

## PASARR (SMI/MRDD) IDENTIFICATION SCREEN

Instructions: Use black ink and print clearly. Please complete all sections unless otherwise specified.

### SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT

Last Name		First Name		MI
Sex	Date of Birth		Soc. Sec. No.	
<input type="checkbox"/> M = Male <input type="checkbox"/> F = Female	Mo.    Day    Year			Medicaid Recipient? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> P = Pending

### SECTION B: REASON FOR SCREENING

Enter Code	<b>PREADMISSION SCREENING CODES</b>	<b>ANNUAL RESIDENT REVIEW CODES</b>		
<input type="checkbox"/>	1 - Nursing Facility Applicant 2 - PASSPORT Waiver Applicant	3 - Expired Time Limit for Convalescent Stay 4 - Expired Time Limit for Emergency Admission 5 - Expired Time Limit for Respite Admission	6 - Significant Change in Condition 7 - No Previous PASARR Records 8 - ODMH Use Only	9 - Other

### SECTION C: DEMENTIA QUESTIONS

Yes  No  (1) Does the individual have a documented PRIMARY diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-III-R? *IF YES, the individual does not have indications of serious MI, go to Section E. If NO, go to the next question.*

Yes  No  (2) Does the individual have a SECONDARY diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-III-R? *If YES, go to the next question. If NO, go to Section D.*

Yes  No  (3) Does the individual have a PRIMARY diagnosis of one of the mental disorders listed in Question D (1) below? *If YES, go to Section D. If NO, the individual does not have indications of serious MI, go to Section E.*

### SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS

Yes  No  (1) Does the individual have a diagnosis of any of the mental disorders listed below? Check all that apply.

a <input type="checkbox"/> Schizophrenic Disorder b <input type="checkbox"/> Mood Disorder c <input type="checkbox"/> Delusional (Paranoid) Disorder d <input type="checkbox"/> Panic or Other Severe Anxiety Disorder	e <input type="checkbox"/> Somatoform Disorder f <input type="checkbox"/> Personality Disorder g <input type="checkbox"/> Other Psychotic Disorder h <input type="checkbox"/> Another Mental Disorder Other Than MR That May Lead to a Chronic Disability
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Describe: \_\_\_\_\_

Yes  No  (2) Within the past 2 years, DUE TO THE MENTAL DISORDER, has the individual:

(a) Utilized intensive psychiatric services more than once? Indicate the number of times the individual utilized each service over the last 2 years, e.g., 0, 1, 2, 7 times.

a  Ongoing case management from a MH agency? ("1" if continuously receiving over the last 2 years.)

b  Emergency mental health services?

c  Number of admissions to inpatient hospital settings for psychiatric reasons?

d  Number of admissions to partial hospitalization treatment programs for psychiatric reasons?

e  Number of admissions to Residential Care Facilities (RCFs) providing MH services or operated by a MH agency?

f  TOTAL SCORE *If total score equals 2 or more, answer YES to Question D (2). Regardless of score, answer Question D (2) (b)*

OR

(b) Had a disruption to his/her usual living arrangement, e.g., arrest, eviction, inter- or intra-facility transfer, locked seclusion?  Yes  No *If YES, answer YES to Question D (2).*

Yes  No  (3) Within the past 6 months, DUE TO THE MENTAL DISORDER, has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis? Check all that apply.

a <input type="checkbox"/> Maintaining Personal Hygiene b <input type="checkbox"/> Dressing Self c <input type="checkbox"/> Walking/Getting Around d <input type="checkbox"/> Maintaining Adequate Diet	e <input type="checkbox"/> Preparing/Obtaining Own Meals f <input type="checkbox"/> Maintaining Prescribed Medication Regimen g <input type="checkbox"/> Performing Household Chores h <input type="checkbox"/> Going Shopping	i <input type="checkbox"/> Using Available Transportation j <input type="checkbox"/> Managing Available Funds k <input type="checkbox"/> Securing Necessary Support Services l <input type="checkbox"/> Verbalizing Needs
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Yes  No  (4) Within the past 2 years, has the individual received SSI or SSDI due to a mental impairment?

**PASARR IDENTIFICATION SCREEN**

Applicant/Resident Name \_\_\_\_\_

**SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS (continued)**

Yes  No

(5) Does the individual have indications of serious mental illness?

*The individual has indications of serious mental illness if the individual received:*

- Yes to **AT LEAST 2** of Questions D (1) , D (2), or D (3) ; OR
- Yes to Question D (4).

**SECTION E: INDICATIONS OF MR OR RELATED CONDITION**

Yes  No

(1) Does the individual have a diagnosis of mental retardation (mild, moderate, severe, or profound as described in the "American Assoc. of Mental Retardation's Manual on Classification in Mental Retardation," 1989)?

Yes  No

(2) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR? *If YES, specify:* \_\_\_\_\_  
*If NO, go to question E (6).*

Yes  No

(3) Did the disability manifest symptoms before the individual's 22nd birthday?

Yes  No

(4) Is the disability likely to continue indefinitely?

Yes  No

(5) Did the disability result in functional limitations, prior to age 22, in 3 or more of the following major life activities? Check all that apply.

- |  |  |  |
|--|--|--|
| a <input type="checkbox"/> Self Care                 | d <input type="checkbox"/> Understanding and Use of Language | f <input type="checkbox"/> Learning                        |
| b <input type="checkbox"/> Mobility                  | e <input type="checkbox"/> Self Direction                    | g <input type="checkbox"/> Capacity for Independent Living |
| c <input type="checkbox"/> Economic Self Sufficiency |  |  |

Yes  No

(6) Does the person currently receive services from the County Board of MR/DD?

Yes  No

(7) Does the person have indications of MR or a related condition?

*The individual has indications of MR or a related condition if the individual received:*

- Yes to Question E (1); OR
- Yes to all of the following in this Section: Questions 2, 3, 4, AND 5; OR
- Yes to Question E (6).

**SECTION F: SUBMITTER INFORMATION/CERTIFICATION**

In order to process the screen, the submitter must provide his/her name and address and sign below. If the individual has indications of serious MI (YES to D (5)) and/or MR or a related condition (YES to E (7)), submitters must also complete Section G (page 3). If the individual has indications of neither, submitters do not have to complete Section G. The NF may not admit or retain individuals with indications of serious MI and/or MR or a related condition without further review by ODMH and/or ODMR/DD (OAC Rules 5101:3-3-151 and 5101:3-3-152).

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_

I understand that this screening information 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.

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Employer \_\_\_\_\_

Mo. - Day - Year

**NOTE:** Original of this screen must be placed on the resident's chart in the NF. The screen should accompany the resident in the event of transfer to another NF.

**SECTION G: MAILING ADDRESSES**

Complete this section **ONLY** if the individual has indications of serious MI, MR, or a related condition.

**(1) What address should be used for mailing results of the PASARR evaluation to the applicant/resident?**

In Care of/

Street Address

City

State

Zip

First 4 Letters of County of Residence

**(2) Please provide the following information about the individual's attending physician:**

Last Name

First Name

Street Address

City

State

Zip

Telephone No.

( )

**(3) If the individual has a legal representative, please provide the following information about the representative:**

Last Name

First Name

Street Address

City

State

Zip

Telephone No.

( )

**(4) If the individual is an applicant to or resident of a NF, please provide the name and address of the NF:**

Name of NF

Street Address

City

State

Zip

First 4 Letters of County

**(5) If the individual is being discharged from a hospital, and the submitter is not employed by the discharging hospital, please provide the name of a contact person and the name and address of the discharging hospital:**

Last Name

First Name

Discharging Hospital

Street Address

City

State

Zip

Telephone No.

( )