

# **CARE LEVEL II INSTRUCTION MANUAL**

## **INTELLECTUAL/DEVELOPMENTAL DISABILITY**

**Effective July 1, 2015**

# **INSTRUCTION MANUAL FOR CARE LEVEL II PASRR SCREENING INTELLECTUAL/DEVELOPMENTAL DISABILITY AND OTHER RELATED CONDITONS**

**Effective July 2015**

## **INSTRUCTIONS FOR CARE LEVEL II PREADMISSION SCREENING for INTELLECTUAL/DEVELOPMENTAL DISABILITY and OTHER RELATED CONDITIONS:**

**1. It is extremely important that the screening is typed.**

**KDOA must receive a copy of the assessment that is legible in order to review it and make a determination. Assessments which are not legible will be considered incomplete and returned to KHS.** An actual interview, with the individual being screened (and legal guardian, if appointed), must take place for the assessment to be complete. All questions must be answered completely.

Please include the full name of the person being assessed at the bottom of each page and on any attached sheets.

### **\*Date of Complete Referral to Consortium Coordinator**

This is the date that Consortium Coordinator receives a complete referral from the Level I CARE Coordinator. This information is to be filled in or given to you by the Consortium Coordinator.

### **Date referred to the Assessor**

State the date that YOU (the Level II assessor) received the referral from the Consortium Coordinator. When you receive the Level II referral, determine whether the client has a legal guardian. By federal law you must contact this individual; you cannot interview the client without this individual's permission. You should also note other individuals who are involved in caring for this individual and make every effort to involve them in the assessment as well.

### **Date of Assessment**

State the date the assessment was conducted. The date you interviewed the individual.

### **Date Faxed to Consortium Coordinator**

This is the date that you FAX the completed assessment to the Consortium Coordinator.

### **Person requesting the Level I screening**

Please supply the name of the person who is requesting this individual to be assessed for nursing facility admission. This might be the individual seeking nursing facility admission, a family member, discharge planner, case manager, social worker, court personnel, Law Enforcement and Corrections, friend or concerned person. This is not the Consortium Coordinator.

**Relationship to person being screened**

Please state the relationship of the person named as requesting the screening to the individual being referred. For example, degree of family relationship, discharge planner, case manager, social worker, etc.

**SECTION I - IDENTIFICATION**

**Name**

Print the individual's name in order of last, first and middle initial.

**Phone Number**

The phone number at the residential address.

**Residential Address**

This is the permanent address of the individual being screened. It may be his/her own home or apartment address, a family member's home at which he/she now resides, or the institution or facility where the individual has lived for so long that it is now his/her home. Please fill in street address, city, county, state and zip code completely. Please include the post office box number if there is one.

**SSN**

Identify the individual's social security number in the space provided. If the client does not know/remember his/her social security number, check his/her available records for the information. Write "unable to determine" if you are unable to determine the client's social security number.

**DOB**

State the individual's date of birth.

**Gender**

Identify whether the individual is male or female by placing an "X" in the appropriate section.

**Medicaid Number**

State the individual's Medicaid number. Please check the individual's chart for this information. If the individual does not have a Medicaid number, state "none". If a Medicaid number has been applied for, state "number pending". Do not leave this question blank.

**County of Origin**

The following list shall be utilized to establish a home county for a person exciting ICF-MR to a community setting. The list is in priority order.

- A. The county of residence of a family member of the person with Developmental Disability.
- B. Then the residence of the persons guardian or
- C. The county in which the person is living.

**Current Location**

Include the full name of the facility. If same as residential address, state "same" and proceed to Contact Person. This is the name of the hospital or facility (example: jail or correctional facility) where the individual currently is residing or currently is a patient.

**Ward or Unit**

Please give the name of the ward, building, or unit in which the individual is residing if the individual is residing in an institution.

**Address**

This is the address where the individual is currently residing or the address of the hospital or nursing facility. Please give the complete address, street, city, county, state and zip code. If there is a post office box, please list it also.

**Contact person**

This is the employee at the current facility that is actively involved with the discharge planning of this individual. This person, when contacted, should be able to discuss the current physical and/or mental status of the individual and the steps that have been taken to find a placement for the individual. This person would probably be a discharge planner, case manager, or social worker.

**Admission date**

This is the date that the individual was admitted to the current hospital or nursing facility.

**Phone**

This is the phone number of the residence, hospital, nursing facility, or institution where the client is currently residing at the time of the assessment.

**Fax number**

This is the fax number of the hospital, nursing facility, or institution where the person is currently residing at the time of the assessment. Please attempt to determine if there is a fax number for the floor, ward or unit where the individual is residing, rather than a general institutional number.

**Attending Physician Name**

State the physician's first and last name. This person will not necessarily be the primary physician. If the person has multiple physicians, state the physician who is caring for their immediate needs. Please attempt to ensure that your information is not outdated.

**Phone**

This is the phone number for the attending physician. Please give it in its entirety.

**Address**

State the complete mailing address for the attending physician, including the city, state and ZIP code. Give PO Box if there is one. A copy of the outcome letter will be sent to the physician.

**Proposed Facility**

Identify the facility where the individual intends to reside, if known. State the facility's complete name. Please be specific, i.e. do not write "Medical Haven", be sure to clarify by stating "Medical Haven - Elkhart". If the location is unknown, state "Not Yet Determined".

**Address**

State the complete address of the proposed facility. Give the street, city, county, state, and zip code. Give the PO Box if there is one.

**Phone number**

Identify the telephone number for the admitting facility, including area code.

**Fax Number**

This is the fax number of the admitting facility, including area code. Please check to be sure that it is the correct fax number.

**Proposed Date of Admission**

Please give the proposed date of admission to this facility. If the individual has already been admitted to the nursing facility, write the date that the individual was admitted.

**Contact Person**

Please give the name of a person that can be contacted at the proposed facility for information regarding this patient. This is also the person to whom any fax communications will be addressed. This individual could be a case manager, social worker, director of nurses, etc.

**Please give the following information about any individual serving as:**

Guardian\*                      DPOA                      Other Legal or Medical Representative

Mark the appropriate legal representative using the definitions below.

**\*Attach copy of signature page of the court's guardianship order, if available.**

In the case of guardianship, please photocopy the signature page of the guardianship order and attach to the assessment.

A **Guardian** is an individual who is legally responsible for the care and management of an individual, as appointed by a court of competent (probate) jurisdiction. A guardian may also be responsible for the care and management of an individual's medical decisions and/or property. A designation as "authorized representative" or as the individual with "power of attorney" is not equivalent to a designation of guardian.

**DPOA** refers to a durable power of attorney. The DPOA may be either a power of attorney for medical care or a general power of attorney. In either case, the individual is fully capable of making his/her own decisions.

**Other Legal or Medical Representative** involvement may include an individual with power of attorney, an authorized representative, an attorney, or a physician.

**Name**

Identify the name(s) of individual(s) specified as legal representative of this individual.

**Address**

Identify the full address of individual(s) specified as legal representatives of this individual. Please give the street, city, state and zip code. If the individual has a PO Box listed, please include it.

**Home Phone Number**

Identify the home telephone number including area code of the person specified as a legal representative of this individual.

**Work Phone Number**

Identify the work telephone number including area code of the person specified as a legal representative of this individual.

**Does the individual have another person involved in a significant way from whom we may be able to obtain additional information about the client's social, medical, emotional, or environmental history and status?**

Yes \_\_\_\_\_ No \_\_\_\_\_

Please mark the appropriate response.

**If yes please provide the following information:**

**Name**

Print the person's full name.

**Address**

Print the person's complete mailing address, including street, city, state, zip code. If there is a PO Box, please give it.

**Home phone number**

Please give the home phone number, including area code, where this person may be reached.

**Work phone number**

Please give the work number, including area code, where this person may be reached during the day.

**Relationship to Individual**

State the person's relationship to the individual, i.e. friend, mother; spouse, etc.

## SECTION II – DIAGNOSIS

1. List **all** diagnoses according to the current DSM manual. Please list diagnosis code as well as description. If the assessor does not concur, state reasoning in the clinical summary portion of this form, question # 25.

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

This section should include **all** diagnoses. All medical, psychiatric, and cognitive diagnoses must be included. This is important to determine the emphasis of current treatment in order to establish exemptions.

If after reviewing the clinical records and interviewing the individual, you believe that the severity of the disorder/condition or the focus of treatment indicates that another diagnosis has taken priority, please explain in the "clinical summary", question # 25

## SECTION III – VERIFICATION OF MENTAL RETARDATION/OTHER DEVELOPMENTAL DISABILITIES AND APPLICABLE EXCLUSIONS

2. **The current psychological report provides the following data:**

### **IQ Test:**

State the test administered, including version/edition.

The most widely accepted intellectual assessments are the Wechsler Adult Intelligence Scale - Revised or III and the Stanford-Binet Intelligence Test - Revised. In special circumstances other assessments of intelligence are acceptable. For example, hearing impaired clients may be assessed via the Nebraska Test of Learning Aptitude. Or, the Arthur Adaptation of the Leiter International Performance Scale for hearing impaired, verbally handicapped, or not facile with English language clients.

**Date:**

State the date the test was administered.

**Results:**

Identify key results; full scale IQ, relevant subscales, etc.

**Examiner Name/Credentials:**

Identify the examiner and his/her credentials. Include the name of the examiner, the examiner's degree (PhD, PsyD, EdD, MS), and the examiner's license type and number.

3. Was mental retardation (IQ Score of 70 or below) manifested prior to the age of 18?

Yes \_\_\_\_\_ No \_\_\_\_\_

This answer should be verified through documentation of an intellectual assessment prior to the age of 18.

This information can be obtained in the client's records. Look for information on special schools and classroom placements; educational history; sheltered workshops; group homes; specialized adult services; etc.

Place an X after the appropriate response.

- 4a. **Was the individual diagnosed with a Developmental Disability, as defined in the manual prior to the age of 22?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If **NO**, proceed to # 5.

If **YES**, list the diagnosis, then continue: \_\_\_\_\_

For purposes of this assessment the definition for Other Developmental Disability as defined by the State of Kansas, Department of Social and Rehabilitation Services Health Care Policy follows:

**The Definition of Other Developmental Disability:**

**Other developmental disability** means a condition such as autism, cerebral palsy, epilepsy or other similar physical or mental impairment (or a condition which has received a dual diagnosis of mental retardation and mental illness) and is evidenced by a *severe, chronic disability* which:

1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, **AND**
2. is manifest before the age of 22, **AND**



3. is likely to continue indefinitely, **AND**
  4. results in substantial functional limitations in any three or more of the following areas of life functioning:
    - a. self-care,
    - b. understanding and the use of language,
    - c. learning and adapting,
    - d. mobility,
    - e. self-direction in setting goals and undertaking activities to accomplish those goals,
    - f. living independently,
    - g. economic self-sufficiency, **AND**
1. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, **AND**
  2. **does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.**

**The definitions follow:**

Self Care:

Performance of basic personal care activities.

Language:

Receptive and Expressive. Communication involving both verbal and nonverbal behavior enabling the individual both to understand others and to express ideas and information to others.

Mobility:

The ability to move throughout one's residence and to get to, access and utilize typical settings in one's community.

Learning:

General cognitive competence and ability to acquire new behaviors, perceptions and information, and to apply experiences in new situations.

Independent living skills:

Capacity for independent living. Age appropriate ability to live safely without assistance from other persons; includes housekeeping, participation in leisure time activities, and use of community resources.

Self direction:

Management and taking control over one's social and personal lives. Ability to make decisions affecting and protecting one's own interests.

Economic self-sufficiency:

The ability to pay for basic needs and services through employment or other financial resources.

- 4b. **Check all areas in which the individual has substantial functional limitations due to other developmental disability.**

Self Care    \_\_\_            Mobility    \_\_\_            Independent living skills    \_\_\_\_\_  
Language    \_\_\_            Learning    \_\_\_            Self direction    \_\_\_\_\_  
Economic self-sufficiency    \_\_\_\_\_

(The ability to pay for basic needs and services through employment or other financial resources)

- 4c. **Does the individual have substantial functional limitations, in at least three of the areas, due to the developmental disability?**

Yes    \_\_\_\_\_ No    \_\_\_\_\_

In order to meet the criteria for functional limitations due to other developmental disability, the individual must have limitations in at least three of the areas.

5. **If the answer to # 3 AND # 4a or # 4c are NO, the individual does not require a Level II PASRR for Mental Retardation/Other Developmental Disability. Proceed to question # 25, 27, through # 39. Otherwise continue with the assessment.**

6. **Does the individual have a primary diagnosis of dementia or a dementia-related disorder?**

Yes    \_\_\_\_\_ No    \_\_\_\_\_

**Place an "X" after the appropriate response.**

This information should be available in the individual's records. If you have a question as to where dementia is currently fitting into the priority of diagnoses, please consult with the doctor or staff (RN or social worker).

For the purposes of clarity and diagnostic accuracy, a brief discussion of dementia follows. In the majority of the cases, the diagnosis of dementia, if applicable, will already be identified. In the event dementia has not been identified and you suspect such a diagnosis, note this on the assessment, BUT DO NOT ATTEMPT TO MAKE A DIAGNOSIS AS PART OF THIS ASSESSMENT.

Examples of dementia and dementia related disorders include: Multi-infarct Dementia, Parkinson's Disease with Dementia, AIDS-related Dementia, Alzheimer's Disease, Senile Dementia, Korsakoffs, dementia related to alcohol/substance abuse, dementia related to a physical condition, etc. *Please note, in order for an individual to meet this qualification,*

*Dementia must be listed as part of the diagnosis (i.e. Dementia, due to Parkinson's Disease, or Dementia secondary to Parkinson's Disease, not just Parkinson's Disease).*

**If you are marking yes**, this means the individual will be exempted from future PASRR due to the diagnosis of Dementia.

**You must provide verification from clinical records which document dementia as the primary diagnosis.** The required documentation may be in the form of the history and physical, the psychiatric evaluation, discharge summary, progress note updates, medication sheets or care plans, that shows the dementia as the primary diagnosis. Any psychological or neurological testing (MRI, PET or CAT Scan, etc.) that is available to you that supports the dementia diagnosis should be faxed in also. In the absence of such records the State Plan allows the following: "Dementia related exemptions require KDOA to establish and document verbal confirmation of the dementia related condition through official medical records maintained by a hospital, nursing facility or physician's office."

**If supportive documentation of the priority of the dementia is not faxed with the assessment it will be considered an inappropriate dementia abort.**

If the appropriate supportive documentation is available, **you must abort** the assessment. If you have concerns regarding this, please attach an addendum to the assessment with your concerns and recommendations.

7. **If the answer to # 6 is YES. The Mental Retardation/Other Developmental Disabilities assessment is finished. please answer question #25, #27, #35 through #39.**

Proceeding to question #25, #27, #35 through #39 at this point in the assessment, marks the end of the Level II assessment, for either mental retardation/other developmental disability or mental illness. The "YES" response to question # 6 suggests that specialized services are not appropriate for this individual. Therefore, the Level II assessment is terminated. You must provide documentation from the clinical record to support your response.

- 8a. **Does this Individual have a medical condition which is: (Mark the appropriate answer for each category.)**

Permanent	Yes	___	No	_____
Progressive	Yes	___	No	_____

For the purpose of this assessment the following definitions apply.

**\*Permanent**

Permanent infirmities of aging are identified as the current primary factor causing the individual to need twenty-four hour nursing care AND the individual will no longer

benefit from specialized services for persons with mental retardation or other developmental disabilities.

\*Progressive

A medical condition of a progressive degenerative nature which, due to the current increasing deterioration directly related to the condition, is a primary factor determining the need of the individual AND the individual can no longer benefit from specialized services for persons with mental retardation or other developmental disabilities.

\*Permanent and Progressive related exemptions require a Level II Assessor to initiate an assessment and make the determination regarding the status of the individual's condition. Documentation is required to be maintained.

8b. **If the response to any of # 8a is “YES”, please describe the permanent or progressive medical condition and the treatment required.**

8c. **If the responses to any of # 8a are marked “YES” proceed to question #25 and #27 through #39, the questions regarding Mental Illness.**

This response suggests that specialized mental retardation services are not appropriate for this individual and the prescreening for MR/DD is finished. Please answer questions#25, 27 through 39 which includes questions about mental illness.

## SECTION IV – PRESENTING PROBLEM

Complete Section IV by placing a check mark in the space provided by each category (a through e) that applies to the individual being screened. For any category checked, place marks in the applicable check boxes below that marked category and provide other explanation as requested on the form. Your determination regarding which items to mark should be based on information obtained from the individual being screened, their family members/guardian/other representatives, the person making the referral for nursing facility admission, the medical history and physical, and other service providers involved in the referral.

In addition to the determination of the presenting problem, this section requires a review of what community services have already been attempted to address the problem and an explanation of why community services have not been provided, were discontinued, or failed to adequately address the presenting problem. For each category (a through e) that you indicate as applying to the individual being screened, provide additional description under the sections titled "Please explain".

9. Why is this individual being referred for nursing facility placement at this time?

a. **Loss of community support system/caretaker?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", please explain: \_\_\_\_\_

Please clarify if this is a family member, friend or a community support system, such as a service provider, CDDO; what specific services this person or agency provided and reason why this person or agency is no longer able to provide support for the individual in the community.

**b. Currently has significant medical needs or need for special treatments.**

- D Incontinence
- D Monitoring of special diet (e.g., Diabetic)
- D Monitoring of fluid intake
- D IV Medications or feeding tube
- D Mobility Assistance
- D Other

D (please explain) \_\_\_\_\_  
\_\_\_\_\_

"Currently" means the needs and behaviors listed are on-going and are causing a need for intervention at the present time.

Check each box that applies. Use the "Other" category to describe medical needs/special treatments not covered by the checkboxes. The "Other" category may include items such as: physical therapy, oxygen, injections, dialysis, wheelchair, walker, meal supplements, assistance technology, etc.

For any items you have identified that would require constant skilled nursing care, describe the specific treatment and medical care that would be needed to maintain the individual's safety and welfare in the section titled "Please explain" below the checkbox.

**c. Currently displays challenging behaviors, such as:**

- D Frequent / continuous yelling
- D Verbally Abusive or threatening
- D Damages / destroys property
- D Sexually aggressive / exposes self
- D Other

D (please explain) \_\_\_\_\_  
\_\_\_\_\_

"Currently" means the needs and behaviors listed are on-going and are causing a need for intervention at the present time.

Check each box that applies.

**Frequent/continuous yelling**

The individual shouts inappropriately.

**Verbally abusive or threatening**

The individual expresses rude, overly critical or hateful verbalizations.

The individual threatens physical harm to others or to property. Indicate whether threats are directed toward people or objects. In some instances, individual may threaten to hurt others in a nonphysical way. For example, an individual may threaten to "report a staff member for an action." If the verbally threatening behavior is not of a physical nature, please indicate.

**Damages/destroys property**

The individual throws or breaks objects.

**Sexually aggressive/exposes self.**

The individual exposes himself/herself by appearing partially nude or removing clothing in public. The individual makes sexually aggressive comments, sexually assaults others or sexually pursues others in a non-reciprocated fashion.

**Other**

Use the "Other" category to describe any behaviors not listed in the checkbox that have significantly impacted the individual's ability to remain in the community. For any behaviors you have identified that are challenging, please describe the specific assistance/supervision that would be needed in the section titled "Please explain" below the check boxes.

d. **Currently exhibits (within the past 6 months) dangerous behaviors.**

- D Injuries to self (including suicide attempts)
- D Injuries to others
- D Wandering without regard to safety
- D Fire Setting
- D Isolates self (refuses basic nutrition, refuses contact with service providers)
- D Other

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D (please explain)

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Check each box that applies. Use the "Other" category to describe any current dangerous behaviors not listed in the check boxes that have significantly impacted the individual's ability to remain in the community without jeopardizing their own or others' safety and well-being.

**Injuries to self**

The individual may injure himself/herself in a number of ways: cutting self, frequent falls, burning self, banging head, etc.

**Injuries to others**

The individual strikes others without just cause and without provocation. The attack is unexpected and/or unwarranted.

**Wandering without regard to safety**

The individual wanders in dangerous settings (i.e. in streets) or near stairs.

**Fire Setting**

The individual sets fires.

**Isolates Self (refuses basic nutrition, refuses contact with service providers)**

The individual isolates self and refuses basic nutrition and refuses contact with service providers.

**Other**

For any current dangerous behaviors you have identified, provide additional explanation and describe the specific assistance/supervision that would be needed in order to maintain the safety and well-being of the individual and others in the section titled "Please explain" below the check boxes.

e. **Did any of the behaviors indicated in the checkboxes marked above result in intervention by the following?**

- D Adult Protective Services
- D Law Enforcement
- D Hospitalization
- D Incarceration
- D Other

D \_\_\_\_\_  
(please explain)  
\_\_\_\_\_

Check each box that applies. Use the "Other" category to describe any additional significant interventions or consequences not covered by the check boxes. Examples include: eviction, loss of services, out-patient commitment orders, etc.

For any interventions you have identified, provide additional explanation in the section titled "Please explain". Include a description of the interventions/consequences, dates of occurrences, names of the agencies intervening, and outcomes (was the situation resolved or are there on-going problems?).

10. **Has the individual received case management services, residential/day support services, medication management, counseling/therapy, or other behavior management assistance from a CDDO or other community agency in the past 6 months?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If “No,” please explain why services were not provided, were discontinued or failed:**

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Answer the Yes/No question and provide a detailed explanation in the space provided. Indicate the amount of assistance that would be needed and indicate why this assistance could not be provided in the community.

11. **Does the individual have a documented history of services/support for MR/DD?**

Yes \_\_\_\_\_ No \_\_\_\_\_

Answer the question based on your review of the available records and interviews with caregivers.

Mark the appropriate response with an “X”.

For the purpose of this assessment, service/support for MR/DD are those services provided by a Community Mental Retardation Agency which might include special education classes for persons with mental retardation. Other examples of Mental Retardation Services would include, but are not limited to, case management, supported living, sheltered workshops, respite care, home care, etc.

12. **If “Yes,” give name of CDDO or Community Service Provider and provide dates of service.**

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13. **Who is current service provider?**

**Name of current community service provider:**

Give the names of the facility or center

**Location:**

Give the complete address of the facility or center

**Provide dates of service:**

Give the dates that the individual received services from this facility or center



**Name of facility or center:**

Give the names of the facility or center.

**Location:**

Give the complete address of the facility or center.

**Date served:**

Give the dates that the individual received services from this facility or center.

**Is there a person centered support plan?    Yes\_\_\_\_\_ No \_\_\_\_\_**

Please ask current service provider if there is a **person centered support plan** available and mark appropriate response with an "X".

## **SECTION V - MEDICAL HISTORY & PHYSICAL**

Assessors will need a knowledge of medical terms and abbreviations to complete a thorough review of available records. To assist in the review, a listing of common medical terminology and abbreviations are provided in the appendix.

14. **Please attach the most recent MEDICAL HISTORY AND PHYSICAL. THIS ASSESSMENT CAN NOT BE ACCEPTED WITHOUT THIS DOCUMENT AND WILL BE COUNTED AS AN INCOMPLETE ASSESSMENT. IF YOU CANNOT OBTAIN THE HISTORY AND PHYSICAL, CONTACT YOUR CONSORTIUM COORDINATOR IMMEDIATELY.**

Photocopy the individual's most recent medical history and physical; this history and physical should include information regarding the individual's neurological status in the areas of motor functioning, sensory functioning, deep tendon reflexes, cranial nerves and abnormal reflexes.

The history and physical should have been completed within the last year. However, if the most recent one is older than a year, submit it with the recommendation that the Medical history and physical needs to be updated. Sometimes the updated history and physical can be found on progress notes if the individual is currently a resident in a long term care facility.

If the assessment is being done in a home setting, try to obtain a H&P from the local physician. The physician should already be involved with the referral, since a physician's order is necessary for admission to the nursing facility. If it is after hours or on a weekend, please ask the individual or their guardian to sign a release of information for Consortium Coordinator to help obtain the H&P and fax it to the Consortium.

**15. List all medications the individual currently takes including over the counter medication, and indicate whether the medication is:**

S=Stable or A=being adjusted

**Medication:**

This information is contained in the individual's records and also may be verified by verbal report. Please include all medications, not only those medications relevant to the presenting problem. Specify the name of the medication (either trade or technical). Be specific, i.e. do not identify "anti-depressant" rather state "Prozac, Anti-depressant." Also indicate whether the medication is over-the-counter, "self-prescribed," (taken without close monitoring or instruction from physician) or physician prescribed.

**Dosage and Frequency:**

Indicate the dosage: dosage refers not only to the amount in terms of milligrams, but also the frequency (i.e. three times a day, as needed, etc.).

**S/A**

Indicate also whether the dosage identified is stable, or in the process of being adjusted. This information should be available in the individual's records. Stable medications generally have been at a set dosage for a significant period of time to adequately treat the condition. Medications being adjusted will be new medications and/or be in the process of raising or lowering the dosage. For new prescriptions, identify the length of time the individual has been taking the dosage.

**Route**

Indicate using the following abbreviations:

P.O. = by mouth	IM = intramuscular
SubQ = subcutaneous	S.L. = sublingual
IV = intravenous	Top = topical

Common abbreviations for time:

Qd = every day	BID = twice daily
TID = three times daily	QID = four times daily
a.c = before meal	p.c. = after meal
qod = every other day	prn = as needed
1M = one time per month	hs = hour of sleep
q4h = every four hours	q6h = every six hours
am = morning	pm = afternoon

16. **Please list all medications the individual has taken during the past three months.**

**Medication Dosage Frequency**

Follow the same procedures as outlined in question 15. Include all medications taken in the past three months, except those mentioned in question 15, unless the dosage has been changed. Include information about when the medication was discontinued; and, if applicable, why the medication was discontinued.

## **SECTION VI - FUNCTIONAL ABILITIES**

17. **Describe the individual's ability to self-administer and schedule medical treatments self-monitor health and nutritional status.**

Provide a description of the individual's ability to:

Seek medical treatment when appropriate

Assess their health status

Schedule medical appointments

Comply with treatment and medications to the extent that their mental or physical health is not jeopardized.

Follow a reasonably healthy diet at least to the extent that their mental or physical health is not jeopardized.

18. **Summarize the individual's developmental or functional abilities in the following areas:**

Provide a summary of each of the following areas:

a). **self-help** - Skills include: toileting, dressing, grooming, transfer and eating.

b). **sensorimotor** - Skills include: ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity.

c). **speech and language** - Skills include: (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which non-oral communication systems can improve the individual's function: capacity, auditory functioning, and extent to which amplification devices (for example, hearing aid) or a program of amplification can improve the individual's functional capacity.

d). **social** - Skills include: interpersonal skills, recreation-leisure skills, and relationships with others.

- e). **academic/educational** - Skills include: survival numerics (basic mathematics, time management), survival reading (basic academic skills, functional reading), and communication (expressive language, receptive language, and writing and spelling skills). This area also includes functional learning skills. Level of education attained should also be addressed
- f). **independent living** - Skills include: meal preparation, budgeting and personal finances, survival skills, mobility skills, (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed-making, care of clothing, and orientation skills (for individuals with visual impairments).
- g). **vocational** - Skills include: job readiness (job awareness, job application and interview skills, on-the-job information), vocational behavior (job performance and productivity, work habits and work attitudes, work-related skills, specific job skills, learning and transfer of job skills), and social behavior on the job. This section also needs to reflect the individual's current vocational skills.
- h). **affective** - Skills include: interests, and skills involved with expressing emotions, making judgments, and making independent decisions.

As a part of this summary, **Please include any maladaptive or inappropriate behaviors observed or documented.** (Including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors.)

## **SECTION VII – LIVING ARRANGEMENT AND SUPPORT NETWORK**

19. **Indicate the individual's preferred living arrangement (individuals choice, not service provider's recommendation)**

Ask the client where they prefer to live and the reasons for this preference. Record this information. If the client is uncertain or unable to offer a preference, please so indicate. Do not assume a response from the individual.

20. **If there is a legal guardian, do they agree with the individual's choice of living arrangement?**

Yes \_\_\_\_\_ No \_\_\_\_\_

The guardian must be consulted! Please indicate guardian's preference and reasons for this preference.

21. **Please check all boxes describing living situations in which the individual has resided since age 18, and indicate the approximate length of time resided and reason individual is not returning to/remaining in living situation:**

Lived Alone in Own Apartment/House/Etc.  
 Lived with Relatives/Friends  
 Lived in Group Home/Assisted Living Facility  
 Lived in Nursing Facility/Nursing Facility for Mental Health  
 ICFMR  
 Other

**Please explain:**

In completing this section, please record the individual's housing history, including length of time resided and reason individual is not returning to/remaining in living situation (for definitions of living situations, see below). If individual has multiple experiences in one category, please indicate.

"Group Home" is defined as any dwelling licensed by a regulatory agency of this state to provide non-medical care and housing to individuals with a disability.

Definition of "Nursing Facility", see question 26. "Nursing Facility for Mental Health", or "NFMH" is defined as an entity meeting all of the criteria for "Nursing Facility" as outlined on question #26, and, was designated as a Nursing Facility for Mental Health through a provider agreement with SRS dated June 30, 1994.

Definition of ICFMR see definition in question # 26.

22. **The individual currently has a residence available?**  
Yes  No

**Please describe:**

Indicate by checking "Yes" or "No" if the individual has a residence available. Describe apartment, house, with family members, etc.)

23. **Individual's Support Network includes:**

**Family Members - Identify:**

**Case Manager - Identify:**

**Guardian or Payee - Identify:**

**Others - Identify:**

Check available supports and provide specific information (Names and phone numbers, availability, etc.). In space provided clarify level of involvement of identified supports.

24. **Support Services and Resources Needed: Check all that apply. Indicate whether they would be available, not available or unknown.**

Indicate which services individual would need to successfully reside in the community.

Mark whether the services are available in the community, not available or unknown  
See attached pages (at the end of the manual) that defines Residential Services, Supportive Home Care, Day Services, Wellness Monitoring, Night Support, Respite Care and Communication Devices.

This information should include how much of the service is needed.

**Please explain:**

This information should include how much of the service is needed, i.e. is In Home Support needed 5 hours a week, 5 hours a day; is Wellness monitoring available 7 days a week, 3 times a day, etc.

*Please list agency responsible for providing these services in question #27.*

## **SECTION VIII - SUMMARY AND FINAL RECOMMENDATIONS**

25. **Clinical Summary:**

The clinical summary should integrate information obtained through a review of the records and clinical interviews. If you do not concur regarding diagnosis or recommendations, please discuss in this section.

The summary of information relayed in this section should support your recommendation for the level of care indicated on question # 26. If additional space is needed, attach another page.

26. **Mark the appropriate placement/service recommendation for this individual:**

Nursing facility level of care **is** needed/Specialized mental retardation services **are not** needed.

Nursing facility level of care **is not** needed/Specialized mental retardation services **are** needed.

Nursing facility level of care **is not** needed/Specialized Mental Retardation Services **are not** needed.

The assessor should use clinical judgment in making this recommendation. Stringent guidelines are not appropriate; consider individual differences and conditions. Use the following definitions for nursing facility and specialized services in making your recommendation:

**FOR THE PURPOSE OF THIS ASSESSMENT:**

**Specialized Services** for individuals with Mental Retardation or Other Developmental Disabilities is defined as those services which necessitate the availability of trained MR personnel from an SRS licensed provider. These services can be provided in the following settings:

1. Intermediate Care Facility for Mental Retardation (ICF/MR)

**OR**

2. Community setting if the services provided are equivalent to the level of services provided in an ICF/MR.

**Nursing facility:** "any place or facility operating for not less than 24 hours in any week and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care."

27. **Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. As a OMRP, please give additional service recommendations that would be beneficial for this individual's developmental disability. (regardless of above recommendations):**

Make service recommendations based on a thorough knowledge of resources available in the community where the individual will be residing. Obtain this knowledge through community networking, written resources, and attendance at CARE program update training. The local Community Developmental Disability Organization and the Department of Social and Rehabilitation Services are excellent resources for information regarding mental retardation and other developmental disabilities services.

A copy of the Area Agency on Aging map has been included in the appendix. Contact Community Developmental Disability Organizations and Kansas Department of Social and Rehabilitation Services, Developmental Disability Services (785-296-3561) for further information regarding mental retardation services. To maintain current knowledge regarding

Specialized Services, network within your community, rely on written resources, networking and attend CARE training updates.

A copy of the Community Developmental Disability Organization map has been included in the appendix.

Include any additional service recommendations relevant to the individual's condition. Some community-based service definitions can be found in the appendix of your manual

An awareness of community resources available in the community where the individual resides is essential in answering this question.

Services available within the community the individual resides in may include: Developmental Programs with Day Activity, Education and Training, Residential Services with Domiciliary and Special Living Arrangements, Employment Services with Preparation, such as Sheltered Workshops or Competitive Placements, Identification Services for Diagnosis and Evaluation, Facilitating Services for Information and Referral Counseling and Case Management Services, Legal Services, Transportation Services, Leisure and Recreation services.

## SECTION IX - DUAL DIAGNOSIS EVALUATION

28. Does the individual have a serious Mental Illness diagnosis?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If **NO**, proceed to question #35 .

If **YES**, proceed with the assessment.

If the answer is No, the individual does not require a Level II PASRR for a mental illness. It is appropriate at this juncture to define serious mental illness for the purpose of clarity and consistency. An individual is considered to have a serious mental illness if he/she meets the following requirements of **diagnosis, level of impairment and duration of illness:**



**Diagnosis:**

The individual has a clinical diagnosis of one of the following serious mental disorder's;

- 295.10 Schizophrenia, Disorganized Type
- 295.20 Schizophrenia, Catatonic Type
- 295.30 Schizophrenia, Paranoid Type
- 295.60 Schizophrenia, Residual Type
- 95.90 Schizophrenia, Undifferentiated Type
- 295.70 Schizoaffective Disorder
- 296.23 Major Depressive Disorder, Single Episode, Severe, without Psychotic Features
- 296.24 Major Depressive Disorder, Single Episode, with Psychotic Features
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 296.33 Major Depressive Disorder, Recurrent, Severe, without Psychotic Features
- 296.34 Major Depressive Disorder, Recurrent, Severe, with Psychotic Features
- 296.35 Major Depressive Disorder, Recurrent, in Partial Remission
- 296.36 Major Depressive Disorder, Recurrent, in Full Remission
- 296.89 Bipolar II Disorder

All Bipolar I Disorders

- 297.10 Delusional Disorder
- 298.9 Psychotic Disorder NOS
- 300.21 Panic Disorder with Agoraphobia
- 300.3 Obsessive-Compulsive Disorder
- 301.83 Borderline Personality Disorder

29. **Does the individual have a non-primary diagnosis of dementia or a dementia related disorder and is the primary diagnosis something other than a major mental disorder?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, proceed to #35.

If **NO**, continue with the assessment.

This information should be available in the individual's records. If you have a question as to where dementia is currently fitting into the priority of diagnosis, please consult with the doctor or staff (RN or Social Worker).

If dementia is diagnosed and a diagnosis other than a serious mental illness is primary, answer "YES" to this question.

**If supportive documentation of priority of the dementia is not faxed with the assessment it will be considered an inappropriate dementia abort.**

30. **Does the individual have a level of impairment resulting in functional limitations in major life activities, due to the mental illness, within the past 3-6 months (interpersonal functioning, concentration, persistence and pace, adaptation to change)?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**Level of Impairment**

The disorder results in functional limitations in major life activities within the past three to six months that would be appropriate for the individual's developmental stage. Typically, an individual has at least one of the characteristics in the following areas on a continuing or intermittent basis:

(a). **interpersonal functioning**

The individual has serious difficulty interacting appropriately and communicating effectively with other persons or a possible history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships and social isolation;

(b). **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, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks;

(c). **adaptation to change**

The individual has serious difficulty in 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

31. **Does the recent treatment history indicate that the individual has experienced at least one of the following:**

- f. Psychiatric treatment more intensive than outpatient care more than one time in the past two years (e.g., partial hospitalization or inpatient hospitalization).

**OR**

- g. within the last two years, due to the mental disorder, an episode of significant disruption to the normal living situation, for which **supportive services** were required to maintain functioning at home, or in the residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Yes \_\_\_\_\_ No \_\_\_\_\_

**Supportive Services...** to maintain functioning... at home or in a residential treatment environment” can be said to have occurred when, during that time period, the individual required a significant increase in mental health services.

For example, due to a mental health need, the customer needed an increase in assistance with: instrumental activities of daily living, such as shopping, meal preparation, laundry, basic housekeeping, money management, etc.; basic health care, such as hygiene, grooming, nutrition, taking medications, etc.; coping with symptoms of extreme withdrawal and social isolation; increased incidents of inappropriate social behavior including screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.; or increased incidents of self harmful behavior.

These services shall have significantly increased for a period of 30 days or more in the last two years.

IF the customer does not remember an increase in these services in the past two years, please contact the Community Mental Health Center (CMHC). The CMHC should be able to tell you whether this customer is receiving services.

**“Intervention by Housing Officials...”** can be said to have occurred when the individual has been evicted (including from a shelter) for situations which include inappropriate social behavior (screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior etc.) and abuse or neglect of physical property (including: failure to maintain property as outlined in the lease, intentional destruction of property such as through kicking or hitting walls or doors, etc.). Note: Nonpayment of rent, substance abuse, and other such situations can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown.

“Intervention by law enforcement officials...” can be said to have occurred when the individual has been arrested and/or taken into custody due to: harm to self, or property; inappropriate social behavior (screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.); or,

32. **If (#29 is NO) and (#28, #30 and #31 are YES), the individual does require a Level II PASRR for Mental Illness. This assessment is not complete until questions 7 (a) (b) (c) and Sections III, VI, VII, VIII, IX, X of the Level II Mental Illness PASRR form are completed. If the individual does not require a Level II PASRR for Mental Illness, proceed to #35.**

If #29 is NO and #28, 30 and 31 are YES, this person does have a Dual Diagnosis of MR and MI, therefor, both assessments **must** be done.

**If the MR assessment has been aborted, and the individual needs a MI PAS completed, the assessment is not complete until questions 7 (a), (b), (c) and Sections III, VI, VII, VIII, IX, X are completed.**

33. Is a Level II PASRR for Mental Illness is required:

- a. **Are you conducting a MI PAS?**  
Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please continue with the assessment and complete the appropriate sections of the MI Level II Preadmission Screening.

If you are doing both the MI and MR assessments, please evaluate each condition separately and make your recommendations for each condition on the basis of your findings.

Consideration will be given to each recommendation in order to determine where this individual will receive the care and treatment that will benefit him/her the most.

- b. **Are you referring to the Consortium for a MI PAS?**  
Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please immediately fax this assessment to the Consortium and call them to alert them to the fact that this assessment is not complete until the MI PAS is done. Do not wait any longer than is absolutely necessary to refer to the Consortium.

34. **What is the county of responsibility?**

The county of responsibility will be the county were the client lived independently or with family (in other than a boarding home, group, home, NF/MH, or other supervised

living program) for 6 continuous months prior to the latest admission to a state hospital or other institution. The 6 month period may be waived or extended by agreement by the two mental health centers involved. (If an individual moves to a particular county for the purpose of receiving mental health services, and remains dependent upon those services, then that individual will remain the responsibility of his/her original county.

35. **What resources were utilized to gather information for this assessment? Include the names of the individuals and titles.**

Every effort must be made to contact and involve the guardian in the assessment. If guardian declines involvement or is unavailable, please explain why in the remarks section of this question. If family member or guardian is not involved in assessment, please explain why in the remarks section of this question.

**Individual (face to face):**

Enter name of client and date of interview with the client

**Guardian:**

Enter the name of the Guardian you talked with and the date you interviewed the guardian. Indicate if the interview was in person or by phone. This assessment is not valid if the guardian has not been involved. If the guardian does not wish to be involved in the assessment, state the date you contacted him/her and that they declined to attend the interview. If he/she wishes to be present you must work with them in order to schedule a time that they can be there. If they gave input from your phone conversation document that they did so.

**Family Members:**

Enter the names and relationship of those family members you interviewed in order to obtain information for this assessment. Family members should be notified prior to assessment and given an opportunity to be involved. If family members were not involved, explain why.

**Health Care Professionals (must be interviewed and listed):**

Enter the names and titles of those health care professionals that you interviewed in order to obtain information for this assessment. Case manager or discharge planners should be included.

**Clinical Records:**

List those clinical records, by name and date, that you accessed in order to obtain information for this assessment. Examples: Current file (should include orders, progress notes, history and physical, medication sheet, etc.) If client is already in a nursing facility Minimum Data Set must be reviewed.

**Minimum Data Set (MDS) 2.0:**

Please note the date of the last MDS that you reviewed for this assessment. During the conversion to the MDS 2.0 from the MDS+, the most recent instrument should be reviewed and listed.

36. **Please give the exact location of where the assessment took place.**

Please give a description of where this assessment took place. For example: Individual's room, day hall, social service office, etc. Give the name of the facility or hospital where the interview took place. If interview was in individual's own home or the home of a care giver, describe the home. Give name of care giver.

## SECTION X - QMRP SIGNATURE

37. **Assessor's name**

Print. your full name (first, middle initial, last) and title (Ph.D., MD., RN., MSW, etc).

**Date:**

Date the form, only after it is completed in full and is ready to be forwarded for further review.

**Assessor's work telephone number:**

Provide the telephone number(s) at which you are most accessible during daytime hours.

**Assessor's license type and number:**

Specify your license type and number.

**Assessor's signature:**

Sign the form, only after it is completed in full.

38. **Is this a Level II courtesy assessment?**

Yes \_\_\_\_\_ No \_\_\_\_\_

A courtesy assessment is an assessment performed by an assessor from one CDDO on a person who is either (1) a current consumer of another CDDO , or (2) a person for whom another CDDO is responsible based upon that person "county of origin" . When assessor learns that a person being assessed is or should be a client of another CDDO, that center should be contacted. If an immediate contact is not possible, then the PASRR Level II may be continued and the situation will be discussed with staff of the Center as soon as possible.

During the discussion with staff of the CDDO responsible for the person being assessed, the responsible CDDOs staff person should either: (1) arrange to complete the assessment by sending the assessor to the location of the person or by utilization of some

other method, such as interactive TeleVideo, or (2) arrange for the screening to be completed by an assessor from the contacting CDDO. This alternative is referred to as a “courtesy assessment”.

A courtesy assessment is commonly required when a person “county of origin” falls within the service area of a CDDO other than the one within which the person comes to the attention of the local assessor.

An important aspect of any PASRR Level II is knowledge of the resources of the person’s home community. Since the person performing the courtesy assessment may not be familiar with those resources, “matching” the person’s assessed needs with the resources of the home area will be difficult. The assessor must make every effort to contact the responsible CDDO in order to obtain necessary information. If the person being screened does not intend to return to their “home” community, then the assessor will need to match local resources with the person’s assessed needs.

**In any case a copy of the assessment and any additional documents needed are to be faxed or sent to the CDDO which has responsibility for that customer.**

In the event that agreement cannot be reached as to which CDDO has responsibility for an individual, the CDDO originally requested to perform the screening must complete it and accept temporary responsibility for that consumer. Therefore, the state MR/DD authority shall make the final determination.

**Date faxed to responsible**

**CDDO:**

Indicate the date you faxed the assessment.

**Contact Person at responsible**

**CDDO:**

Indicate staff person at the responsible CDDO who the assessor spoke to about this individual.

39. **Time Documentation Summary**

Screen Time:	—	Hours	—	Minutes
Travel Time:	—	Hours	—	Minutes
Total Time:	—	Hours	—	Minutes

Please document the time it took to complete the screen in hours and minutes, whether it was completed in its entirety or aborted.