

**PASRR SCREENING DOCUMENT  
LEVEL I**

**A. PATIENT INFORMATION**

1) NAME: last, first  
\_\_\_\_\_

2) DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

3) AHCCCS ID #: \_\_\_\_\_

4) PATIENT COMING FROM?  
ADDRESS: Street, City, State, Zip Code, nurses' station  
\_\_\_\_\_  
\_\_\_\_\_

5) Receiving Facility Name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Include nurses' station)

**B. EXEMPTIONS (circle answer)**

6) YES NO Primary Diagnosis Dementia? (includes Alzheimer's or related)

7) YES NO Secondary Diagnosis Dementia without primary diagnosis of serious mental illness?

8) YES NO Diagnosis Dementia with mental retardation or related diagnosis and without an SMI diagnosis?

9) YES NO Convalescent care? (admission from hospital after receiving acute inpatient care, requires NF services for same condition and physician has certified before admission to NF that individual requires 30 days or less NF services).

10) YES NO Respite care? (brief and finite stay up to 30 days per period to provide respite to in-home caregivers to whom individual is expected to return).

**C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (circle answer)**

**MENTAL RETARDATION (MR) EVALUATION CRITERIA**

11) YES NO Diagnosis of Mental Retardation (MR)?  
12) YES NO History of MR/Developmental Disability?  
13) YES NO Any presenting evidence to indicate MR?  
14) YES NO Referred by agency serving MR clients or eligible for such services?  
15) YES NO Individual has any of the following conditions diagnosed prior to 22<sup>nd</sup> birthday?

- Autism
- Seizure Disorder
- Cerebral Palsy
- Developmental Delays (children age 5 and under only)
- Epilepsy
- Mental Retardation

**D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (circle answer)**

**MENTAL ILLNESS (MI) EVALUATION CRITERIA**

16) YES NO Primary Diagnosis of serious mental illness (SMI) defined in DSM IV as:

- Major Depression
- Psychotic Disorder
- Delusional Disorder (i.e. paranoid)
- Mood Disorder
- Schizophrenia

and  
Level of impairment limiting life activities within the past 3 to 6 months

and  
Recent treatment within the past two years?

**E. REFERRAL ACTION (circle only one)**

17) NO Referral Necessary for any Level II

18) YES Referral for Level II determination for MR only (ADES)

19) YES Referral for Level II determination for MI only (ADHS)

20) YES Referral for Level II determination for Dual MR/MI

**F. Signature of Patient or Representative for a Level II PASRR**

I understand that I am required to undergo a Level II evaluation as a condition of admission to or my continued residence in a Title XIX Medicaid Nursing Facility. I also give my permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation.

\_\_\_\_\_  
Patient or Patient's Representative

\_\_\_\_\_  
Date

**G. Signature of Medical Professional Completing Level I PASRR**

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

In addition, I acknowledge that information supplied in this report may be shared with other State agencies involved in patient screening.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_  
Telephone Number Date

**PASRR SCREENING DOCUMENT  
INSTRUCTIONS/EXPLANATION*****PLEASE PRINT***

Initial PASRR Identification and evaluation must take place Prior to Admission to a Medicaid certified nursing facility. If a referral for a Level II is indicated, the patient must not be admitted to a Medicaid certified nursing facility until the Level II portion of the evaluation process has been completed.

**A. PATIENT INFORMATION**

1. NAME: LAST FIRST
2. DATE OF BIRTH: month, day, year
3. INSERT AHCCCS ID# (IF APPLICABLE)
4. PT. COMING FROM: (where client is at time of Level I evaluation)  
PRINT: street address, city, State, zip code, nurses' station
5. RECEIVING FACILITY: INSERT NAME

*THIS LEVEL I MR/MI IDENTIFICATION PROCESS IS COMPLETE WHENEVER A DECISION IS MADE IN SECTION "E", REFERRAL ACTION.*

**B. EXEMPTIONS**

6. through 10. Please answer these questions based on the patient's current condition and the most recent medical information. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", SKIP SECTIONS C AND D AND GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT NO REFERRAL FOR LEVEL II DETERMINATION IS NECESSARY.

**C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (MR)**

11. through 15. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MR [Department of Economic Security (ADES)] IS NECESSARY. Attach any supportive documentation.

**D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (MI)**

16. IF THE ANSWER TO THIS QUESTION IS "YES", GO TO SECTION "E" REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MI [Department of Health Services (DHS)] IS NECESSARY. Attach any supportive documentation.

**E. REFERRAL ACTION**

17. through 20. CIRCLE ONLY ONE (1) ANSWER.

**F. SIGNATURE OF PATIENT OR REPRESENTATIVE**

Read the disclosure to the patient or representative and obtain signature prior to the Level II referral.

**G. SIGNATURE OF MEDICAL PROFESSIONAL**

Sign and complete the information as requested. Be sure to include a phone number.

**Revised 03/2006**