMITATION, OR**
- **THE INDIVIDUAL HAS A "YES" IN IV-D, OR E, OR F.**

Name _____ SS# (last 4 digits): _____

Section V– OTHER RELATED CONDITIONS (ORC)

"ORC" include physical, sensory or neurological disability(ies). Examples of an ORC may include but are not limited to: Arthritis, Juvenile Rheumatoid Arthritis, Cerebral Palsy, Autism, Epilepsy, Seizure Disorder, Tourette's Syndrome, Meningitis, Encephalitis, Hydrocephalus, Huntingdon's Chorea, Multiple Sclerosis, Muscular Dystrophy, Polio, Spina Bifida, Anoxic Brain Damage, Blindness **and** Deafness, Paraplegia or Quadriplegia, head injuries (e.g. gunshot wound) or other injuries (e.g. spinal injury), so long as the injuries were sustained **prior to age of 22.**

V-A – Does the individual have an ORC diagnosis that manifested **prior to age 22** and is expected to continue indefinitely?

☐ NO – Skip to Section VI

☐ YES – Specify the ORC Diagnosis(es): _____

_____

V-B – Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC:

☐ **Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.

☐ **Receptive and expressive language:** An individual is unable to effectively communicate with another person without the aid of a third person, a person with special skill or with a mechanical device, or a condition which prevents articulation of thoughts.

☐ **Learning:** An individual that has a condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

☐ **Mobility:** An individual that is impaired in their use of fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.

☐ **Self-direction:** An individual that requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest.

☐ **Capacity for independent living:** An individual that is limited in performing normal societal roles or is unsafe for the individual to live alone to such as extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

NOTE: A PASRR LEVEL II EVALUATION MUST BE COMPLETED BY AGING WELL OR OLTL FIELD OPERATIONS (FOR A CHANGE IN CONDITION IN A NF) AND FORWARDED TO THE ORC PROGRAM OFFICE FOR FINAL DETERMINATION, IF THE INDIVIDUAL HAS AN ORC DIAGNOSIS PRIOR TO THE AGE OF 22 AND AT LEAST ONE BOX CHECKED IN V-B.

Section VI – HOME AND COMMUNITY SERVICES

Was the individual/family informed about Home and Community Based Services that are available?

☐ NO ☐ YES

Is the individual/family interested in the individual going back home, back to the prior living arrangement, or exploring other community living options?

☐ NO ☐ YES

Name _____ SS# (last 4 digits): _____

Section VII – EXCEPTIONAL ADMISSION

Does the individual meet the criteria to have a PASRR Level II Evaluation done by one of the Program Offices, is not a danger to self and/or others, and meets the criteria for Exceptional Admission to a NF below?

☐ NO – Skip to Section VIII ☐ YES

NOTE: IT IS THE RESPONSIBILITY OF THE NF TO VERIFY THAT ALL CRITERIA OF THE EXCEPTION ARE MET PRIOR TO ADMISSION.

Check the Exceptional Admission that applies:

☐ **VII-A – Individual Is an Exceptional Hospital Discharge -** Must meet all the following prior to NF Admission and have a known Mental Illness (MI), ID/DD, or ORC:

- Admission to NF directly from the Acute Care Hospital after receiving **acute inpatient medical care**, **AND**

  NOTE: Exceptional Hospital Discharge cannot be an admission from any of the following: emergency room, observational hospital stay, rehabilitation unit/hospital, Long-Term Acute Care Hospital (LTACH), inpatient psych, behavioral health unit, or hospice facility.

- Requires NF services for the same medical condition for which the individual received care in the Acute Care Hospital, (Specify the condition: _____), **AND**

- The hospital physician shall document on the medical record **(which the NF must have prior to admission)** that the **individual will require less than 30 calendar days of NF service and the individual's symptoms, or behaviors are stable.**

  ☐ NO ☐ YES – Physician's name: _____

☐ **VII-B – Individual Requires Respite Care -** An individual with a serious MI, ID/DD, or ORC, may be admitted for Respite Care for a period up to 14-days without further evaluation if they are certified by a referring or individual's attending physician to require 24-hour nursing facility services and supervision.

☐ NO ☐ YES

☐ **VII-C – Individual Requires Emergency Placement -** An individual with a serious MI, ID/DD, or ORC, may be admitted for emergency placement for a period of up to 7-days without further evaluation if the Protective Services Agency and their physician has certified that such placement is needed.

☐ NO ☐ YES

☐ **VII-D – Individual is in a coma or functions at brain stem level -** An individual with a serious MI, ID/DD, ORC may be admitted without further evaluation if certified by the referring or attending physician to be in a coma or who functions at brain stem level. The condition must require intense 24-hour nursing facility services and supervision and is so extreme that the individual cannot focus upon, participate in, or benefit from specialized services.

☐ NO ☐ YES

FOR A CHANGE IN EXCEPTIONAL STATUS:

IF THE INDIVIDUAL'S CONDITION CHANGES OR THE INDIVIDUAL WILL BE IN THE NF FOR MORE THAN THE ALLOTTED DAYS:

- OLTL Field Operations must be notified on the MA 408 within 48 hours that a PASRR Level II Evaluation needs to be completed within the timeframes as noted below:
  - If VII-A is a "YES", the PASRR Level II must be done on or before the 40th day from the date of admission.
  - If VII-B is a "YES", the PASRR Level II must be done on or before the 24th day from the date of admission.
  - If VII-C is a "YES", the PASRR Level II must be done on or before the 17th day from the date of admission.
  - If VII-D is a "YES", the PASRR Level II must be done when the individual comes out of the Coma.
- Do not complete a new PASRR Level I form; just update the current form with the changes and initial the changes. Enter your full signature and date below to indicate you made the changes to this form.

_____ _____

SIGNATURE OF PERSON NOTIFYING FIELD OPERATIONS **DATE OF NOTIFICATION**

Name _____ SS# (last 4 digits): _____

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME

Check appropriate outcome:

☐ **Individual has negative screen for Serious MI, ID/DD, or ORC; no further evaluation (Level II) is necessary.**

☐ **Individual has a positive screen for Serious MI, ID/DD, and/or ORC; the individual will require a further PASRR Level II evaluation. You must notify the individual that a further evaluation needs to be done. Have the individual or their legal representative sign that they have been notified of the need to have a PASRR Level II evaluation done. Indicate by your signature here that you have given the notification (last page of this form) to the individual or their legal representative.**

Name of Individual or legal representative that has received the notification (page 8):

NAME: _____ (print) **SIGNATURE:** _____ (sign)

Name of individual who filled out the PASRR Level I and gave the notification to the individual/legal representative:

NAME: _____ (print) **SIGNATURE:** _____ (sign)

☐ **Individual has positive screen for a further PASRR Level II evaluation but has a condition which meets the criteria for an Exceptional Admission indicated in Section VII. NF must report Exceptional Admissions on the PASRR Positive Resident Reporting Form (MA 408).**

SECTION IX – INDIVIDUAL COMPLETING FORM

By entering my name below, I certify the information provided is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

PRINT NAME:	**SIGNATURE:**	**DATE:**
FACILITY:	**TELEPHONE NUMBER:**	

Affix Nursing Facility Field Operations stamp here:

Name _____ SS# (last 4 digits): _____

NOTIFICATION OF THE NEED FOR A PASRR LEVEL II EVALUATION

All persons considering admission to a nursing facility for care must be screened with the Preadmission Screening Resident Review (PASRR) Level I to identify for any evidence of mental illness (MI), intellectual disability/developmental disability (ID/DD), or another related condition (ORC). If you do have evidence or suspicion of MI, ID/DD, or ORC, you need to have a further PASRR Level II evaluation completed before you can be admitted to a nursing facility for care.

You have had the PASRR Level I screening process done and you are in need of a further PASRR Level II evaluation to make certain that a nursing facility is the most appropriate setting/placement for you and to identify the need for possible MI, ID/DD, or ORC services in the nursing facility's plan of care for you, if you choose to be admitted to a nursing facility.

You will have this evaluation done within the next several days to determine your need.

Federal PASRR Regulation:

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-C?toc=1

MEDICAL/ASSESSMENT/CARE PLANNING RELEASE
ALLEGHENY COUNTY AREA AGENCY ON AGING

The purpose of this form is to authorize release of information protected under both federal and state privacy laws to establish a level of care, a plan of care, and coordinate services to be administered by the Allegheny County Area Agency on Aging (AC/AAA). This information may also be used for consideration in evaluating the consumer for possible admission to a nursing home.

I, _____, hereby authorize AC/AAA staff and AC/AAA subcontractors and affiliated providers certified by MA/DPW to:

1. Review my medical records and review my medical history;
2. Discuss my daily care needs with my hospital physicians, nurses, physical therapists, social workers and other appropriate providers; and/or
3. Obtain other confidential information as needed to order to provide services deemed necessary for my care.

If applicable, I hereby authorize_____
(hospital, nursing home, physician, health plan, clinic, other agencies, etc.) to release my complete medical records, including, but not limited to, test results, x-rays, lab reports, consultations and any other reports pertaining to my treatment to AC/AAA staff and AC/AAA subcontractors and affiliated providers certified by MA/DPW. This release also allows the AC/AAA, subcontractors and affiliated providers certified by MA/DPW to release pertinent health information about the health care services provided to me to better coordinate my care.

I understand that this authorization will remain in effect until revoked. I may revoke this authorization at any time by notifying the AC/AAA in writing and specifying a date, event, or condition upon which my authorization will expire. I realize that by signing this authorization, I will be permitting the disclosure of my protected health information to agencies not specifically subject to federal privacy protections under the Health Insurance Portability & Accountability Act (HIPAA). As such, that information may no longer be subject to privacy protections.

_____ _____

***Printed* Name** of Consumer/Legal Representative Witness

_____ _____

Signature of Consumer/Legal Representative Date of Signature

_____ _____

Legal Representative's Relationship to Consumer Consumer Date of Birth

_____

Consumer's Social Security Number

Please return the above information to:

_____

_____

_____