

**PASRR Evaluation**

<b>Section A</b>			
<b>Submitter Information</b>			
A0100. Name		<input type="text"/>	
A0200A. Street Address		<input type="text"/>	
A0200B. City		<input type="text"/>	
A0200C. State	<input type="text"/>	A0200D. ZIP Code	<input type="text"/>
A0300. NPI/API		<input type="text"/>	
A0400. Provider No.	<input type="text"/>	A0500. Vendor No.	<input type="text"/>
<b>Evaluation Information</b>			
A0600. Type of Evaluation(s)		<input type="text"/>	
		1. IDD only 2. MI only 3. IDD and MI	
<b>IDD Information</b>			
A0700. LA - IDD Provider No.	<input type="text"/>	A0800. IDD Vendor No.	<input type="text"/>
A0900. LA - IDD NPI/API	<input type="text"/>	A1000. Date of IDD Assessment	<input type="text"/>
A1100A. First Name	<input type="text"/>	A1100B. Middle Initial	<input type="text"/>
A1100C. Last Name	<input type="text"/>	A1100D. Suffix	<input type="text"/>
A1200. Evaluator Position/Title IDD Assessment		<input type="text"/>	
A1300A. Type of Credential for Evaluator - IDD Assessment		<input type="text"/> 1. Qualified Intellectual Disability Professional (QIDP) 2. Qualified Developmental Disability Professional (QDDP) 3. Registered Nurse (RN) 4. Licensed Clinical Social Worker (LCSW) 5. Licensed Professional Counselor (LPC) 6. Licensed Marriage and Family Therapist (LMFT) 7. Licensed Psychologist 8. Advanced Practice Nurse (APN) 9. Physician (MD or DO) 10. Other	
A1300B. Other Type of Credential for IDD Evaluator		<input type="text"/>	

<b>MI Information</b>			
A1400. LA - MI Provider No.	<input type="text"/>	A1500. LA - MI Vendor No.	<input type="text"/>
A1600. LA - MI NPI/API	<input type="text"/>	A1700. Date of MI Assessment	<input type="text"/>
A1800A. First Name	<input type="text"/>	A1800B. Middle Initial	<input type="text"/>
A1800C. Last Name	<input type="text"/>	A1800D. Suffix	<input type="text"/>
A1900. Evaluator Position/Title MI Assessment		<input type="text"/>	
A2000A. Type of Credential for Evaluator - MI Assessment		<input type="text"/> 1. Qualified Mental Health Professional (QMHP) 2. Registered Nurse (RN) 3. Licensed Clinical Social Worker (LCSW) 4. Licensed Professional Counselor (LPC) 5. Licensed Marriage and Family Therapist (LMFT) 6. Licensed Psychologist 7. Advanced Practice Nurse (APN) 8. Physician (MD or DO) 9. Other	
A2000B. Other Type of Credential for MI Evaluator		<input type="text"/>	
<b>Setting of Assessment</b>			
A2100. Type of Setting	<input type="text"/> 1. Acute Care 2. Psychiatric Hospital 3. Intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) 4. Own Home/Family Home 5. Nursing Facility 6. Other		
A2200. Other Type of Setting	<input type="text"/>		
A2300A. Name	<input type="text"/>		
A2300B. Street Address	<input type="text"/>		
A2300C. City	<input type="text"/>		
A2300D. State	<input type="text"/>	A2300E. ZIP Code	<input type="text"/>
A2300F. County	<input type="text"/>	A2300G. Phone Number	<input type="text"/>

Personal Information			
A2400A. First Name	<input type="text"/>	A2400B. Middle Initial	<input type="text"/>
A2400C. Last Name	<input type="text"/>	A2400D. Suffix	<input type="text"/>
A2500A. Social Security No.	<input type="text"/>	A2500B. Medicare No.	<input type="text"/>
A2600. Medicaid No.	<input type="text"/>	A2700. Birth Date	<input type="text"/>
A2800. Age at Time of Screening	<input type="text"/>	A2900. Gender	<input type="text"/>
A3000. Height (in inches)	<input type="text"/>	A3100. Weight (in pounds)	<input type="text"/>
Previous Residence			
A3200A. Previous Residence Type	<input type="text"/>	1. Private Home 2. ICF/IID 3. Waiver Setting 4. Nursing Facility 5. Other	
A3200B. Other Residence Type	<input type="text"/>		
A3200C. Street Address	<input type="text"/>		
A3200D. City	<input type="text"/>		
A3200E. State	<input type="text"/>	A3200F. ZIP Code	<input type="text"/>
A3200G. County of Residence	<input type="text"/>	A3200H. Did the individual live with others?	<input type="text"/> 0. No <input type="text"/> 1. Yes
Next of Kin			
A3300A. Relationship to Individual	<input type="text"/>	1. Legally Authorized Representative 2. Spouse 3. Child 4. Parent 5. Sibling 6. Other	
A3300B. Other Relationship to Individual	<input type="text"/>		
A3300C. First Name	<input type="text"/>	A3300D. Middle Initial	<input type="text"/>
A3300E. Last Name	<input type="text"/>	A3300F. Suffix	<input type="text"/>
A3300G. Phone Number	<input type="text"/>		

A3300H. Street Address	<input type="text"/>		
A3300I. City	<input type="text"/>		
A3300J. State	<input type="text"/>	A3300K. ZIP Code	<input type="text"/>
<b>A3400. Additional Contact Information - 1</b>			
A3400A. Relationship to Individual	<input type="text"/>		
	1. Spouse 2. Child 3. Parent 4. Sibling 5. Other		
A3400B. Other Relationship to Individual	<input type="text"/>		
A3400C. First Name	<input type="text"/>	A3400D. Middle Initial	<input type="text"/>
A3400E. Last Name	<input type="text"/>	A3400F. Suffix	<input type="text"/>
A3400G. Phone Number	<input type="text"/>		
A3400H. Street Address	<input type="text"/>		
A3400I. City	<input type="text"/>		
A3400J. State	<input type="text"/>	A3400K. ZIP Code	<input type="text"/>
<b>A3400. Additional Contact Information - 2</b>			
A3500A. Relationship to Individual	<input type="text"/>		
	1. Spouse 2. Child 3. Parent 4. Sibling 5. Other		
A3500B. Other Relationship to Individual	<input type="text"/>		
A3500C. First Name	<input type="text"/>	A3500D. Middle Initial	<input type="text"/>
A3500E. Last Name	<input type="text"/>	A3500F. Suffix	<input type="text"/>
A3500G. Phone Number	<input type="text"/>		
A3500H. Street Address	<input type="text"/>		
A3500I. City	<input type="text"/>		
A3500J. State	<input type="text"/>	A3500K. ZIP Code	<input type="text"/>

**Section B****TO BE COMPLETED FOR INDIVIDUALS SUSPECTED OF HAVING INTELLECTUAL DISABILITY OR DEVELOPMENT DISABILITIES**B0050. I am completing the IDD section **Determination for PASRR Eligibility (IDD)**B0100. To your knowledge, does the individual have an Intellectual Disability which manifested before the age of 18? (e.g. Mental Retardation)  0. No  
1. YesB0200. To your knowledge, does the individual have a Developmental Disability other than an Intellectual Disability that manifested before the age of 22? (e.g. autism, cerebral palsy, spina bifida)  0. No  
1. YesB0300. Has the individual experienced intervention by law enforcement, protective services agencies or other housing officials in the last two years? (i.e. evicted, arrested, charged or convicted of a crime)  0. No  
1. Yes  
2. Unknown

If Type of Assessment is IDD and MI and the answer to B0100 and B0200 is No, skip to Section C.

**Specialized Services Determination/Recommendations**

B0400. Does this individual need assistance in any of the following areas? Check all that apply:

B0400A. Self-monitoring of nutritional support B0400B. Self-monitoring and coordinating medical treatments B0400C. Self-help with ADLs such as toileting, grooming, dressing and eating B0400D. Sensorimotor development with ambulation, positioning, transferring, or hand eye coordination to the extent that a prosthetic, orthotic, corrective or mechanical support devices could improve independent functioning B0400E. Social development to include social/recreational activities or relationships with others B0400F. Academic/educational development, including functional learning skills B0400G. Expressing interests, emotions, making judgments, or making independent decisions B0400H. Independent living skills such as cleaning, shopping in the community, money management, laundry, accessibility within the community B0400I. Vocational development, including current vocational skills B0400J. Additional adaptive medical equipment or adaptive aids to improve independent functioning B0400K. Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal) B0400L. Other 

B0400M. Other areas

B0400N. None of the above apply





**Section C****TO BE COMPLETED FOR INDIVIDUALS SUSPECTED OF HAVING MENTAL ILLNESS**C0050. I am completing the MI section **Determination for PASRR Eligibility (MI)**

C0100. Primary Diagnosis of Dementia  
Does this individual have a PRIMARY diagnosis of Dementia?  0. No  
1. Yes  
2. Unknown

C0200. Severe Dementia Symptoms  
Are the individual's Dementia symptoms so severe that they cannot be expected to benefit from PASRR Specialized Services?  0. No  
1. Yes

**C0300. Mental Illness Check all that apply:**C0300A. Schizophrenia C0300B. Mood Disorder (Bipolar Disorder, Major Depression or other mood disorder) C0300C. Paranoid Disorder C0300D. Somatoform Disorder C0300E. Other Psychotic Disorder C0300F. Schizoaffective Disorder C0300G. Panic or Other Severe Anxiety Disorder C0300H. Personality Disorder C0300I. Any other disorder that may lead to a chronic disability diagnosable under the current DSM C0300J. None of the above apply **C0400. Functional Limitation Check all that apply:**C0400A. Appetite Disturbance C0400B. Sleep Disturbance C0400C. Personal Hygiene C0400D. Impaired Social Interaction C0400E. Threatening or Aggressive Behavior C0400F. Danger to Self or Others C0400G. Employment Difficulties C0400H. Housing Difficulties C0400I. Co-Occurring Substance Abuse C0400J. Criminal Justice Involvement C0400K. None of the above apply



**Recent Occurrences****C0500. Inpatient Psychiatric Treatment**

Has this individual experienced a psychiatric treatment more intensive than outpatient care more than once in the past 2 years?

0. No  
1. Yes  
2. Unknown

**C0600. Disruption to normal living situation**

Has this individual experienced a significant disruption to their normal living situation requiring supportive services (e.g. residential or respite services) in the last two years due to mental illness?

0. No  
1. Yes  
2. Unknown

**C0700. Intervention by law enforcement**

Has this individual experienced intervention by law enforcement, protective services agencies or other housing officials in the last two years due to mental illness? (i.e., evicted, arrested, charged or convicted of a crime)

0. No  
1. Yes  
2. Unknown

C0800. Based on the QMHP assessment, does this individual meet the PASRR definition of mental illness?

0. No  
1. Yes

**Specialized Services Determination/Recommendations****C0900. Does the individual need assistance in any of the following areas? Check all that apply**

C0900A. Self-monitoring of health status

C0900B. Self-administering of medical treatment

C0900C. Self-scheduling of medical treatment

C0900D. Self-monitoring of medications

C0900E. Self-monitoring of nutritional status

C0900F. Self-help with ADLs such as appropriate dressing and appropriate grooming

C0900G. Independent living such as supported housing

C0900H. Management of money

C0900I. Vocational development, including current vocational skills

C0900J. Psychological evaluation – for individuals who are suspected of having mental illness, but no diagnosis is available

C0900K. Discharge Planning – assessment, planning, facilitation of discharge (may only be delivered within 180 days or less, before planned discharge)

C0900L. Other

C0900M. Other Areas

C0900N. None of the above apply

**C1000. Recommended Services Provided/Coordinated by Local Authority**

	1. Group Skills Training
	2. Individual Skills Training
	3. Intensive Case Management (This service is also subject to the <180 day stay requirement)
	4. Medication Training & Support Services (Group)
	5. Medication Training & Support Services (Individual)
	6. Medication Training Group
	7. Medication Training Individual
	8. Psychiatric Diagnostic Interview Examination
	9. Psychosocial Rehabilitative Services (Group)
	10. Psychosocial Rehabilitative Services (Individual)
	11. Routine Case Management (This service is also subject to the <180 day stay requirement)
	12. Skills Training & Development (Group)
	13. Skills Training & Development (Individual)

**Section D**

**Nursing Facility Level of Care Assessment**

**Evaluation of History and Physical Information**

<b>D0100A. Physical/Mental Diagnosis Code</b>	<b>D0100B. Physical/Mental Diagnosis Description</b>	<b>D0100C. Date of Onset, if known</b>	<b>D0100D. Primary Diagnosis</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

**D0200. Medications - 1**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

<b>D0200D. Reason for antipsychotic</b>	<input type="text"/>
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**D0200. Medications - 2**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

<b>D0200D. Reason for antipsychotic</b>	<input type="text"/>
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D0200. Medications - 3		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		
D0200. Medications - 4		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		
D0200. Medications - 5		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

D0200. Medications - 6		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		
D0200. Medications - 7		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		
D0200. Medications - 8		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 9**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 10**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 11**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 12**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 13**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 14**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

D0200. Medications - 15		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
D0200D. Reason for antipsychotic	<input type="text"/>	

D0200. Medications - 16		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
D0200D. Reason for antipsychotic	<input type="text"/>	

D0200. Medications - 17		
D0200A. Current Medications	D0200B. Any known side effects for this individual	D0200C. Check if antipsychotic
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
D0200D. Reason for antipsychotic	<input type="text"/>	



**D0200. Medications - 18**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 19**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0200. Medications - 20**

<b>D0200A. Current Medications</b>	<b>D0200B. Any known side effects for this individual</b>	<b>D0200C. Check if antipsychotic</b>
		<input type="checkbox"/>
<b>D0200D. Reason for antipsychotic</b>		

**D0300. Medication Allergies**

<b>D0300. Medication Allergies</b>	
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D0400. Number of hospitalizations in the last 90 days	<input type="text"/>	Between 00-90
D0500. Number of emergency room visits in the last 90 days (include all emergency room visits)	<input type="text"/>	Between 00-90
D0600. Is this individual a danger to himself/herself?	<input type="text"/> 0. No 1. Yes	D0700. Is this individual a danger to others? <input type="text"/> 0. No 1. Yes
D0800. Is this individual known to demonstrate self-injurious behaviors?	<input type="text"/>	0. No 1. Yes
D0900. Does the NF supervision and structure mitigate danger to self or others?	<input type="text"/>	0. No 1. Yes 2. Unknown
D1000. Is there a physician certification that the individual is expected to live less than 6 months in the individual's chart?	<input type="text"/>	0. No 1. Yes
D1100. Is this individual on hospice?	<input type="text"/>	0. No 1. Yes
D1200. Does this individual require pacemaker monitoring?	<input type="text"/>	0. No 1. Yes 2. Unknown
D1300. Does this individual have an internal defibrillator?	<input type="text"/>	0. No 1. Yes 2. Unknown
D1400A. Does this individual have a tracheostomy?	<input type="text"/>	0. No 1. Yes
D1400B. If Yes, do they require care for their tracheostomy at least one time every day?	<input type="text"/>	0. No 1. Yes
D1500. Does this individual require a ventilator or respirator on a continuous basis to breathe?	<input type="text"/>	0. No 1. Yes
D1600. Does this individual require a ventilator or respirator to breathe at least one time every day?	<input type="text"/>	0. No 1. Yes
D1700A. Does this individual require Oxygen Therapy?	<input type="text"/> 0. No 1. Yes	
D1700B. If yes, how often?	<input type="text"/>	
	<ul style="list-style-type: none"> <li>1. Less than once a week</li> <li>2. 1 to 6 times a week</li> <li>3. Once a day</li> <li>4. Twice a day</li> <li>5. 3 - 11 times a day</li> <li>6. 6 - 23 hours</li> <li>7. 24-hour continuous</li> </ul>	
D1800. Does this individual have any Special Ports/Central Lines/PICC ?	<input type="text"/>	0. No 1. Yes 2. Unknown
D1900. Does this individual receive any treatments by injection?	<input type="text"/>	0. No 1. Yes 2. Unknown

D2000A. Does this individual have a pressure ulcer (bed sore or decubitus ulcer)?		<input type="text"/>	0. No 1. Yes 2. Unknown
D2000B. If Yes, is it staged as:	<input type="text"/>	D2000C. Number of Ulcers	<input type="text"/> Between 00-99
1. Stage 1 2. Stage 2 3. Stage 3 4. Stage 4 5. Unstageable 6. SDTI (suspected deep tissue injury)			
D2100A. Does this individual have any other ulcers, wounds, or skin issues?		<input type="text"/>	0. No 1. Yes 2. Unknown
D2100B. If Yes, is it staged as:	<input type="text"/>		
1. Stage 1 2. Stage 2 3. Stage 3 4. Stage 4 5. Unstageable 6. SDTI (suspected deep tissue injury)			
D2200. Is this individual in a coma (persistent vegetative state or no discernible consciousness)?		<input type="text"/>	0. No 1. Yes
D2300A. Does this individual experience memory loss?		<input type="text"/>	0. No 1. Yes
D2300B. If Yes, indicate the appropriate answer for type of memory loss:	<input type="text"/>		
1. Short Term 2. Long Term 3. Unspecified			
D2400A. Is this individual's developmental level normal for their chronological age?		<input type="text"/>	0. No 1. Yes
D2400B. If No, at what developmental level is the individual functioning?	<input type="text"/>		
1. < 1 Infant 2. 1 - 2 Toddler 3. 3 - 5 Pre-School 4. 6 - 10 School age 5. 11 - 15 Young Adolescence 6. 16 - 20 Older Adolescence 7. Unknown or unable to assess			
D2500A. Is the individual oriented to person?		<input type="text"/>	0. No 1. Yes 2. Unknown
D2500B. Is the individual oriented to place?		<input type="text"/>	0. No 1. Yes 2. Unknown
D2500C. Is the individual oriented to time?		<input type="text"/>	0. No 1. Yes 2. Unknown

<b>D2600. Is there any documentation that indicates that the individual has an appliance assisting with bladder or bowel function? Check all that apply:</b>	
D2600A. Indwelling catheter	<input type="checkbox"/>
D2600B. External catheter	<input type="checkbox"/>
D2600C. Ostomy	<input type="checkbox"/>
D2600D. Intermittent catheterization	<input type="checkbox"/>
D2600E. None of the above	<input type="checkbox"/>
D2600F. Unknown	<input type="checkbox"/>

Section E	
Evaluation of History and Physical Information	
E0100A. Enter the number of times this individual has fallen in the last 90 days.	<input type="text"/> Between 000-999
E0100B. In how many of the falls listed above was the individual physically restrained prior to the fall?	<input type="text"/> Between 000-999
E0100C. Environmental (e.g. debris, slick or wet floors, lighting)	<input type="text"/> Between 000-999
E0100D. Medication(s)	<input type="text"/> Between 000-999
E0100E. Major Change in Medical Condition (e.g. Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting))	<input type="text"/> Between 000-999
E0100F. Poor Balance/Weakness	<input type="text"/> Between 000-999
E0100G. Confusion/Disorientation	<input type="text"/> Between 000-999
E0100H. Assault by Resident or Staff	<input type="text"/> Between 000-999
E0200. Does this individual have a history of medication error, non-compliance with a self-medication regimen or drug seeking?	<input type="text"/> 0. No 1. Yes 2. Unknown
E0300. Which option best describes this individual's speech pattern?	<input type="text"/> 1. Clear speech - distinct intelligible words 2. Unclear speech - slurred or mumbled words 3. No speech - absence of spoken words
E0400. Which option best describes this individual's ability to express ideas and wants? Consider both verbal and non-verbal expressions	<input type="text"/> 1. Understood 2. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time 3. Sometimes understood - ability is limited to making concrete requests 4. Rarely/never understood
E0500. Which option best describes this individual's ability to understand others? Understanding verbal content, however able, with a hearing aid or device if applicable	<input type="text"/> 1. Understands - clear comprehension 2. Usually understands - misses some part/intent of message but comprehends most conversation 3. Sometimes understands - responds adequately to simple, direct communication only 4. Rarely/never understands

E0600. Does this individual have an impaired mental status?	<input type="text"/>	0. No 1. Yes 2. Unknown
E0700. Does this individual have a hearing impairment?	<input type="text"/>	0. No 1. Yes
E0800. Does this individual have a vision impairment?	<input type="text"/>	0. No 1. Yes
E0900. Does the individual typically reject attempts at evaluations and assistance that are necessary to achieve goals for health and well being?	<input type="text"/>	0. No 1. Yes 2. Unknown
E1000A. Is there an indication that the individual currently has issues with pain?	<input type="text"/>	0. No 1. Yes
E1000B. If Yes, how severe is the pain?	<input type="text"/>	1 – Mild 2 – Moderate 3 – Severe 4 – Very severe, horrible 5 – Unable to answer
E1000C. If Yes, what frequency is the pain occurring?	<input type="text"/>	1 – Almost constantly 2 – Frequently 3 – Occasionally 4 – Rarely 5 – Unable to answer
E1100. Does this individual require assistance with eating and drinking?	<input type="text"/>	0. No 1. Yes
E1200A. How does this individual eat?	<input type="text"/>	1. By mouth 2. By tube inserted in nose 3. By tube inserted into abdomen 4. By tube inserted into artery
E1200B. How much food is eaten by mouth?	<input type="text"/>	1. 75% or more 2. 50-74% 3. 49% or less
E1200C. Does this individual require a mechanically altered diet?	<input type="text"/>	0. No 1. Yes
E1200D. Is this individual on a therapeutic diet?	<input type="text"/>	0. No 1. Yes
E1300. Which option best describes the individual's functioning around urination?	<input type="text"/>	1. Always continent 2. Occasionally incontinent 3. Frequently incontinent 4. Always incontinent

**E1400. Activities of Daily Living (ADL)****Instructions for Rule of 3**

- \* When an activity occurs three times at any one given level, code that level.
- \* When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- \* When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full caregiver performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full caregiver performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

**1. ADL Self-Performance**

Code for individual's performance of ADL's - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

0. Independent - no help or staff oversight at any time

1. Supervision - oversight, encouragement or cueing

2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance

3. Extensive assistance - resident involved in activity, staff provide weight-bearing support

4. Total dependence - full staff performance every time during entire 7-day period

7. Activity occurred only once or twice - activity did occur but only once or twice

8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

**2. ADL Support Provided**

Code for most support provided; code regardless of individual's self performance classification

0. No setup or physical help from staff

1. Setup help only

2. One person physical assist

3. Two+ persons physical assist

8. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

<p>E1400A.1. Self Performance A. Bed mobility - how individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture</p>	
<p>E1400A.2. Support A. Bed mobility - how individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture</p>	
<p>E1400B.1. Self Performance B. Walk in room - how resident walks between locations in his/her room</p>	
<p>E1400B.2. Support B. Walk in room - how resident walks between locations in his/her room</p>	
<p>E1400C.1. Self Performance C. Walk in hallway - how individual walks in hallway</p>	
<p>E1400C.2. Support C. Walk in hallway - how individual walks in hallway</p>	
<p>E1400D.1. Self Performance D. Locomotion On Unit Or In Room - how individual moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair</p>	
<p>E1400D.2. Support D. Locomotion On Unit Or In Room - how individual moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair</p>	
<p>E1400E.1. Self Performance E. Locomotion Off Unit Or In Home - how resident moves to or returns from distant areas in his/her home (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how individual moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair</p>	
<p>E1400E.2. Support E. Locomotion Off Unit Or In Home - how resident moves to or returns from distant areas in his/her home (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how individual moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair</p>	
<p>E1400F.1. Self Performance F. Dressing - how individual puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses</p>	
<p>E1400F.2. Support F. Dressing - how individual puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses</p>	



<p>E1400G.1. Self Performance Eating - how individual eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).</p>	<input type="text"/>
<p>E1400G.2. Support Eating - how individual eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).</p>	<input type="text"/>
<p>E1400H.1. Self Performance Toilet use - how individual uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal or bedside commode, catheter bag or ostomy bag</p>	<input type="text"/>
<p>E1400H.2. Support Toilet use - how individual uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal or bedside commode, catheter bag or ostomy bag</p>	<input type="text"/>
<p>E1400I.1. Self Performance Medication management - level of assistance the individual needs to take prescribed medications</p>	<input type="text"/>
<p>E1400I.2. Support Medication management - level of assistance the individual needs to take prescribed medications</p>	<input type="text"/>
<p>E1400J.1. Self Performance Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)</p>	<input type="text"/>
<p>E1400J.2. Support Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)</p>	<input type="text"/>
<p>E1500A. Is placement in an NF appropriate for this individual at this time?</p>	<input type="text"/> 0. No <input type="text"/> 1. Yes
<p>E1500B. Explanation of findings to support that the individual meets or does not meet a nursing facility level of care. Include any additional information to support why this individual does or does not require the level of care provided in a Nursing Facility.</p>	<input type="text"/>

**Section F****Return to Community Living**

F0100. Did the individual or LAR participate in this assessment discussion?

0. No  
1. Yes**F0200. Information And Expectations**

F0200A. Has this individual received information regarding the services and support alternatives to the nursing facility admission (for Preadmission Screening) or continuation of the nursing facility stay (for Resident Review)?

0. No  
1. Yes

F0200B. Does this individual/LAR expect to return to live in the community either following a short term stay in the nursing facility or at some point in the future?

0. No  
1. Yes**F0300. Employment**

F0300A. Has this individual been employed in the past 12 months?

0. No  
1. Yes  
2. Unknown

F0300B. If Yes, what was the occupation?

**F0400. Did this individual receive community-based services? Check all that apply**

F0400A. Adult Foster Care

F0400B. Community Attendant Services

F0400C. Community Based Alternative Program (CBA)

F0400D. Community Living Assistance and Support Services (CLASS)

F0400E. Consumer Manages Personal Assistance Services (CMPAS)

F0400F. Day Activity and Health Services

F0400G. Deaf Blind with Multiple Disabilities (DBMD)

F0400H. Emergency Response Services

F0400I. Home and Community Based Services (HCS)

F0400J. In Home and Family Support Services

F0400K. Medically Dependent Children's Program (MDCP)

F0400L. Primary Home Care

F0400M. Psychological Rehabilitation

F0400N. STAR+Plus

F0400O. Substance Use Treatment Services

F0400P. Texas Home Living (TxHmL)		<input type="checkbox"/>
F0400Q. Youth Empowerment Services (YES) Waiver		<input type="checkbox"/>
F0400R. None of the above		<input type="checkbox"/>
F0400S. Unknown		<input type="checkbox"/>
F0400T. Other		<input type="checkbox"/>
F0400U. Other community-based services		
F0500. Would this individual like to live somewhere other than a Nursing Facility?	<input type="text"/>	0. No 1. Yes 2. Unknown
<b>F0600. Where would this individual like to live now? Check all that apply</b>		
F0600A. Live alone with support		<input type="checkbox"/>
F0600B. A place where there is 24 hour care		<input type="checkbox"/>
F0600C. A group home		<input type="checkbox"/>
F0600D. Family home		<input type="checkbox"/>
F0600E. Other		<input type="checkbox"/>
F0600F. Other Location		
F0600G. Unknown		<input type="checkbox"/>
<b>F0700. Community-based Program Check all that apply</b>		
F0700A. Is this individual interested in enrolling in a community-based program?	<input type="text"/>	0. No 1. Yes
F0700B. Adult Foster Care		<input type="checkbox"/>
F0700C. Community Attendant Services		<input type="checkbox"/>
F0700D. Community Based Alternative Program (CBA)		<input type="checkbox"/>
F0700E. Community Living Assistance and Support Services (CLASS)		<input type="checkbox"/>
F0700F. Consumer Manages Personal Assistance Services (CMPAS)		<input type="checkbox"/>

F0700G. Day Activity and Health Services	<input type="checkbox"/>
F0700H. Deaf Blind with Multiple Disabilities (DBMD)	<input type="checkbox"/>
F0700I. Emergency Response Services	<input type="checkbox"/>
F0700J. Home and Community Based Services (HCS)	<input type="checkbox"/>
F0700K. In Home and Family Support Services	<input type="checkbox"/>
F0700L. Medically Dependent Children's Program (MDCP)	<input type="checkbox"/>
F0700M. Primary Home Care	<input type="checkbox"/>
F0700N. Psychological Rehabilitation	<input type="checkbox"/>
F0700O. STAR+Plus	<input type="checkbox"/>
F0700P. Substance Use Treatment Services	<input type="checkbox"/>
F0700Q. Texas Home Living (TxHmL)	<input type="checkbox"/>
F0700R. Youth Empowerment Services (YES) Waiver	<input type="checkbox"/>
F0700S. None of the above	<input type="checkbox"/>
F0700T. Unknown	<input type="checkbox"/>
F0700U. Other	<input type="checkbox"/>
F0700V. Other community-based services	<input type="checkbox"/>
<b>F0800. What challenges or barriers has the individual indicated that could impede the opportunity to return to return to the community? Check all that apply</b>	
F0800A. Care needs are likely greater than support available in community	<input type="checkbox"/>
F0800B. Accessible housing limited	<input type="checkbox"/>
F0800C. Limited or no family/friend support available	<input type="checkbox"/>
F0800D. Limited income to support community living	<input type="checkbox"/>
F0800E. Guardian/family likely not to support community living	<input type="checkbox"/>
F0800F. Interest list slot not available at this time	<input type="checkbox"/>

F0800G. Lost house during NF stay		<input type="checkbox"/>
F0800H. Affordable housing limited		<input type="checkbox"/>
F0800I. Other		<input type="checkbox"/>
F0800J. Other challenges/ barriers		
F0800K. No challenges/barriers		<input type="checkbox"/>
F0800L. Describe the individual's strengths, available supports, and barriers to living in the community		
<b>F0900. This individual's needs can be met in: Check all that apply</b>		
F0900A. An appropriate community setting		<input type="checkbox"/>
F0900B. List settings and supports required to enable community placement in the space below		
F0900C. In an institutional setting		<input type="checkbox"/>
F0900D. NF		<input type="checkbox"/>
F0900E. ICF/IID		<input type="checkbox"/>
F0900F. Other		<input type="checkbox"/>
F0900G. Other Location		

**F1000. Referrals**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>1. Adult Foster Care</li> <li>2. Community Attendant Services</li> <li>3. Community Based Alternative Program (CBA)</li> <li>4. Community Living Assistance and Support Services (CLASS)</li> <li>5. Consumer Manages Personal Assistance Services (CMPAS)</li> <li>6. Day Activity and Health Services (DAHS)</li> <li>7. Deaf Blind with Multiple Disabilities (DBMD)</li> <li>8. Emergency Response Services</li> <li>9. Home and Community Based Services (HCS)</li> </ul> | <ul style="list-style-type: none"> <li>10. In Home and Family Support Services</li> <li>11. Medically Dependent Children’s Program (MDCP)</li> <li>12. Primary Home Care</li> <li>13. Psychological Rehabilitation</li> <li>14. Star Plus</li> <li>15. Substance Use Treatment Services</li> <li>16. Texas Home Living (TxHmL)</li> <li>17. Youth Empowerment Services (YES) Waiver</li> <li>18. None of the above</li> <li>19. Other</li> </ul> |
|---|--|

**F1000. Referrals - 1**

<b>F1000A. Program</b>	<b>F1000B. Other Program</b>	<b>F1000C. Phone Number</b>	<b>F1000D. Date of Referral</b>
<b>F1000E. Referral Comments</b>			

**F1000. Referrals - 2**

<b>F1000A. Program</b>	<b>F1000B. Other Program</b>	<b>F1000C. Phone Number</b>	<b>F1000D. Date of Referral</b>
<b>F1000E. Referral Comments</b>			

**F1000. Referrals - 3**

<b>F1000A. Program</b>	<b>F1000B. Other Program</b>	<b>F1000C. Phone Number</b>	<b>F1000D. Date of Referral</b>
<b>F1000E. Referral Comments</b>			

<b>F1000. Referrals - 4</b>			
<b>F1000A. Program</b>	<b>F1000B. Other Program</b>	<b>F1000C. Phone Number</b>	<b>F1000D. Date of Referral</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>F1000E. Referral Comments</b>	<input type="text"/>		

<b>F1000. Referrals - 5</b>			
<b>F1000A. Program</b>	<b>F1000B. Other Program</b>	<b>F1000C. Phone Number</b>	<b>F1000D. Date of Referral</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>F1000E. Referral Comments</b>	<input type="text"/>		

Authorization (System Use Only - Do Not Complete)		
H0100A. PTID <input type="text"/>	H0100B. Status <input type="text"/> Coach Pending More Info Coach Review Invalid/Complete LA Action Required PCS Processed/Complete Pending More Info Processed/Complete SAS Request Pending Submit to SAS Submitted to PCS	H0100C. Action <input type="text"/> Coach Pending More Info Coach Review Invalid/Complete LA Action Required PCS Processed/Complete Pending More Info Processed/Complete Submitted to PCS Submit to SAS
H0200A. PTID <input type="text"/>	H0200B. Status <input type="text"/> Coach Pending More Info Coach Review Invalid/Complete LA Action Required PCS Processed/Complete Pending More Info Processed/Complete SAS Request Pending Submitted to PCS Submit to SAS	H0200C. Action <input type="text"/> Coach Pending More Info Coach Review Invalid/Complete LA Action Required PCS Processed/Complete Pending More Info Processed/Complete Submitted to PCS Submit to SAS