Vernon Manor Children's Home

Admission Requirements

- ☐ CXR (chest x-ray) within the last 6 months.
- ☐ Mantoux within the last 3 months or the day of admission by VMCH staff.
- ☐ Current H & P (history and physical). (Our Form)
- ☐ Most current Immunization record.
- ☐ List of current medications and how to administer, diet and/or feeding tube orders from Dr's Office.
- ☐ Face Sheet (if coming from Hospital).
- ☐ Physicians Progress Report (if coming from Hospital).
- ☐ Copy of dental exam to have been completed no more than 30 days prior to admission (for 18 years of age and older.
- ☐ Copy of Birth Certificate.
- ☐ Copy of legal documents pertaining to custody, guardianship, advanced directives, etc.
- ☐ Copy of Medicaid/Medicare card, private insurance, Social Security card, etc.
- ☐ Copy of most recent labs, psychological tests, developmental assessments, clinic reports, discharge summaries from hospital, social history, anything that assists in the continuity of car.
- ☐ Information on SSD or SSI, child support, amounts if applicable.
- ☐ Level I.
- ☐ Level II.
- ☐ Physician Certification / 450 B.
- ☐ Application for Long Term Care Services.
- ☐ Follow-up appointments, labs, etc.

____

____

____

____

- ☐ Misc. Needs

____

____

____

____

Thank you for assisting us in keeping in compliance with state and federal guidelines and for the assured continuity of care for your family member.

ADMISSION MEDICAL HISTORY & PHYSICAL

Portion B is the responsibility of the physician per State Board of Health Regulations
Portion A may be completed by a Nurse

A

To be admitted from:
_____ Home
_____ Hospital
_____ Nursing Home (specify)

Resident Name (Please Print):

Birth Date:

Hospital/Nursing Home Admission date:
(if admitted from another facility)

Sex:

Physician:

Eating:
_____ Self
_____ Assist
_____ Fed
_____ Other

Behavior:

Elimination:
_____ Continent
_____ Incontinent
_____ Urine
_____ Bowel
_____ Catheter
_____ Colostomy
_____ Other

Mobility:
_____ Self
_____ Assist
_____ Bed Rest
_____ Transfer Assist
_____ Restraints Required (List Below)
_____ Wheelchair
_____ Cane
_____ Walker

B/P:	Temp:	Pulse:	Respiration:	Weight:	Height:

Chest X-ray (within past 6 months required by ISDH)
Date:
Results:

Where done:

Mantoux (within past 3 months with STU PPD read at 72 hours:
Date given: ____________________ Site: ____________________
Size of bleb: ____________ mm Given by: _______________________
Date read: ____________________ Result: ____________ mm
Read by: _______________________

Signature of Nurse completing the above section: Facility of affiliation:

B - MUST BE COMPLETED BY A PHYSICIAN

Physical exam:	Normal	Abnormal
1. Gen. Appearance		
2. Skin		
3. Nodes		
4. Head & Neck		
5. Eyes		
6. Throat		
7. Ears		
8. Nose		
9. Chest		
10. Lungs		
11. Heart		
12. Abdomen		
13. Extremities		
14. Pulses		
15. Neurological		
16. Galt		
17. Grasp		
18. Genitalia		
19. Recent Papa		
Oral Exam		
1. Gums		
2. Teeth		
3. Tongue		

Diagnosis: (include date of onset)

Describe Abnormalities Checked on Physical Exam:

Medical History: (include surgeries & immunization records)

Medications, Therapy & Activity:

Diet: Allergies:

This patient is Certifiable as:
_____ Skilled
_____ Intermediate
_____ Residential

Has this patient been informed of his/her condition?
_____ Yes _____ No
If no, please explain:

Rehabilitation Potential
_____ Good
_____ Fair

Is this patient free from all communicable diseases including T.B. in an infectious stage?

_____ Yes _____ No

Signature of Physician completing the above section: **Facility of affiliation:**

PRE-ADMISSION DENTAL EXAM

If exam has been done during past year, a copy will suffice.

Patient: ______________________________ Date: ______________

Diagnosis: ____

Note any special technique, position and/or equipment needed:

Dental Exam
Dental Treatment Plan
Dental Diagnosis

Dentist Printed Name Dentist Signature Date

Indiana's Pre-Admission Screening IPAS Program

Indian's Nursing Facility PreAdmision Screening (IPAS) program can help you evaluate your situation and provie information on possible alternatives to admission to a nursing facility (NF). Indiana's Pre-Admission Screening (PAS) started in 1983. It's primary purpose is to assure that, before an individual is placed in a Nursing Facility (NF), alternatives (in-home and community services) have been explored.

The State Legislature was concerned about rising Medicaid costs for NF care and the increasing number of elderly people. The IPAS program monitors NF admissions to insure that placements are appropriate. Individuals are helped to stay at home by finding and assisting them to access in-home and community services that are necessary to avoid or delay NF placement. Nursing facility beds are then available for those who need them most.

What Is Pre-Admission Screening (PAS)?

IPAS is a process which consists of an application, a comprehensive assessment of needs, a plan of care, and a finding or decision concerning the most appropriate placement for an individual made by professionals familiar with the needs of individuals seeking admission to nursing facilities.

Do I Have To Participate In IPAS?

By state law, ALL persons, regardless of income or resources, must participate in IPAS to be admitted to a NF in Indiana. You may choose to agree or refuse to participate. However, if you refuse and are admitted to a NF, you will incur a penalty of non-payment by Medicaid of per diem costs for up to one (1) year.

NOTE : It is the responsibility of every NF in Indiana to inform each individual seeking admission that there is an IPAS program, what it is, and the penalty for non-participation.

How Do I Apply For IPAS?

Application is usually made through the NF to which you are seeking admission. It may also be made at a hospital in which you are a patient or at your local Area Agency on Aging.

The NF must assure that the IPAS application is immediately sent to the IPAS agency. A NF which admits an individual without following IPAS program requirements commits a Class A infraction. Federal law also requires the NF to provide answers to a series of questions call a Level 1 screen. The answers to these questions will indicate whether a specialized assessment (Level II) should be done to identify additional services your may need for a condition of mental illness or developmental disability.

How Long Does The IPAS Decision Take?

The time limit for the IPAS process varies according to the situation. It should be completed within the following time frames:

- At home: As soon as possible, but no later than 25 days
- In the nursing facility: Within the time limits specified under the designee authorization for admission
- Emergency / APS: Within 25 days from the date of admission
- Short-Term (30-Day): If discharged within the 30-day limit, no assessment is completed. If longer stay is needed, complete assessment within an additional 25 days

APPLICATION FOR LONG-TERM CARE SERVICES

State Form 45943 (R9 / 7-06) / BAIS 0018

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

*THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Application is for (*check one*):
☐ Indiana's PreAdmission Screening (IPAS) / PreAdmission Screening and Resident Review (PASRR) ☐ In-Home Services

Initialed by

If In-Home Services, check all that apply: ☐ A & D Waiver ☐ C.H.O.I.C.E. ☐ Autism Waiver ☐ S.S.B.G. ☐ MFC Waiver ☐ Title III In-Home Services ☐ Support Services Waiver ☐ AL Waiver ☐ TBI Waiver ☐ AFC Waiver ☐ DD Waiver

SECTION I - To be completed by the applicant, guardian, or responsible person.

Name of applicant | Telephone number ( ) | Social Security number *

Home address (*number and street, apartment number, R.R. number, city, state, and ZIP code*)

State of residence prior to NF placement
☐ Indiana ☐ Other ______________________

Reason why out-of-state resident is requesting admission to an Indiana nursing facility
☐ No bed available in home state
☐ Family is moving to or resides in Indiana, etc.
☐ Other ______________________

Date of birth (*month, day, year*) | Sex ☐ Male ☐ Female | Age

Medicaid status (*check all that apply*) State: ______________
☐ a. Medicaid applicant county number: ______________
☐ b. Medicaid recipient number: ______________
☐ c. Will apply for Medicaid ☐ At admission or within ☐ 30 ☐ 60 ☐ 90 ☐ 120 days
☐ d. Non-Medicaid / Private-pay for at least 6 months after admission
☐ e. Medicaid Waiver Services recipient ☐ Yes ☐ No
☐ f. Medicaid MCO Enrollee ☐ Medicaid effective date: __________

Marital status:
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Applicant's location at time of application:
☐ a. Home ☐ b. Hospital (☐ In-state ☐ Out-of-state) ☐ c. CMHC ☐ d. Nursing Facility
☐ e. Other ______________________
Address: ______________________

Name of relative or contact person / address (*number and street, city, state, and ZIP code*) | Telephone number ( )

Name of physician / address (*number and street, city, state, and ZIP code*) | Telephone number ( )

PREADMISSION SCREENING NOTIFICATION

Every person applying for admission to a nursing facility in Indiana must be assessed by the PreAdmission Screening Program (PAS) to determine the person's need for care in a nursing facility. Failure to participate in the PreAdmission Screening Program will result in the applicant's ineligibility for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission. **NOTE: See IPAS Information Sheet for program details.**

☐ **I AGREE** to participate in the PreAdmission Screening Program to determine my need for care in a nursing facility and/or home and community-based services.

I AUTHORIZE THE RELEASE OF INFORMATION to and among state agencies and their agents on my medical condition and other relevant information necessary to determine appropriate long-term care services and/or In-Home Services, by my physician, hospital, nursing facility, Community Mental Health Center, Division of Mental Health and Addiction, Office of Family Resources, other social service or health services providers, and family members. I understand I may revoke this release of information in writing at any time.

☐ **I DO NOT AGREE** to participate in the PreAdmission Screening Program and I understand that I will not be eligible for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission.

Signature of applicant or responsible person | Date (*month, day, year*) | Time

If signature is by a responsible person, what is the relationship to the applicant?

Signature of witness (*Required if the signature is by an "X"*) | Date (*month, day, year*)

SECTION II - Temporary Admission Authorization - To be completed by PAS agency designee or discharge planner designee.

I authorize temporary admission to the nursing facility named on this application for a period of time from the date of admission to the nursing facility, as designated below. **NOTE - This authorization does not apply to PASRR Level II cases; see PASRR forms (State Form 45932 and 45277).**

Type of admission: (*Check box*)
☐ Direct from hospital (*M.D. ETR + 25 up to 120*)
☐ Emergency/APS (*25 days*)
☐ 30 Day Short Term (*30 days*)
☐ Continuing care retirement community (*30 days - extend 25 up to 55*)
☐ PASRR (*State Form 45932 or Level I required*)

Hospital Discharge Planner Designee: (*Check all that apply.*)
☐ Medicaid MCO Enrollee and NF placement for: ☐ Short-Term ☐ Long-Term
☐ I certify that this patient is a nonresident admitted to acute hospital care after treatment in the emergency room.
☐ I certify that the applicant has been given a list of long term care options that may be available to the applicant, located within the hospital's service area, and are known to the hospital. (IC 10-12-10-28.5)

Period of care authorized: Start date (*month, day, year*) ______________ Stop date (*month, day, year*) ______________

Signature of (*circle one*) IPAS agency or Discharge Planner Designee (*for direct from in state acute care only*) | Date (*month, day, year*)

Affiliation | Telephone number ( ) | FAX number ( )

Name of nursing facility / address (*number and street, city, state, and ZIP code*)

DISTRIBUTION: ☐ Original - IPAS Agency ☐ Applicant ☐ Nursing Facility File ☐ CMHC ☐ BDDS ☐ OMPP ☐ State PASRR unit

SECTION III - Estimated Nursing Facility Cost - To be completed by the nursing facility.		
Name of nursing facility / address (*number and street, city, state, and ZIP code*)		
Name of applicant		
Per 460 IAC 1-1-8(e), the nursing facility must provide to the IPAS agency an estimate of the cost of all services that the applicant is anticipated to require.		
State level of NF services needed		
Estimated NF cost for NF services at the rate charged to private payers $		
Information provided by	Telephone number ( )	FAX number ( )

PHYSICIAN CERTIFICATION FOR LONG-TERM CARE SERVICES

State Form 38143 (R5 / 6-93) Form 450B / PASARR2A

Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE
- ☐ Initial Assessment
- ☐ Re-Screening
- ☐ ARR

MEDICAID STATUS
- ☐ Medicaid Pending
- ☐ Medicaid Recipient
- ☐ Non-Medicaid

Name of contact

Upon completion return to: ☐ Area PAS agency ☐ IFSSA ☐ Integrated Field Services Case Manager ☐ Other ________________

I - RECIPIENT IDENTIFICATION

Name of applicant *(last, first, middle)*	Date of birth *(mo., day, yr.)*	Sex	Name of county
Name of nursing facility or ICF / MR	Facility admission date *(mo., day, yr.)*		Medicaid number
Address of facility *(street and number)*	Re-admission date from hospital		Level of care transfer date
City, state and ZIP code	Requested length of care ☐ Short-term ☐ Long-term		Facility provider number(s) "I". "S".

Admitted from:
- ☐ a. Acute Hospital
- ☐ b. Psychiatric Bed
- ☐ c.Home
- ☐ d. Nursing Facility ________________________________
- ☐ e. ICF/MR
- ☐ f. Out-of-state ________________________________
- ☐ g. Other ________________________________

II - PHYSICIAN'S MEDICAL EVALUATION

Federal and state regulations require a physician's medical evaluation, plan of treatment and explicit recommendation for care prior to admission or continued care in a nursing facility, the C.H.O.I.C.E. program, or the Medicaid Home and Community-Based Waiver program.

Patient Evaluation *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Ambulatory	☐ Contractures	☐ Colostomy / Ileostomy	☐ Self Fed
☐ Wheelchair	☐ Incontinent *(bladder)*	☐ Other Ostomy	☐ I.V. Fluids / Nutrition *
☐ Cane or Walker	☐ Incontinent *(bowel)*	☐ Aphasic	☐ Tube Fed - Type ____________
☐ Bedfast	☐ Catheter ________________	☐ Agitated / Combative	☐ Decubiti *(size, stage, treatment)* *
☐ Ventilator Dependent	☐ Tracheotomy	☐ Confused / Disoriented	☐ Other *______________________

Primary diagnosis *(include dates)*	Secondary / tertiary diagnosis *(include dates)*

Patient's overall prognosis

Plan and Treatment *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Medications *(describe below)*	☐ Regular Diet	☐ Minimum Nursing Intervention	☐ Independent with ADLs
☐ *Restorative Services* *	☐ Other (specify ______________	☐ Moderate Nursing Intervention *	☐ Assisted with ADLs
☐ *Sterile Dressing* *	☐ ________________________	☐ Intensive Nursing Intervention *	☐ Dependent for all ADLs

Medications *(dosage and frequency)*

Clinical summary *(attach additional information as necessary)*

LEVEL OF CARE PHYSICIAN CERTIFICATION

Complete for all Applications	Complete for Home Care *(if applicable)*
Level of care recommended ☐ Skilled ☐ Intermediate ☐ ICF/MR - Large/Small ☐ Other *(specify)* ________________________	☐ Medicaid Home and Community Based Waiver service ☐ C.H.O.I.C.E.

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of physician *(stamps are NOT acceptable)*	Date signed *(month, day, year)*	Typed or printed name of physician

III - STATE DEPARTMENT AUTHORIZATION

This certification is for: ☐ Admission ☐ Transfer ☐ Continued Care		Comments
☐ Approved ☐ Disapproved	Effective Medicaid reimbursement date	

Authorized signature ☐ IFSSA ☐ Area PAS agency	Date signed *(month, day, year)*

INSTRUCTIONS

Physician's Certification for Long-Term Care Services

1. Form 450B is used for both Medicaid and private-pay applicants for long-term care services and C.H.O.I.C.E. eligibility. Do not use for non-Medicaid/private pay individuals being readmitted from hospitalizations or being transferred to another facility.

2. Form 450B shall be completed for persons making application for long-term care services.

3. The recipient's or patient's physician shall complete Section II, PHYSICIAN'S MEDICAL EVALUATION, including the patient's evaluation, plan of treatment, specify a level of care, sign, date and return the original to the appropriate agency as designated below.

Pre-Admission Screening	Local PAS Agency
C.H.O.I.C.E.	Local Area Agency on Aging
ICF / MR	Integrated Field Services Case Manager
Facility Transfers	State Office of Medicaid Policy and Planning
Medicaid Waiver Application	Local Area Agency on Aging
Medicaid Waiver Redetermination	Waiver Case Manager

4. Form 450B will be sent to the State Office of Medicaid Policy and Planning for final review and determination.

   For C.H.O.I.C.E. applicants / clients and private pay applicants for long-term care, Form 450B will be sent to the Area Agency on Aging for final review and determination.

5. The decision on admission, as well as the level of care *(as applicable),* will be entered in Section III and will be sent to the County Division of Family and Children, to the nursing facility and the PAS agency as appropriate.

6. For ICF / MR applicants, Section VI must also be completed and submitted for level of care determinations.

   For PAS ARR/ MR applicants / residents requiring a Level II assessment, Section VI must also be completed and submitted for level of care determinations.

Appeal Rights / How to Request an Appeal

If you are not satisified with this decision, you may request an appeal within 30 days of the date of receipt of this decision. Send a letter with your signature to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, 402 W. Washington St., Rm. W392, Indianapolis, Indiana 46204. (470 IAC 1-4 *et. seq*.) Be sure that the letter contains your address and a telephone number where you can be reached. It is also helpful if you attach a copy of this decision or state the nature of the action you are appealing. If you are unable to write this letter yourself, you may have someone assist you in requesting this appeal.

You will be notified in writing by the Division of Family and Children of the date, time and place for the hearing. Prior to, or at the hearing, you will have the right to examine the entire contents of your case record. You may represent yourself at the hearing or authorize a representative such as an attorney or other spokesperson to do so. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question or refute any testimony or evidence presented.

C.H.O.I.C.E. PROGRAM APPLICANTS / CLIENTS: If you are not satisified with the decision on your C.H.O.I.C.E. case, you should discuss this matter with staff at your Local Area Agency on Aging.

DISCLOSURE STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of public assistance and/or services administered by the State of Indiana. Disclosure of the information requested is mandatory pursuant to the provision of IC 12-15-2 *et. seq.* (Medicaid Programs); IC 12-10-10 *et. seq.* (C.H.O.I.C.E. Program); and IC 12-21 (Division of Mental Health). Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance or services to you. All personal information collected on this form will be treated as confidential pursuant to Regulation 470 IAC 1-3-1.

CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES AND PHYSICAL EXAMINATION FOR PASARR LEVEL II

State Form 45278 (2-92) / Form 450B/PASARR2A - Section VI

This form is **CONFIDENTIAL** according to IC 12-1-7 *et esq.*, IC 4-28-6.1,IC 16-4-1.6-8, 470 IAC 1-3-1.

INSTRUCTIONS: This form must be completed for long-term care services for individuals with mental retardation; developmental disability or related condition.

Name of applicant / resident	Name of facility / city

VITALS

Weight	Height	Pulse	Blood pressure	Temperature

HEAD	EYES (*Include Fundi*)			EARS			
	(*Complete if individual is visually impaired.*)			(*Complete if the individual is hearing impaired.*)			
	DISTANT VISION	R	L	HEARING (*Air Conduction*)			
	Uncorrected	/20	/20	CPS 500 1000 1500 2000 4000 6000			Weber Test R
	Corrected	/20	/20	R		L	Renne Test L

PHYSICAL EXAM	N	AB	Describe abnormalities checked on physical:
1. Nose			
2. Throat			
3. Mouth / Teeth			
4. Speech / Language			
5. Neck			
6. Lymphatic system			
7. Chest			
8. Breasts			
9. Lungs			
10. Cardio Vascular			
11. Abdomen			
12. Genitalia			
13. Orthopedic			
14. Neurological			
15. Skin			
FEMALE			
16. Pelvic			
17. Rectal			
18. Bimanual exam			
MALE			
19. Rectal			
20. Prostate			

DISPOSITION AND RECOMMENDATION

Referral or special examinations required?

☐ No ☐ Yes (*if "Yes", specify*)

Medical rehabilitation potential: ☐ Good ☐ Fair ☐ Poor	Type of facility recommended:

Signature of physician	Typed/Printed name of physician	Date

PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES

State Form 45277 (R2 / 7-02) / Form 450B/PASRR2A - Sections IV and V, Part A

This form is **CONFIDENTIAL** according to IC12-15-2 *et seq.*, IC 12-10-10 *et.seq.,* IC 12-21 and 470 IAC 1-3-1.

This form **MUST** be completed for **ALL** persons prior to nursing facility admission in accordance with 42 CFR 483.106. All of the following questions must be answered as indicated.

Name of applicant / resident	Name of facility / city

Current location of applicant ☐ Residential ☐ Home ☐ Nursing facility ☐ Psychiatric bed ☐ Acute hospital ☐ Other:

Please check any of the following that applies to the applicant / resident:

☐ New admission ☐ Readmission to NF from psychiatric hospital stay ☐ Transfer between NF's ☐ Out-of-state resident
☐ Transfer from residential to NF ☐ Other: ______________________________

SECTION IV

Question	Answer
1. Does the individual have a documentable diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) based on criteria in DSM-IV, without a concurrent primary diagnosis of a major mental illness or a diagnosis of mental retardation or developmental disability?	☐ Yes ☐ No
2. Does the individual have a diagnosis of major mental illness *[limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability]?*	☐ Yes ☐ No
3. a. Does the person have a diagnosis of mental illness not listed above? List diagnosis:	☐ Yes ☐ No
b. Has the individual been prescribed *(within the past 1 year)* a major tranquilizer or psychoactive drug on a regular basis for a mental health condition? *(If given for another purpose, explain by listing the name of the drug and the purpose of the prescription; for example, Mellaril for dementia. When explained and documented in the individual's medical record, check "No".)* ** A Yes answer to 3a and / or 3b DOES NOT ALONE trigger a Level II.*	☐ Yes ☐ No
4. Has the person had any recent (*within the last two years*) history of in patient / partial hospitalization care? Explain:	☐ Yes ☐ No
5. Does the individual have a diagnosis of mental retardation, developmental disability (*MR / DD*) or other related condition?	☐ Yes ☐ No
6. Is there any history of a MR / DD or related condition in the individual's past?	☐ Yes ☐ No
7. Is there any presenting evidence (*cognitive or behavior characteristics*) that may indicate the person has MR / DD or related condition? (*Explain*)	☐ Yes ☐ No

Signature of authorized assessor	Title / Position	Date signed

SECTION V - PART A

PASRR Determination Criteria - Level II Exemption: See back of form for explanation. *(Exemption **MUST** be certified by a physician's signature.)*

NOTE: Exemption applies only to initial nursing facility admission, not to RR or transfers.

EXEMPTED HOSPITAL DISCHARGE: An individual may be admitted to a nursing facility directly from a hospital after receiving acute inpatient care *(non-psychiatric)* at the hospital if: (1) the individual requires nursing facility services for the condition for which he/she received care in the hospital; and (2) the attending physician certifies before the admission that the individual is likely to require less than 30 days nursing facility care.

In accordance with the requirements above, I certify that this individual requires less than 30 days of care in a nursing facility.

Signature of physician	Printed name of physician	Date signed
If applicable, hospital or other affiliation:	City	

NOTE: If the individual requires care beyond the initial 30 day period, the nursing facility must notify the PAS agency prior to the expiration of 30 days and provide a written explanation of the reason continued residence is required and the anticipated length of stay. Admission under the above exemption does not exempt the nursing facility from providing services to an individual who has mental health or MR/DD or related needs and would benefit from services. Refer to II B on back for complete instructions

CERTIFICATION OF LEVEL II REFERRAL

PASARR LEVEL II ASSESSMENT REFERRAL NEEDED	PAS: ☐ Yes ☐ No	
Signature of PAS agency respresentative	Title / Position	Date signed

INSTRUCTIONS

I. SECTION IV: PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA

Answer **all** questions as indicated.

A. "No" answer to **all** questions, stop here and return to local PAS agency. *[If temporary placement under PAS is authorized by 1. the hospital Discharge Planner (for individuals who are not MI and/or MR/DD), or 2. the physician under the "Exempted Hospital Discharge" this form must accompany the applicant to the nursing facility.]*

B. If question 1 is answered "Yes" and there is also a "Yes" answer to any of questions 2 through 4, the nursing facility **MUST** have adequate documentation of the dementia diagnosis. The PASRR / MI Level II Mental Health Assessment will **NOT** be done. The dementia documentation must be maintained in the active resident record and readily available for federal and state audit. (*NOTE: Level II is always required if there is a concurrent diagnosis of a major mental illness specified in Question 2 of the Level I.)*

C. Questions 3b: When an adequate explanation is provided to document that the medication is given for a non-mental illness problem *(Question 2)* or the serious behavioral problems are due to a non-mental illness or excluded condition *(dementia),* "No" should be checked for that question. If there is no explanation of the medication use or serious behavioral problem, the question should be checked "Yes". For example, the explanation might read: "Haldol for sleep problems", "Mellaril for dementia", etc. ** A Yes answer to question 3a and / or 3b DOES NOT ALONE trigger a Level II.*

D. Questions 5 - 7: When any question 5 - 7 is answered "Yes", Form 450B - Section VI - "Physical Examination" must be completed. Send with PASRR Level I to the local PAS agency.

II. SECTION V, Part A: PASRR DETERMINATION CRITERIA - LEVEL II EXEMPTION

A. Complete Section V only when question 1 is answered "No" and there is a "Yes" answer to any question 2 through 7.

B. The "Exempted Hospital Discharge" allows only temporary nursing facility admission of less than 30 days without Level II Assessment immediately following a non-psychiatric acute hospital inpatient stay. If the person does not convalesce and requires longer temporary placement, the nursing facility must contact the PAS agency as soon as possible but no later than 30 days following admission for completion of the PASRR Level II Assessment process. At that time the nursing facility must provide to the PAS agency documentation explaining the reason for the request for approval of extended placement. The PASRR Level II Assessment must be received by the nursing facility no later than the 40th day of placement.

C. Definition of EXEMPTED HOSPITAL DISCHARGE:

CONVALESCENT CARE FOR A PRIMARY ACUTE PHYSICAL DIAGNOSIS: A person may be admitted for short-term recuperative care to a Medicaid-certified nursing facility after release from an acute care hospital stay necessitated by a primary physical diagnosis as long as that person is not a danger to self and/or others. This convalescent period shall **not exceed 30 days** and **must be part of a medically prescribed period of recovery for the primary physical diagnosis**. The purpose of the convalescent stay is for a short recuperation period with the intention to leave the facility prior to the expiration of the approved time. (*Medical documentation must substantiate the need for short-term convalescent care. Whenever possible, attach a copy of the hospital discharge summary to this form when it is sent to the PAS agency.*)

CONVALESCENT CARE FOLLOWING AN ACUTE CARE HOSPITAL STAY NECESSITATED FOR TREATMENT OF A PSYCHIATRIC ILLNESS RATHER THAN A PHYSICAL ILLNESS IS NOT INCLUDED.

NOTE: MI and/or MR individuals cannot be temporarily placed in nursing facilities merely because appropriate placements in institutions for mental diseases (*IMD's*), intermediate care facilities for the mentally retarded (*ICF's/MR*), etc. are not available at the time of discharge from an acute care hospital. **It is the responsibility of the NF to notify the PAS agency immediately if the resident needs to remain beyond 30 days and explain why continued stay is necessary**. The NF will also need to provide a current Form 450B, Physician's Certification. The required Level II assessment(s) must be completed within 40 days of the admission.

NOTE: Medicaid is not allowed to reimburse for more than 40 days unless the individual is found to be appropriately placed in the NF. Further, Medicaid will not reimburse for inappropriate use of this category, such as when the anticipated stay at the time of admission is realistically more than 30 days.

III. CERTIFICATION OF THE LEVEL II REQUIREMENT

A. ALL Level I forms completed for initial admission or transfer **MUST** be certified by the local PAS agency for the need for Level II Assessment. The PAS agency will check "Yes" or "No" in the section marked "PAS", sign and date the form.

ADMISSION MEDICAL HISTORY & PHYSICAL

Portion B is the responsibility of the physician per State Board of Health Regulations
Portion A may be completed by a Nurse

A

To be admitted from: _____ Home _____ Hospital _____ Nursing Home (specify)	Resident Name (Please Print): Hospital/Nursing Home Admission date: (if admitted from another facility)	Birth Date: Sex: Physician:

Eating:	Behavior:	Elimination:	Mobility:
_____ Self _____ Assist _____ Fed _____ Other _____ _____		_____ Continent _____ Catheter _____ Incontinent _____ Colostomy _____ Urine _____ Other _____ Bowel	_____ Self _____ Wheelchair _____ Assist _____ Cane _____ Bed Rest _____ Walker _____ Transfer Assist _____ Restraints Required (List Below)

B/P:	Temp:	Pulse:	Respiration:	Weight:	Height:

Chest X-ray (within past 6 months required by ISDH) Date: Results: Where done:	Mantoux (within past 3 months with STU PPD read at 72 hours: Date given: ____________________ Site: ____________________ Size of bleb: ____________ mm Given by: _______________________ Date read: ____________________ Result: ____________ mm Read by: _______________________

Signature of Nurse completing the above section: Facility of affiliation:

B - MUST BE COMPLETED BY A PHYSICIAN

Physical exam:	Normal	Abnormal
1. Gen. Appearance		
2. Skin		
3. Nodes		
4. Head & Neck		
5. Eyes		
6. Throat		
7. Ears		
8. Nose		
9. Chest		
10. Lungs		
11. Heart		
12. Abdomen		
13. Extremities		
14. Pulses		
15. Neurological		
16. Galt		
17. Grasp		
18. Genitalia		
19. Recent Papa		
Oral Exam		
1. Gums		
2. Teeth		
3. Tongue		

Diagnosis: (include date of onset)

Describe Abnormalities Checked on Physical Exam:

Medical History: (include surgeries & immunization records)

Medications, Therapy & Activity:

Diet: Allergies:

This patient is Certifiable as: _____ Skilled _____ Intermediate _____ Residential	Has this patient been informed of his/her condition? _____ Yes _____ No If no, please explain:
Rehabilitation Potential _____ Good _____ Fair	Is this patient free from all communicable diseases including T.B. in an infectious stage? _____ Yes _____ No

Signature of Physician completing the above section: Facility of affiliation: