PRE-ADMISSION SCREENING / RESIDENT REVIEW CERTIFICATION FOR NURSING FACILITY SERVICES

State Form 46922 (R / 2-98) / BAIS 0024

1. Name of applicant / resident			2. Medicaid number
3. Social Security number	4.Sex	5. Date of birth *(month, day, year)*	6. Age
7. Name of facility			
Address of facility *(number, street, city, state, ZIP code)*			
8. Date of admission *(month, day, year)*		9. Method of payment ☐ Medicaid Funding ☐ Medicaid Pending ☐ Private Pay	

LEVEL I

The applicant / resident was referred as having a:

10. Date received Level II *(month, day, year)*

11. ☐ Developmental disability; or
12. ☐ Developmental disability and a mental illness.

LEVEL II

The applicant / resident:

13. ☐ Has a developmental disability;
14. ☐ Has a developmental disability and a mental illness;
15. ☐ Does **NOT** have a developmental disability.
16. ☐ Determination deferred.
17. ☐ Requires resident review in one year.

The applicant / resident:

18. ☐ Requires Specialized Services for a developmental disability;
    18a. Provided by: _____
19. ☐ Requires Specialized Rehabilitation Services for a developmental disability;
20. ☐ Has medical needs that take precedence over other service needs;
    20a. ☐ Short term - Length of stay _____
    20b. ☐ Long term
21. ☐ Requires **NO** additional services for a developmental disability.

Nursing facility services:

22. The applicant/resident ☐ does ☐ does not meet PASRR Level II criteria for:
23. ☐ Admission to a nursing facility;
24. ☐ Continued residence in a nursing facility.

Criteria:

25. ☐ Exempted hospital discharge;
26. ☐ APS admission;
27. ☐ Respite admission;
28. ☐ Nursing services for medical needs; *(see attachments)*
29. ☐ Geriatric medical issues;
30. ☐ Resident alternative;
31. ☐ None of the above criteria apply.

Signature of IDDARS PASRR representative	Title of IDDARS PASRR representative
Telephone number ( )	Date of certification *(month, day, year)*

C: DDFS File; AAA; Consumer / Guardian / HCR; Nursing Facility; BAIHS; D & E Team

PRE-ADMISSION SCREENING / RESIDENT REVIEW
CERTIFICATION FOR NURSING FACILITY SERVICES

Directions for completion:

* Form is to be completed by PASRR representative in BDDS District Office.

* Statements numbered 1 through 9 require identifying information regarding the individual. In most cases, the information will be generated when the Level II is completed. Review for accuracy. The Date of Admission should note the date the individual was first admitted to a nursing facility if the individual has not been discharged except for hospitalizations. **Check all for accuracy.**

* Statement 10 is for logging purposes. For all cases, this is the date the Level II is received at the BDDS District Office from the D & E team. For those persons requiring a case conference, the conference is to occur within 30 days of the receipt of the Level II.

* Either number 11 **OR** number 12 must be marked. Use Level II to complete. Check for accuracy.

* When number 15 or 16 is marked, **DO NOT** mark any of the items numbered 18 through 31. Mark 17 **IF** number 16 is marked and a RR is required in one year, sign and date.

* Do not mark number 17 if number 15 is marked.

* For RRs, when 18 is marked, 18a. must be completed.

* When number 20 is marked on PAS cases, mark 20a. for short term and specify length of time recommended (*example: 30, 60, 90, 120 days*) or long term for no end date.

* With number 28 (Nursing Services for Medical Needs) and number 29 (Geriatric Medical Issues) number 20 (Has Medical Needs is marked.

* There may be cases where with number 28, number 19 (Requires Specialized Rehabilitation Services for a developmental disability) **AND** number 20 (Has Medical Needs) are both marked.

* With number 25 (Exempted Hospital Discharge), number 26 (APS Admission) or number 27 (Respite Admission) or number 21 (Requires NO additional services for a developmental disability) is marked.

* If number 28 (Nursing Services for Medical Needs) is marked, for PAS cases that information must be in the attached Level II submitted. For RRs the information may be attached or summarized on the form.

* The **Exempted Hospital Discharge, APS Admission and Respite Admission** must originate with and be signed by the local PAS agency. They are used only for PAS cases.

* Information on the CERTIFICATION FORM should be consistent with the Level II packet and services recommended. If it is not, an addendum **IS REQUIRED.**