

NEBRASKA LEVEL I FORM

Pre-Admission Screening and Resident Review (PASRR)



First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Marital Status: M S W D Other: _____
 Gender: Male Female Race: Caucasian African American Asian Hispanic Other: _____

Payment Method: Medicare Private Pay Medicaid Pending Medicaid # _____

Living Situation Prior to Current Placement: NF Assisted Living Group Home Hospital Other: _____

Current Location: Name: _____ Admission Date: _____
 *Medical Facility *Psychiatric Facility *Nursing Facility Community Other: _____

Receiving Nursing Facility: _____ Date Admitting: ____ / ____ / ____

Receiving Nursing Facility Address: _____ City: _____ State: _____ Zip: _____

Section I: MENTAL ILLNESS

<p>1. Does the individual have any of the following Major Mental Illnesses (MMI)?</p> <input type="checkbox"/> No <input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply) <input type="checkbox"/> Yes: (check all that apply) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Paranoid Disorder <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Psychotic/Delusional Disorder <input type="checkbox"/> Bipolar Disorder (manic depression)	<p>2. Does the individual have any of the following mental disorders?</p> <input type="checkbox"/> No <input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply) <input type="checkbox"/> Yes: (check all that apply) <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Depression (mild or situational)	<p>3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)</p> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, enter the diagnosis(es) below): <input type="checkbox"/> Diagnosis 1: _____ <input type="checkbox"/> Diagnosis 2: _____
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Section II: SYMPTOMS

<p>4. Interpersonal— Currently or within the <u>past 6 months</u>, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions, or unstable employment <input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers</p>	<p>5. Concentration/Task related symptoms – Currently or within the <u>past 6 months</u>, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Serious difficulty completing tasks that she/he should be capable of completing <input type="checkbox"/> Required assistance with tasks for which s/he should be capable <input type="checkbox"/> Substantial errors with tasks in which she/he completes</p>			
<p>Adaptation to change—Currently or within the <u>past 6 months</u>, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? <input type="checkbox"/> No (proceed to Section III) <input type="checkbox"/> Yes (complete 6-8)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; border: none; padding: 5px;"> <p>6. <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p> </td> <td style="width: 33%; vertical-align: top; border: none; padding: 5px;"> <p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p> </td> <td style="width: 33%; vertical-align: top; border: none; padding: 5px;"> <p>8. <input type="checkbox"/> Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms: _____ _____</p> </td> </tr> </table>		<p>6. <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p>	<p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p>	<p>8. <input type="checkbox"/> Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms: _____ _____</p>
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Section III: HISTORY OF PSYCHIATRIC TREATMENT

<p>9. Currently or within the <u>past 2 years</u>, has the individual received any of the following mental health services? <input type="checkbox"/> No <input type="checkbox"/> Yes (the individual has received the following service[s]): <input type="checkbox"/> Inpatient psychiatric hospitalization(if yes, provide date: _____) <input type="checkbox"/> Partial hospitalization/day treatment(if yes, provide date: _____) <input type="checkbox"/> Residential treatment (if yes, provide date: _____) <input type="checkbox"/> Other: _____ (if yes, provide date: _____)</p>	<p>10. Currently or within the <u>past 2 years</u>, has the individual experienced significant life disruption because of mental health symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply): <input type="checkbox"/> Legal intervention due to mental health symptoms (date: _____) <input type="checkbox"/> Housing change because of mental illness(date: _____) <input type="checkbox"/> Suicide attempt or ideation (date[s] _____) <input type="checkbox"/> Other: _____ (date: _____)</p>
<p>11. Has the individual had a recent psychiatric/behavioral evaluation? <input type="checkbox"/> No <input type="checkbox"/> Yes (date: _____)</p>	

Section IV: DEMENTIA

<p>12. Does the individual have a diagnosis of dementia or Alzheimer's disease? <input type="checkbox"/> No (proceed to 14) <input type="checkbox"/> Yes</p>	<p>13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply): <input type="checkbox"/> Dementia work up <input type="checkbox"/> Comprehensive Mental Status Exam <input type="checkbox"/> Other (specify): _____</p>
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Patient Last Name _____ Patient First Name _____

Section V: PSYCHOTROPIC MEDICATIONS

14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months? No Yes (list below) [use separate sheet if necessary] * ***Do not list medications if used for a medical diagnosis***

Medication	Dosage MG/Day	Diagnosis	Started	Ended

VI: MENTAL RETARDATION & RELATED CONDITIONS

15. Does the individual have a diagnosis of mental retardation (MR)? No Yes

16. Does the individual have presenting evidence of mental retardation (MR) but it has not been diagnosed? No Yes

17. Is there presenting evidence of a cognitive or behavioral impairment or suspicion of MR condition that occurred prior to age 18? No Yes

18. Has the individual ever received services from an agency that serves people affected by MR? No
 Yes – agency: _____

19. Does the individual have a diagnosis which affects intellectual or adaptive functioning? No

Yes – (specify) Autism Epilepsy Blindness
 Cerebral Palsy Closed Head Injury
 Deaf Other: _____

20. Did this condition develop prior to age 22? No Yes

21. Are there substantial functional limitations in any of the following? No

Yes (Specify) Mobility Self-Care
 Self-Direction Learning
 Understanding/Use of Language
 Capacity for living independently

VII: EXEMPTIONS AND CATEGORICAL DECISIONS

(DDM MUST APPROVE USE OF CATEGORICALS AND EXEMPTIONS PRIOR TO ADMISSION)

22. Does the admission meet criteria for Hospital Exemption? No

Yes (meets all the following **and** has a known or suspected SMI or MR/RC):

- Admission to NF directly from hospital after receiving acute inpatient medical care, and
- Need for NF is required for the condition treated in the hospital (specify condition: _____, and
- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services **and** the individual's symptoms or behaviors are stable.
Physician Name: _____
Physician Phone: _____
Physician Licenses #: _____

23. Additional Comments: _____

24. Does the admission meet the criteria for Terminal Illness? No

Yes (Has a known or suspected SMI or MR/RC **and** MD has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted to DDM via facsimile within 6 business hours of submission of this form)

25. Does the admission meet the criteria for Severity of Illness? No Yes (Has a known or suspected SMI or MR/RC **and** is ventilator dependent or comatose/unresponsive)

26. Does the admission meet criteria for 30 day Respite? No

Yes (Has a known or suspected SMI or MR/RC **and** is in need of respite stay for up to 30 calendar days in caregiver's absence)

27. Does the admission meet criteria for 7 day EPS Admission? No Yes (Has a known or suspected SMI or MR/RC **and** is in imminent need for short-term placement to ensure safety **and** no other placements are available)

28. Does the admission meet criteria for Dementia/MI? No

Yes (Has a known or suspected MI **and** Dementia is primary)

29. Does the admission meet criteria for Dementia/MR? No

Yes (Has a known or suspected MR/RC **and** Dementia is primary)

Section VIII: Guardianship & Physician Information

30. Does the individual have a legal guardian? No legal guardian. Yes, legal guardian information is below:

Guardian Last Name _____ First Name _____

Street _____ City _____ State _____ Zip _____

31. Primary Physician's Name: _____ Phone: _____ Fax: _____

Street _____ City _____ State _____ Zip _____

Section IX: REFERRAL SOURCE SIGNATURE

Print Name: _____ Signature: _____ Date: / /

Agency/Facility: _____ Phone: _____ Fax: _____

Enter online at www.PASRR.com

The *Level I Form* is used to identify individuals who may be subject to a *Level II PASRR evaluation* (those *known or suspected* as having diagnoses of Serious Mental Illness [SMI], Mental Retardation [MR], and/or Related Conditions [RC]). The PASRR Level I screen applies to applicants and residents of all Medicaid certified nursing facilities, regardless of the individual's method of payment. This form must be completed on all individuals prior to NF admission. This format is consistent with federal requirements for identifying individuals with known or suspected SMI, MR, and RC. Screening information can be entered two ways:

- ~ Online at www.pasrr.com
- ~ Complete the PASRR Level I form and fax to DDM at 1.877.431.9568 if you do not have web access.

 Note: Advantages to completing the Level I online at www.pasrr.com:

- *Increased efficiency* by providing the ability to submit all information at one time (**including** the questions historically asked by DDM reviewers when certain presenting information is present).
- *Increased accessibility* by offering the capacity to submit information 24-hours per day, 7 days per week, 365 days per year, along with **the capacity to obtain a decision for the majority of individuals about the need for Level II evaluation (or the approval for admission when a Level II is not needed) without delays.**
- *Immediate information access and improved communication between referring agencies and admitting nursing homes* through the ability to electronically print the completed web-based form (and authorizations when the admission approval is granted) for the admitting nursing home, signifying to the admitting facility that appropriate approvals were provided. The web-based system will allow the person entering the information to print both the screening information and a description of the outcome.
- *Federal compliance and reduced exposure for nursing homes through providing nursing homes with documentation* of all information reported to DDM so that, in the event of a state or federal audit, the basis for the Level II referral decision is clearly provided.
- *HIPAA Compliance* through the web-based system which only allows *submission* of information, with users unable to gain access to DDM's database or any client data. Our web-based data is HIPAA compliant and integrates access control, authentication, and a 128-bit encryption key signed by Verisign to guarantee the security of network connections, the authenticity of local and remote users, and the privacy and integrity of data communications. As a contractor of the State of Nebraska, DDM maintains fully compliant HIPAA practices with all communications about personally identifiable client information
- *'User Friendly' access* with no IS/IT modifications or programming needs from providers to access information or submit screens. With web-based access, the provider simply accesses a specified internet address, enters a code (which will be provided to each facility prior to implementation), and begins entering information. The only changes necessary on the part of the provider may be to change settings on individual computers to print the completed screening information. Any special printing instructions will be provided on the website.
- *Scoring:* The outcome is scored electronically and, in many cases, will not require DDM review as frequently as will be required when the screening form is submitted by fax.

It is recommended that the referral source gather all screening information prior to initiating the electronic screen. Information is best obtained from several sources – the individual, any family or caregivers, and the treating provider. This information is required by federal law and must accurately portray known *or suspected* conditions, behaviors, or symptoms. The following instructions should be used as a guide for completion.



Demographics: Name/Mailing Address/SS#/Date of Birth/Gender

Complete all items. Ensure that spelling is correct and numbers are correctly entered. If the screening information does not include all identifying information, the screen cannot be processed.

Payment Method

Provide the client's method of payment. Note that PASRR Level I and Level II screening is required for all admissions to Medicaid certified nursing facilities, regardless of the individual's method of payment.

Living Situation Prior to Current Placement

Identify the individual's placement prior to his/her current placement. Prior living situation can have an impact on whether a person meets criteria for a Level II screen.

Current Location

Identify the location category of the screened individual. *Community* includes any community placement (such as home, with family, independent living, group home, etc.).

*Provide Admission Date

If the individual is currently residing in a facility setting (medical facility, nursing facility, or psychiatric facility), provide the admission date.

Receiving Nursing Facility Name and Address

Provide the name of the nursing home that agreed to accept the client for admission. The accepting nursing home information must be provided before the screen can be printed by the referral source.

SECTION I: MENTAL ILLNESS SCREEN

NOTE: The federal definition for mental illness is designed to include individuals with a potential for and history of episodic changes in treatment and service needs. Federal guidelines include a three component definition that includes:

Diagnosis of a serious mental illness, such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Panic Disorders, Obsessive Compulsive Disorder; -and- the individual does not have a primary diagnosis of Dementia; and
Duration: *Recent Treatment*, related to significant disruption or major treatment episodes within the past two years and due to the disorder. This might include at least one episode of hospital care for a mental disorder within the preceding two years - or- significant life disruption related to the disorder; and
Disability: referred to as *Level of Impairment* in regulatory language, is characterized by active psychiatric symptoms within the preceding six month period and related to interpersonal functioning, concentration/pace/persistence, or adaptation to change.

Each of the questions in Sections I-IV is directed at determining suspicion or presence of those components.

1. Does the individual have any of the following Serious Mental Illnesses (SMI)?

These diagnoses (schizophrenia, schizoaffective disorder, major depression, psychotic/delusional disorder, bipolar disorder or *manic depression*, and paranoid disorder) typically reflect the presence of a serious mental illness and generally qualify as federally mandated conditions which automatically warrant further evaluation through PASRR. Check the box(es) to reflect applicable diagnoses. If the suspicion of one or more of these diagnoses is present, check *suspected*, and note those suspected conditions.

2. Does the individual have any of the following Mental Disorders?

These diagnoses (personality disorder, anxiety disorder, panic disorder, and situational depression) typically reflect mental health conditions that *may* require further evaluation through PASRR depending upon their *extent* and *severity*. Check the box(es) to reflect applicable diagnoses. If the suspicion of one or more of these diagnoses is present, check *suspected*, and note those suspected conditions.

NOTE: *Situational depression* (generally a recent diagnosis and short term condition that occurs as a result of the individual's life situation) should be noted in this section. A situational depression *may* require PASRR evaluation if the depression is *more severe* than or *lasts longer* than a typical reaction to life stressors.

3. Does the individual have a Diagnosis of a Mental Disorder that is Not Listed in #1 or #2? (do not list dementia here)

List any additional diagnoses not provided in Sections 1 or 2. Note that situational depression must be listed in number 2, and dementia must be listed in number 12. Do not list dementia or situational depression in this section.

SECTION II: SYMPTOMS

4. Interpersonal – Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors (not due to a general medical condition)?

These reflect serious interpersonal problems which generally occur when serious mental illness is present. Each of the three is to be rated according to its presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify interpersonal symptoms which apply to the individual.**

5. Concentration/Task related symptoms– Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors (not due to a general medical condition)?

These reflect concentration and performance problems which generally occur when serious mental illness is present. Each of the three is to be rated according to its presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify task or concentration related symptoms which apply to the individual.**

6-8. Adaptation to Change – Currently or within the past 6 months, has the individual exhibited any of the following symptoms in #6, 7, or 8 related to adapting to change?

These reflect serious adaptation problems which generally occur when serious mental illness is present. Each of the three is to be rated according to its presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify adaptation symptoms which apply to the individual.**

SECTION III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the past 2 years, has the individual received any of the following mental health services?

Treatment information is sought over the past two years, because of the cyclical nature of mental illness. As such, it is very important that the screener obtain information from the individual, caregivers, or others who know the client well. These services (inpatient psychiatric hospitalization, partial hospitalization, and residential treatment) are generally received by persons with serious mental illness conditions. If the exact dates are unknown, obtain approximate dates from the client or caregiver. **Regardless of whether a known mental illness is present, identify applicable treatments received by the individual.**

10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms?

Treatment information is sought over the past two years, because of the cyclical nature of mental illness. As such, it is very important that the screener obtain information from the individual, caregivers, or others who know the client well. These types of disruption (legal intervention, housing changes, or suicide attempts) often occur for persons with serious mental illness conditions. If the exact dates are unknown, obtain approximate dates from the client or caregiver. Note that, to be applicable, these occurrences should be a result of the mental health symptoms (for example, if a housing change occurred due to a medical condition, this item would not be applicable). **Regardless of whether a known mental illness is present, identify disruptions reported for the individual.**

11. Has the individual had a recent psychiatric/behavioral evaluation?

If a psychiatrist, psychologist, or behavioral specialist has been consulted within the past 60 days, respond *yes*. Provide the approximate date of the consultation.

SECTION IV: DEMENTIA

12. Does the individual have a diagnosis of dementia or Alzheimer 's disease?

If the individual has received a medical diagnosis of dementia or Alzheimer's Diseases, respond *yes*. If the answer is no, proceed to question 15.

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia?

If specific tests have been administered to verify the presence and/or progression of dementia, list those in this section.

✍ A note about dementia: Under federal law, a person with dementia, who has no other mental health conditions, is excluded from further evaluation through PASRR. On the other hand, a person who has both dementia **and** a serious mental illness is not necessarily excluded from further review – The exclusion **can only occur if the dementia diagnosis is primary** over (and more progressed than) the other mental health diagnosis. When co-occurring diagnoses are present, Federal guidelines are very strict that an exemption cannot occur unless sufficient evidence is present to confirm the progression of the dementia. The kinds of information helpful to establishing primary Dementia (when it co-occurs) include: a neurological assessment, mental status examinations, CT scans, and any other tests that establish that executive functioning symptoms (e.g., disordered memory, orientation, abstract thinking, etc.) are associated with progressed dementia.


SECTION V: PSYCHOTROPIC MEDICATIONS

14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months?

List any psychoactive medications (antidepressants, anti-psychotics, mood stabilizers, anti-anxiety medications, and/or tranquilizers) which are prescribed currently or have been prescribed over the past 6 months. If any of the medications are prescribed for the client, list the medication, cumulative milligrams per day, diagnosis, and start and end dates (as applicable). While start and end dates may be approximate, the remaining items must be provided. Do not list medications if used for a medical diagnosis.

NOTE: This section is assessing for TWO conditions: MR and RC. Because some individuals may have RC without MR, it is very important that all questions in this section be completed.

SECTION VI: MENTAL RETARDATION/RELATED CONDITION

 NOTE: Criteria for identifying Related Condition

Nebraska statute defines related condition as;
“disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons; is manifested before the person reaches age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.”
(471 NAC 12-001.04).

15. Does the individual have a diagnosis of mental retardation (MR) or related condition (RC)?

Answer *yes* or *no* to reflect whether the individual is currently diagnosed as having either of the conditions described in the box above.

16. Does the individual have presenting evidence of MR or RC that has not been diagnosed?

Answer *yes* or *no* to reflect whether the individual is suspected of having either of the conditions described in the box above.

17. Is there presenting evidence of a cognitive or behavioral impairment or suspicion of MR that occurred prior to age 18?

Answer *yes* or *no* to reflect whether the individual exhibits symptoms of meeting criteria in the box above.

18. Has the individual ever received services from an agency that serves people affected by MR/RC?

Answer *yes* or *no* to reflect whether the individual has received services from an agency that typically specializes in provider services for individuals with MR or RC.

19. Does the individual have a diagnosis which affects intellectual or adaptive functioning?

Answer *yes* or *no* to reflect whether the individual has a diagnosis of an RC as defined in the box above. Examples of Related Conditions include but are not limited to blindness, deafness, traumatic brain injury, quadriplegia, paraplegia, autism, and epilepsy.

20. Did this condition develop prior to age 22?

If you answered *yes* to 19, you should answer *yes* or *no* to whether this condition developed prior to age 22.

21. Are there substantial functional limitations?

Answer *yes* or *no* to reflect whether the individual has functional limitations in any of the listed areas due to the condition indicated in question 19.

SECTION VII: EXEMPTIONS AND CATEGORICAL DECISIONS (DDM MUST APPROVE USE OF CATEGORIES AND EXEMPTION PRIOR TO ADMISSION)

22. Does the admission meet criteria for Exempted Hospital Discharge?

The *Exempted Hospital Discharge* only applies to individuals with SMI and/or MR/RC, and it allows those individuals to be placed in a NF for 30 calendar days without performance of a *Level II PASRR evaluation*. DDM **must** approve the exemption before admission can occur. Several provisions apply and all of these must be met before the individual may be admitted under this exemption (see below).

- *The individual must have evidence of a SMI or MR/RC;*
- *The admission to a NF must occur directly from a hospital:* The individual must be in a medical hospital at the time of application, receiving treatment for a medical (non-psychiatric) condition; and
- *The need for NF care is required for the condition for which care was provided in the hospital;* and
- *The attending physician has certified prior to admission that the individual will require less than 30 calendar days NF care* (clearly, an individual whose medical condition will require longer than 30 calendar days to stabilize will not be eligible for convalescent exemption [e.g., broken hip] and should not apply for this exemption). Contact information for the attending physician should be included.

Note: An exempted Hospital Discharge determination can not occur if the individual was admitted for psychiatric issues.

23. Additional Comments:

Provide any additional comments which DDM and/or the nursing home will need.

24. Does the admission meet the criteria for Terminal Illness?

Applies to individuals with SMI and/or MR/RC and, in order for this to apply, the individual's MD must certify in writing that the patient has 6 months or less to live. This certification must be submitted to DDM via facsimile either with the document based form (if the form is faxed) or within 6 hours of the electronic submission of screening information on www.pasrr.com. Regardless of whether the screen is submitted to DDM electronically or via facsimile, DDM approval is required before the admission can occur.

25. Does the admission meet criteria for Severity of Illness?

Applies to individuals with SMI and/or MR/RC and, in order for this to apply, the individual's condition must be either ventilator dependent or comatose unresponsive. Regardless of whether the screen is submitted to DDM electronically or via facsimile, DDM approval is required before the admission can occur.

26. Does the admission meet criteria for 30 day Respite?

Applies to individuals with SMI and/or MR/RC Regardless of whether the screen is submitted to DDM electronically or via facsimile, DDM approval is required before the admission can occur. Respite is appropriate for individuals who needs nursing facility placement in their caretaker's absence. An individual is only eligible for 30 days of respite per year.

27. Does the admission meet criteria for 7 day Emergency Protective Services Admission?

Applies to individuals with SMI and/or MR/RC. Regardless of whether the screen is submitted to DDM electronically or via facsimile, DDM approval is required before the admission can occur. A 7 day EPS Admission is appropriate for individuals who cannot safely remain in their previous setting. Approval is for 7 days only, and a new screen should be submitted if the individual needs to remain in the NF beyond the end date.



Section VIII: GUARDIANSHIP AND PHYSICIAN INFORMATION

Please provide contact information for the individual's legal guardian, if applicable, and primary physician.

Section IX: REFERRAL SOURCE SIGNATURE

This must be completed by the individual submitting information for this screen. If faxed to DDM, all information must be completed and signed.

Indicative findings on mental status examination

Exam item	Dementia	Depression	Delirium
<i>General appearance</i>	Normal-to-neglected according to amount of care provided and degree of impairment		
<i>Behavior</i>	Variable	Recent self-neglect, psychomotor retardation or agitation	Restlessness, picking at clothes or bedclothes
<i>Affect</i>	Flat, apathetic, occasionally irritable	Depressed, tearful, apathetic, irritable	Fluctuates, labile. May be tearful, giggly, anxious
<i>Thought stream</i>	May be normal, depends on degree of impairment	Normal to slow	Not fluent. Fluctuating
<i>Thought form</i>	May be normal, depends on degree of impairment	Normal. Perhaps some "blocking"	Thought disorder
<i>Thought content</i>	Poverty of thought content, may be perseverative	Themes of hopelessness, helplessness, guilt, poverty, emptiness, unworthiness or paranoia. There may be suicidal ideas or intent. Possible mood-congruent delusions or somatic complaints such as constipation or contamination. Occasionally negativistic and nihilistic thoughts are of delusional intensity	There may be a variety of florid delusional beliefs of paranoid, grandiose or depressive nature.
<i>Perception</i>	Occasional hallucinatory experiences (usually auditory). May have periods of misidentification	Occasional hallucinatory experiences that are congruent with the depressive thought processes. Usually auditory hallucinations	Frequent florid and bizarre hallucinations. May be visual and in all other senses
Cognition			
<i>Attention and concentration</i>	Usually intact	May be poor but can be engaged	Very poor
<i>Orientation</i>	Poor	Usually unaffected but may be uninterested	Absent
<i>Short term memory</i>	Poor	Usually intact but may not want to be bothered	Absent or fluctuates

Assessing the elderly

Aggression in dementia

- Usually inexplicable by patient
- Unpredictable
- Occurs impulsively, particularly when being attended to (e.g., hygiene)
- Easily distracted from target of aggression
- Cannot remember being aggressive or why

Aggression in delirium

- May be in response to delusions or hallucinations
- Appears to be random
- Unpredictable
- Fluctuating aggressive episodes

Aggression in depression

- Occurs in setting of irritability (e.g., of wanting to be left alone)
- May be angry with him/herself

Aggression in paranoia

- Occurs in response to delusional beliefs
- Patient may be aggressive as a defense against profound fear
- Remembers aggressive outbursts and may have associated guilt
- Has clear reasons for aggression, which are associated with paranoid delusions and self-defense

Tearfulness after a stroke*

- Usually inexplicable by patient

- Not associated with sadness
- "Emotional incontinence"
- Typically associated with "pseudobulbar palsy"
- May revert to uncontrollable laughter

Tearfulness in delirium

- Emotionally labile
- Tears not sustained
- Can be distracted from sadness

Tearfulness in depression

- Occurs in setting of sustained lowered mood
- Associated with reported sadness and misery
- Other features of depression are present

Tearfulness in adjustment reaction

- Associated with recent upsetting experience
- "Understandable sadness" or anger of recent onset

Warning signs of psychiatric disturbance in the elderly

- Self-neglect
- Sudden onset or escalation in confusion
- Any self-harming behavior
- Persistent somatic complaints without organic basis
- Persistent requests for hypnotic medication
- Exhaustion of caregivers
- Repeated complaints by neighbors or the police



Nebraska PASRR Level I Screening Instructions

Notes: