INDIANA PASARR PROGRAM
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

State Form 47180 (9-95) / BAIS 0028

See instructions on the reverse side.

Name of applicant / resident	Social Security number or date of birth	Medicaid number (RID)

Location (*include name of NF or hospital when appropriate*) / Address (*number and street, city, state, ZIP code*)

From CMHC name

Address (*number and street, city, state, ZIP code*)

INSTRUCTIONS: Use this form in lieu of the PASARR / MI Level II Mental Health Assessment when a referral for Level II is found to be inappropriate or Level II needs to be deferred. Clearly indicate the reason(s) below, adding additional information as needed.

SEND THE COMPLETED FORM FOR:

☐ PAS to: Originating / Local IPAS Agency

☐ ARR to:

Check one: ☐ Routine ☐ Non-Routine

PASARR / MI Program, Bureau of Aging / In-Home Services
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

On _____ this agency received a request for PASARR / MI Level II assessment of the above-named individual. Based on a review of the referral and / or other information, a Level II assessment is not required at this time because:

☐ 1. Neither answers to question #2 - 5 on the Level I or other information should trigger a Level II assessment.

☐ 2. Questions #2 - 5 would trigger a Level II assessment, but the person is excluded from the Level II because there is a diagnosis of dementia (*including Alzheimers Disease and related conditions*) without a primary diagnosis of a major mental illness (MI) or any diagnosis of mental retardation / developmental disability (MR/DD). NOTE: It is the responsibility of the NF to obtain and maintain adequate documentation of the dementia on the NF chart.

☐ 3. ARR not required at this time. The individual was admitted under an exlusion and the PAS-Level II is currently being done.

☐ 4. PASARR / MI Level II assessment was done within the past quarter and no change in mental health condition has occurred. (*At a minimum, give the date of the psychiatrist's signature / determination, Axis I diagnosis (es), and need for specialized services.*)

☐ 5. Records indicate the person is mentally retarded / developmentally disabled (MR /DD) or is dually-diagnosed with MI (MR / DD / MI).

☐ 6. PASARR / MI Level II assessment is deferred until the individual is able to participate in the assessment. (*Explain the reason.*) The NF is responsible to monitor the individual's condition and make a referral to the CMHC when the individual has sufficiently recovered to have a Level II. (*Clearly explain reason for deferral and give any recommendations.*)

☐ 7. Death on (*date*) _____

☐ 8. Discharged. Briefly explain:

☐ 9. Other:

A Level II is not required at this time. If new information becomes available concerning the need for PASARR / MI Level II, or a significant change occurs in the individual's mental status / behavior, referral for a Level II should be made by letter to the CMHC with a brief explanation of the change / additional information.

When completed by the CMHC, this form is in lieu of a PASARR / MI Level II and must be submitted to the State PASARR Unit for review and determination. It must always be made part of the applicable PAS or ARR case and retained on the individual's chart if admitted to a NF. The CMHC should retain a copy for audit purposes. The NF will receive a copy with the final determination packet

Completed by:	Date	Telephone number

Title / Credentials:	Date of referral for Level II: ☐ By IPAS agency ☐ By NF ☐ By hospital

INSTRUCTIONS
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

PURPOSE: This form has been designed to document the decision by the CMHC that referral for PASARR / MI Level II assessment is inappropriate at the time the referral is made. It will:

1. Document the reason for termination of the Level II referral and identify the entity / individual making the determination;
2. Provide notification of the decision to the IPAS agency (*for PAS*) and / or the State PASARR / MI Unit (*for ARR*);
3. Replace the Level II assessment for documentation purposes; and
4. Serve as documentation of CMHC action for reimbursement / audit purposes.

INSTRUCTIONS: Complete the form as follows:

Section 1: Identifying Information:

A. Enter the **full name of applicant (PAS) or resident (ARR)** in the following order: last, first, middle initial.
B. Enter the individual's **Social Security number** or, only if not available, the **date of birth**.
C. Enter the individual's **Medicaid number (RID)**, if appropriate.
D. Record the **home, hospital or NF address** which reflects the current location of the individual. Include the name of the hospital or NF, if appropriate.

Section 2: CMHC Name and Address

A. Enter the **name of the CMHC**.
B. At a minimum, record the city in which the main office of the CMHC is located.

Section 3: Purpose of Referral

A. **If PAS,** check the box labeled PAS and send the completed form to the originating / local IPAS agency.
B. **If ARR,** check the box labeled ARR. Differentiate whether the referral is a "routine" or "non-routine" ARR. Send the completed form with other documentation to the PASARR / MI program.

Section 4: Reason for Decision

A. On the first blank line, enter the **date the referral was received** by the CMHC from the IPAS agency or the NF.
B. Check the applicable box(es) which states the **reason** the referral for a Level II was inappropriate.
C. Write **additional information**, if applicable, in the spaces provided.

Section 5: CMHC Certification

The CMHC PASARR reviewer (*a qualified mental health professional*) must **sign** and **date** the form, with a **telephone number** and specifying his / her **title / credentials**.