# Level One Nursing Facility Pre-Admission Screening for Mental Illness/ Intellectual Disability or Related Condition

DHSS/COMRU

November 2022

# Key Points

- The new process is now automated – the link to complete the application will be located on COMRU's webpage: https://health.mo.gov/seniors/nursinghomes/pasrr.php
- The Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability, or Related Condition (Level One Form) replaces the previous DA 124 C form.
- This new application will be required for any individual seeking admission into a Medicaid certified bed in a nursing facility on or after October 31, 2021.
- The automated system will give the submitter a Return Code that is unique to each individual application. Please ensure the submitter writes down this code as it will be utilized throughout the process.

# Objectives

- The participants will receive information regarding the background reason for PASRR.
- The participants will be able to submit the online application (Level I form / Level of Care form)
- The participants will be able to identify what triggers a Level 2 screening.
- The participants will be able to access the status of the online process, including corrections and completion.

# PASRR (Level 2 Screening)

- Federal Regulation

483.102 (a) This subpart applies to the screening or reviewing of all individuals with Mental Illness or Intellectual Disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnosis.

# PASRR (Level 2 Screening)

- PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing home for long term care. PASRR requires that Medicaid-certified nursing facilities:
    1. Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID)
    2. Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting)
    3. Provide all applicants the serves they need in those settings.

# PASRR (Level 2 Screening)

- The PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.



**https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review**

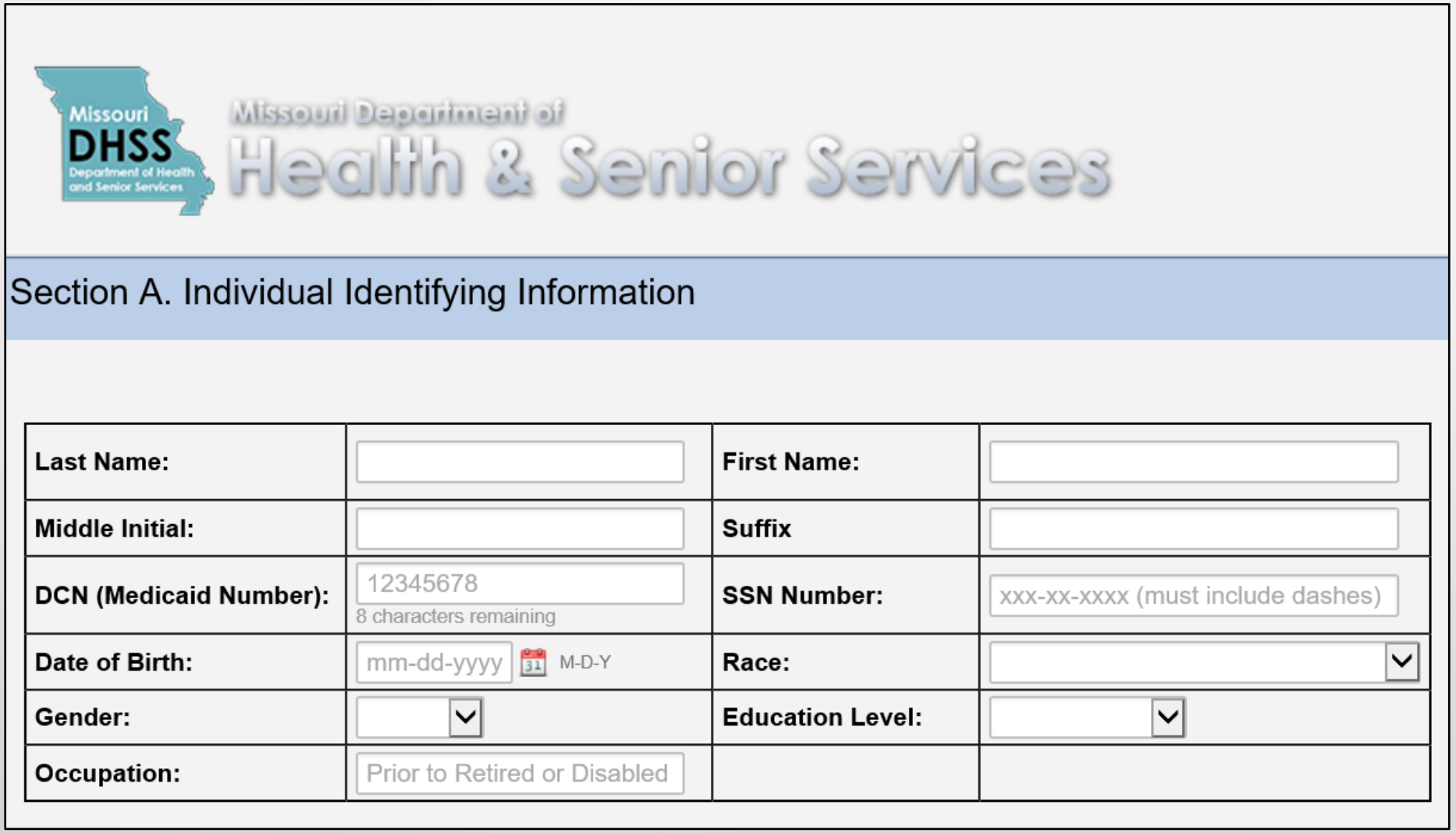
# When should an application submitted to COMRU?

- All client's entering/residing in a Medicaid certified bed must have a Level One Form completed.

- An application does not need to be submitted to COMRU if the client is not applying for Medicaid **or** does not trigger a Level 2 screening (per Level One Form).

  If the client later applies for Medicaid or triggers a Level 2 screening, a new online application must be completed and submitted to COMRU.

# Section A.  Individual Identifying Information



Missouri Department of Health & Senior Services

## Section A. Individual Identifying Information

| | | | |
|---|---|---|---|
| **Last Name:** | | **First Name:** | |
| **Middle Initial:** | | **Suffix** | |
| **DCN (Medicaid Number):** | 12345678<br>8 characters remaining | **SSN Number:** | xxx-xx-xxxx (must include dashes) |
| **Date of Birth:** | mm-dd-yyyy M-D-Y | **Race:** | |
| **Gender:** | | **Education Level:** | |
| **Occupation:** | Prior to Retired or Disabled | | |

- Individual's First and Last Name
  This should be the individual's **legal name**

- Suffix
  Examples include: "Sr.", "Jr.," or "I, II, III"

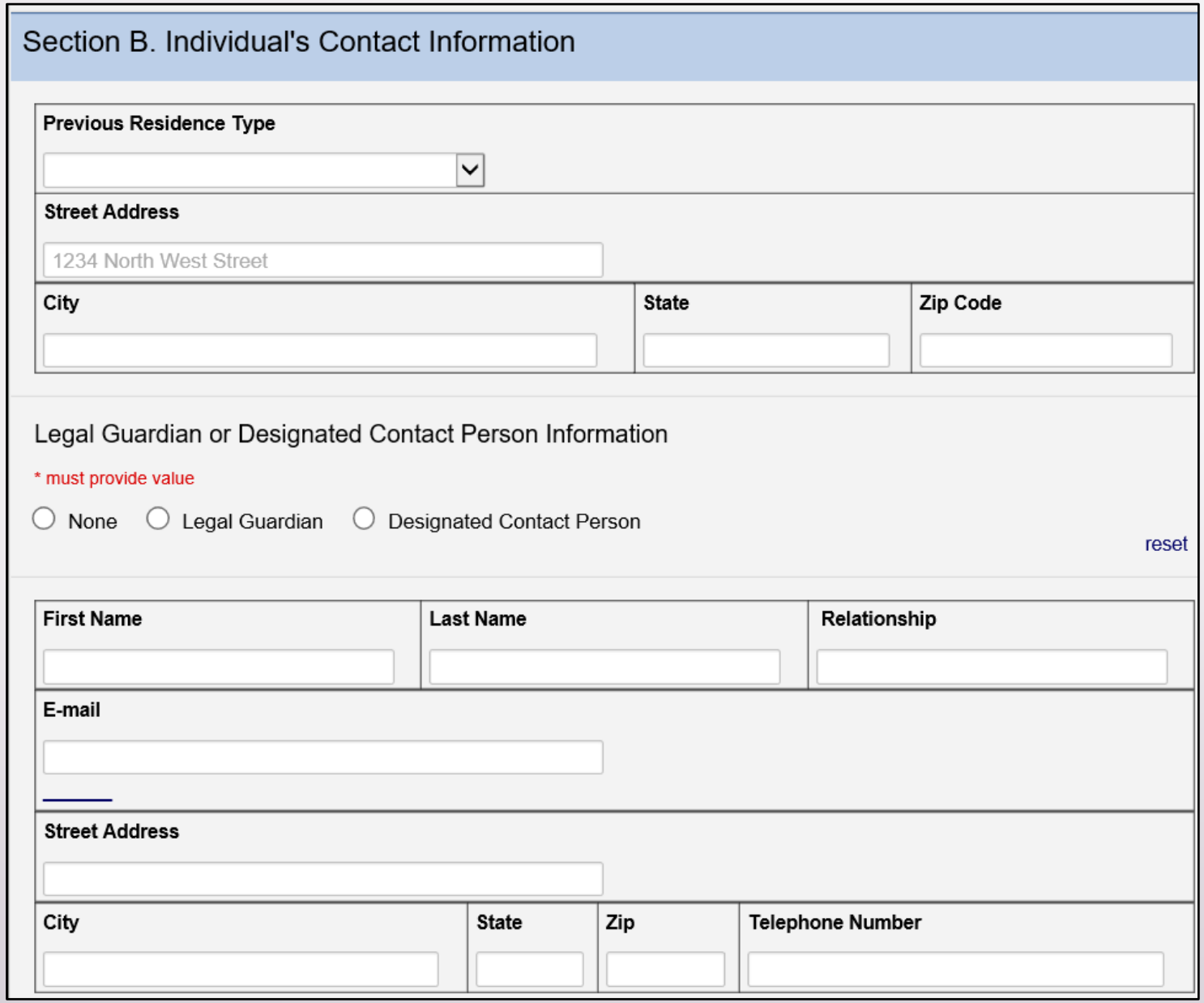
- DCN (aka Medicaid Number)
  This is an eight digit number
  If the individual has not yet applied for Medicaid, this field should be left blank.

- Date of Birth
  This is entered in a "mm-dd-yyyy" format

- SSN Number
  Dashes must be entered between numbers "XXX- XX-XXXX"

- Occupation
  This would be the occupation prior to the individual becoming disabled or retired
  If the individual never worked indicate "never worked"

# Section B. Individual's Contact Information



Section B. Individual's Contact Information

**Previous Residence Type**

**Street Address**

1234 North West Street

**City** | **State** | **Zip Code**

Legal Guardian or Designated Contact Person Information

* must provide value

None  Legal Guardian  Designated Contact Person

reset

**First Name** | **Last Name** | **Relationship**

**E-mail**

**Street Address**

**City** | **State** | **Zip** | **Telephone Number**

- Previous Residence Type

  What type of setting was the Individual residing **prior** to this admission?

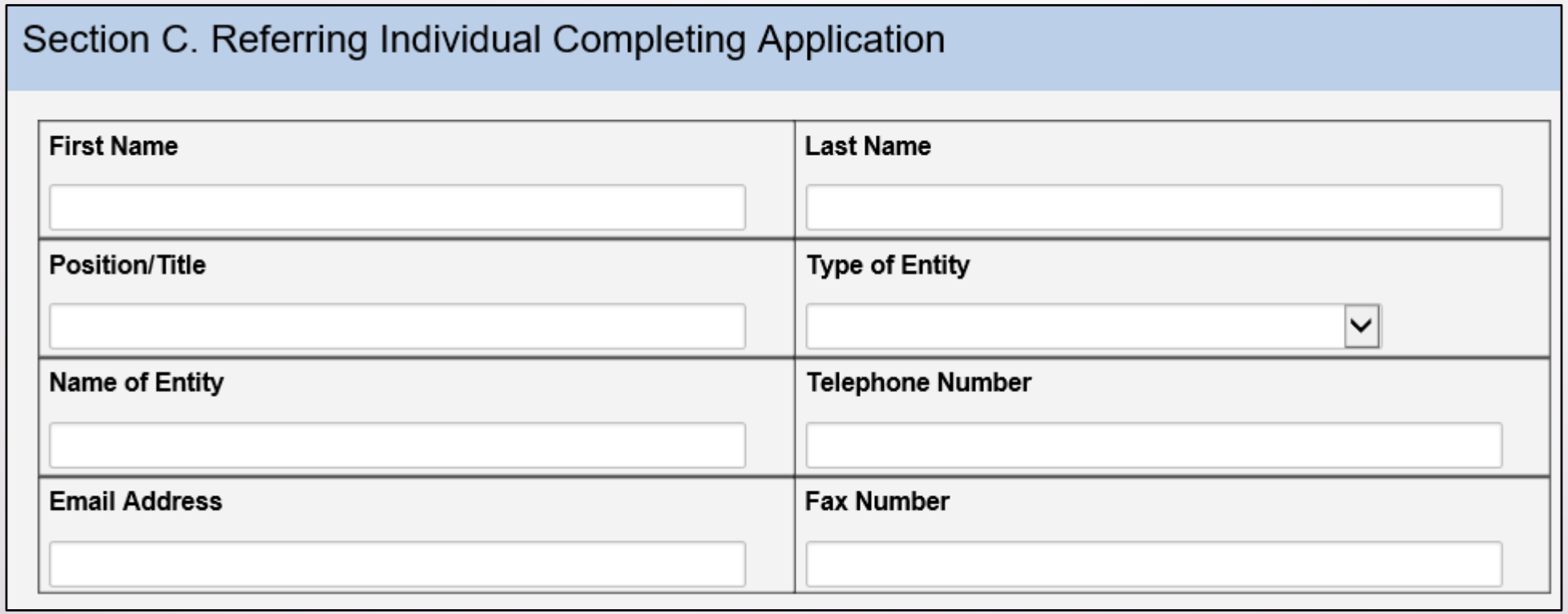
  There is a drop down menu with the following options:

  - Home / Facility Residence
  - RCF (Residential Care Facility)
  - ICF (Intermediate Care Facility)
  - SNF (Skilled Nursing Facility)
  - ALF (Assisted Living Facility)
  - ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disability)
  - DMH Group Home / Individualized Supported Living
  - DMH Psychiatric Hospital and Facilities
  - Homeless / Shelter
  - Incarcerated

- Provide Address of the Previous Residence Type

- Legal Guardian or Designated Contact Person  Information
  - If “None” is marked, the requested fields for the Legal/Guardian or Designated Contact information will disappear
  - If the individual has a **Legal Guardian,** please provide the requested information.  This email will be used as the primary mode of providing letters and reports to the legal guardian.  These records will be sent via an encrypted email.  The email address is a required field on the application.

# Section C. Referring Individual Completing Application

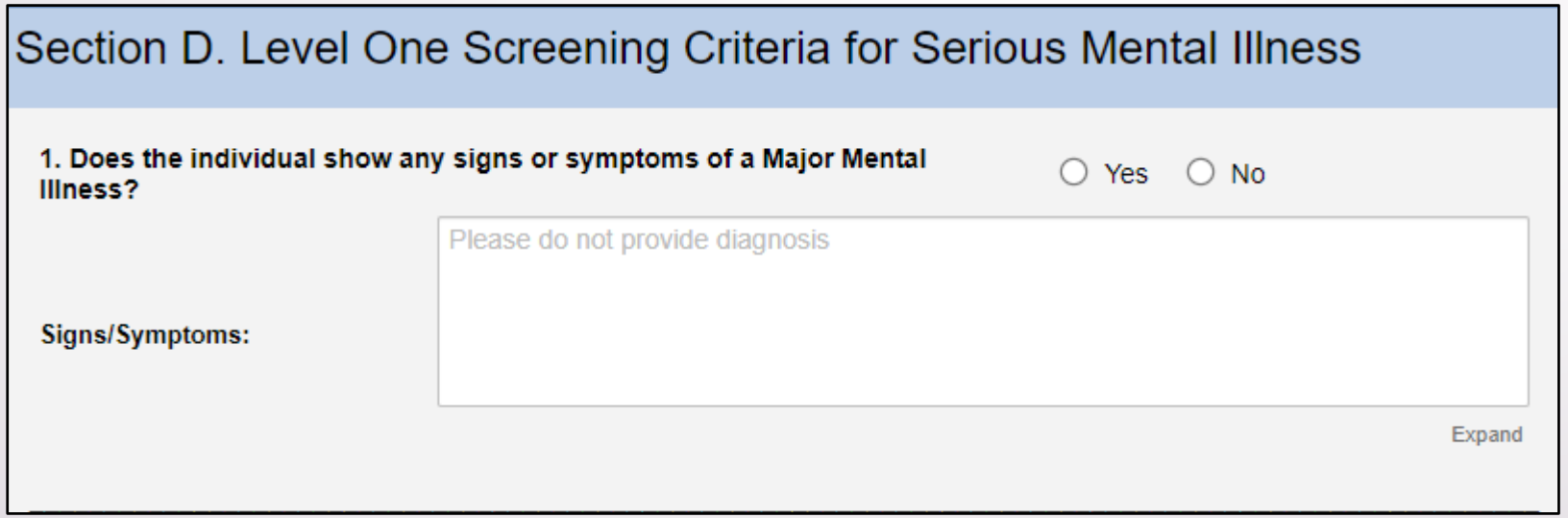


Section C. Referring Individual Completing Application

| First Name | Last Name |
|---|---|
| | |
| **Position/Title** | **Type of Entity** |
| | |
| **Name of Entity** | **Telephone Number** |
| | |
| **Email Address** | **Fax Number** |
| | |

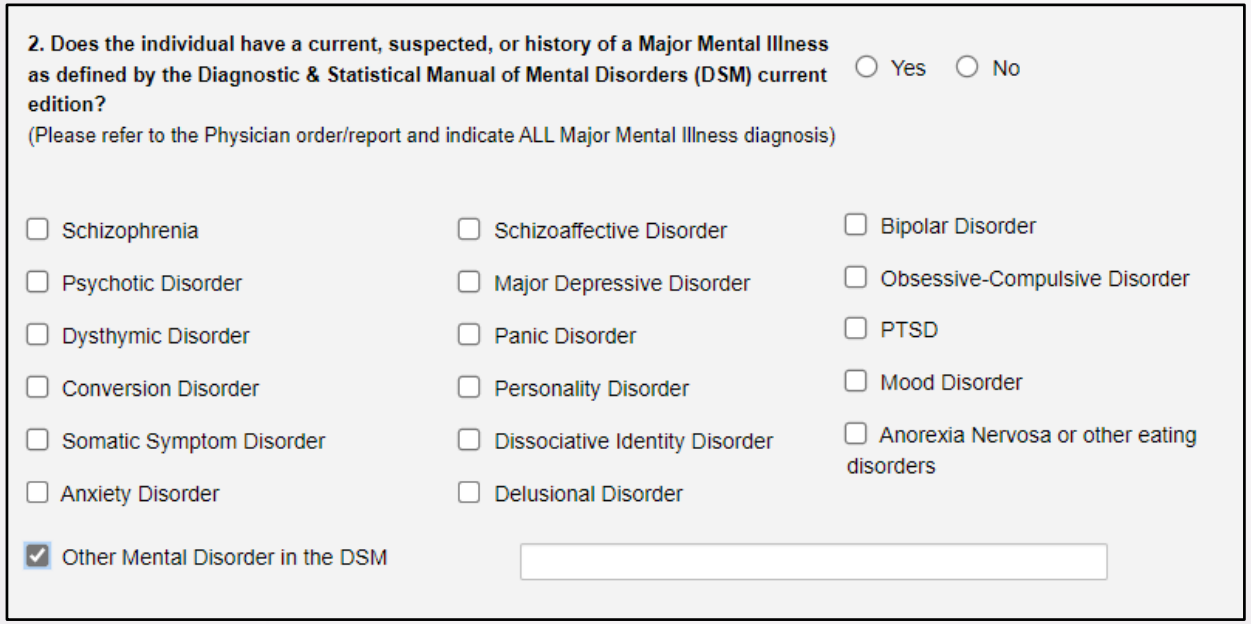
- This is the identifying information of the person completing the application prior to the physician's signature.

# Section D. Level One Screening Criteria for Serious Mental Illness




- Please provide the signs and symptoms that the individual is displaying. Diagnoses are not accepted.

# Section D. Level One Screening Criteria for Serious Mental Illness



**2. Does the individual have a current, suspected, or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition?** ○ Yes ○ No

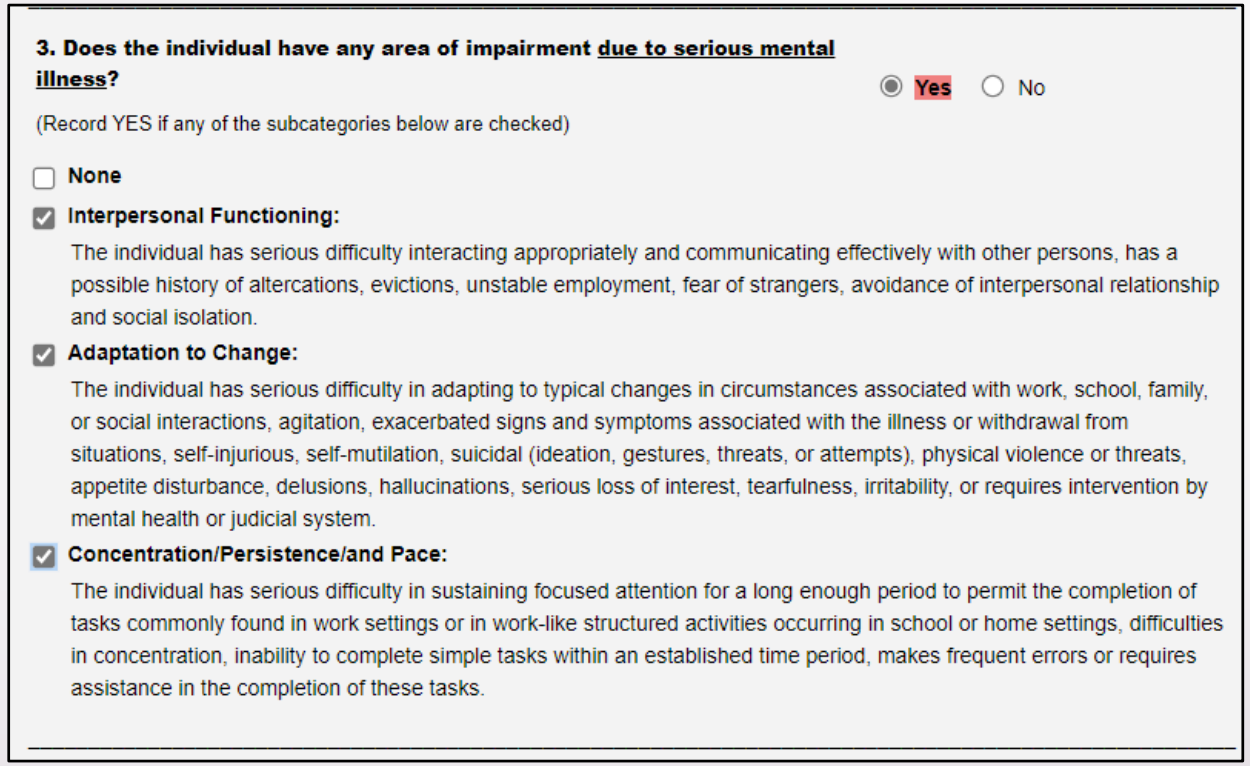
(Please refer to the Physician order/report and indicate ALL Major Mental Illness diagnosis)

| | | |
|---|---|---|
| ☐ Schizophrenia | ☐ Schizoaffective Disorder | ☐ Bipolar Disorder |
| ☐ Psychotic Disorder | ☐ Major Depressive Disorder | ☐ Obsessive-Compulsive Disorder |
| ☐ Dysthymic Disorder | ☐ Panic Disorder | ☐ PTSD |
| ☐ Conversion Disorder | ☐ Personality Disorder | ☐ Mood Disorder |
| ☐ Somatic Symptom Disorder | ☐ Dissociative Identity Disorder | ☐ Anorexia Nervosa or other eating disorders |
| ☐ Anxiety Disorder | ☐ Delusional Disorder | |

☑ Other Mental Disorder in the DSM

- Please refer to the Physician's orders, History and Physical, and other supporting documentation to ensure that all the individual diagnoses are indicated on the application.
- The submitter is able to mark more than one diagnosis.
- If the diagnosis is not listed, mark the "Other Mental Disorder in the DSM" box and list the diagnosis in the box. Please list **only** Major Mental Illness diagnoses.
- A Level 2 screening is **not** automatically indicated if an individual has a Major Mental Illness diagnosis.

# Section D. Level One Screening Criteria for Serious Mental Illness



**3. Does the individual have any area of impairment due to serious mental illness?**

(●) Yes ( ) No

(Record YES if any of the subcategories below are checked)

- [ ] **None**
- [x] **Interpersonal Functioning:**
  The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationship and social isolation.
- [x] **Adaptation to Change:**
  The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (ideation, gestures, threats, or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention by mental health or judicial system.
- [x] **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, 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.

- The submitter must choose at least one of the four categories.
- The submitter can choose more than 1 of the 3 categories (Interpersonal Functioning, Adaptation to Change and Concentration/Persistence and Pace) if applicable.

- Adaptation to Change:
  Requires intervention by mental health or judicial system

  Is the individual currently receiving services in the community through Comprehensive Psychiatric Services (CPS – DMH)? If the individual is receiving services, this category would be marked.

- A Level 2 screening would be indicated if any of the three categories are marked and Dementia is **not** the primary mental illness diagnosis

# Section D. Level One Screening Criteria for Serious Mental Illness

**4. Within the last 2 years, has the individual:** ◉ **Yes** ○ No

**(Record YES if Either/Both of the two subcategories below are checked)**

☑ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g. had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

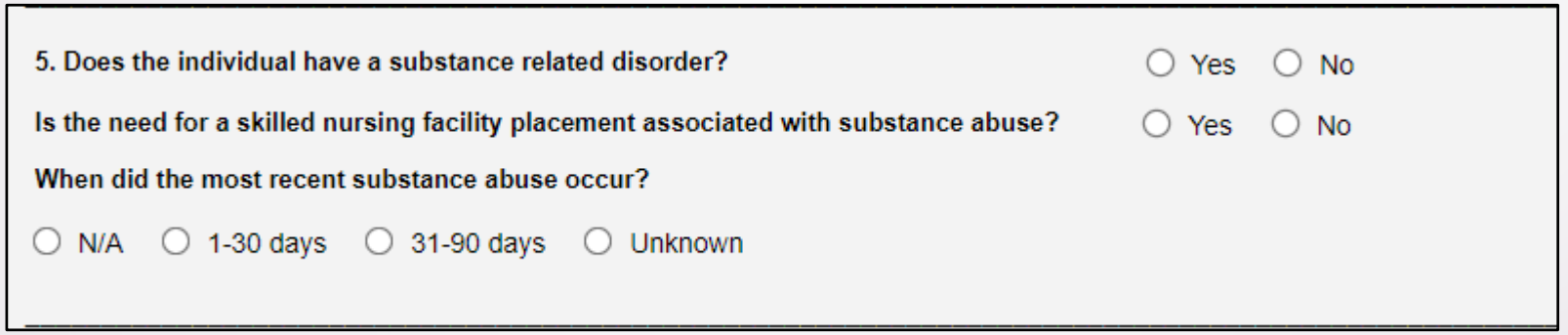
☑ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials?

**Check yes, if treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider individual positive for serious mental illness.**

# Section D. Level One Screening Criteria for Serious Mental Illness

- If treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the individual is positive for serious mental illness. Examples might include (not an exclusive list):
    - The individual went to the hospital and no psychiatric beds were available so the individual was not admitted to the psychiatric unit even though the client was having an episode. Instead, the individual stabilized on the medical floor.
    - The facility does not know whether or not the individual has had an inpatient stay due to the individual being a poor historian.
- A Level 2 screening would be indicated if this question is marked "Yes" and Dementia is **not** the primary mental illness diagnosis

# Section D. Level One Screening Criteria for Serious Mental Illness



5. Does the individual have a substance related disorder? ○ Yes ○ No

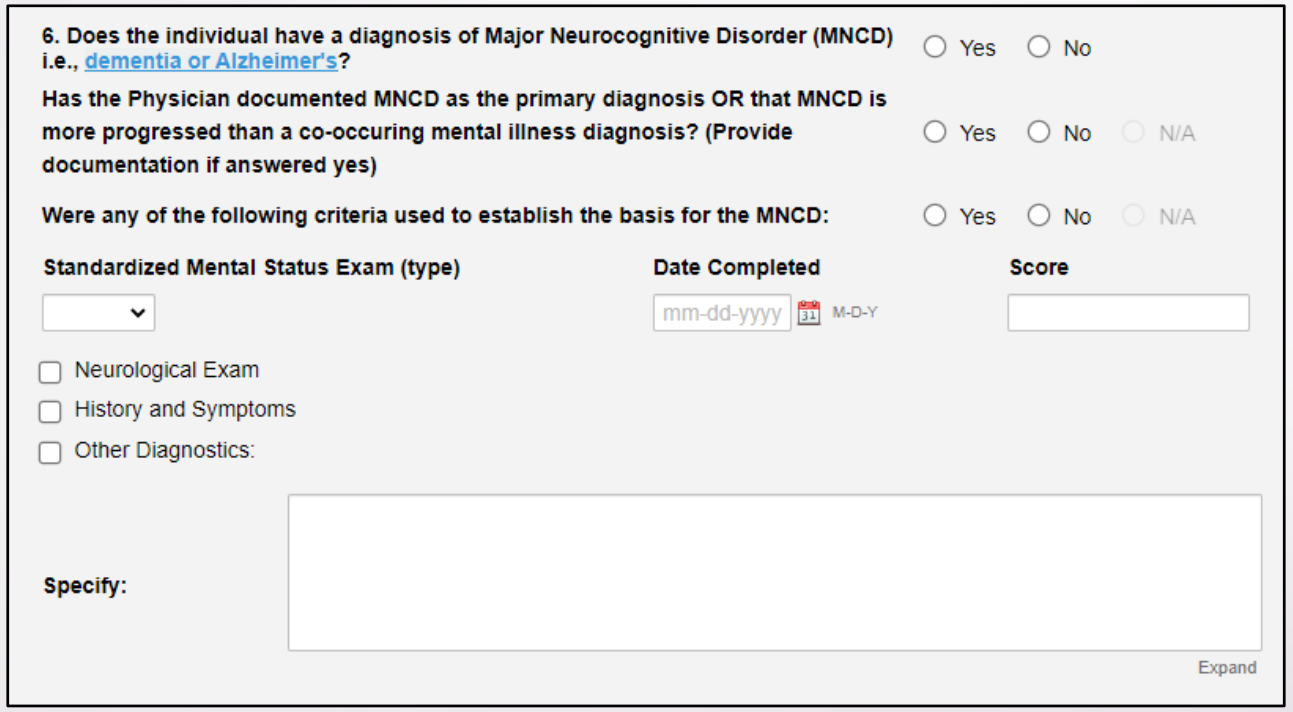
Is the need for a skilled nursing facility placement associated with substance abuse? ○ Yes ○ No

When did the most recent substance abuse occur?

○ N/A ○ 1-30 days ○ 31-90 days ○ Unknown

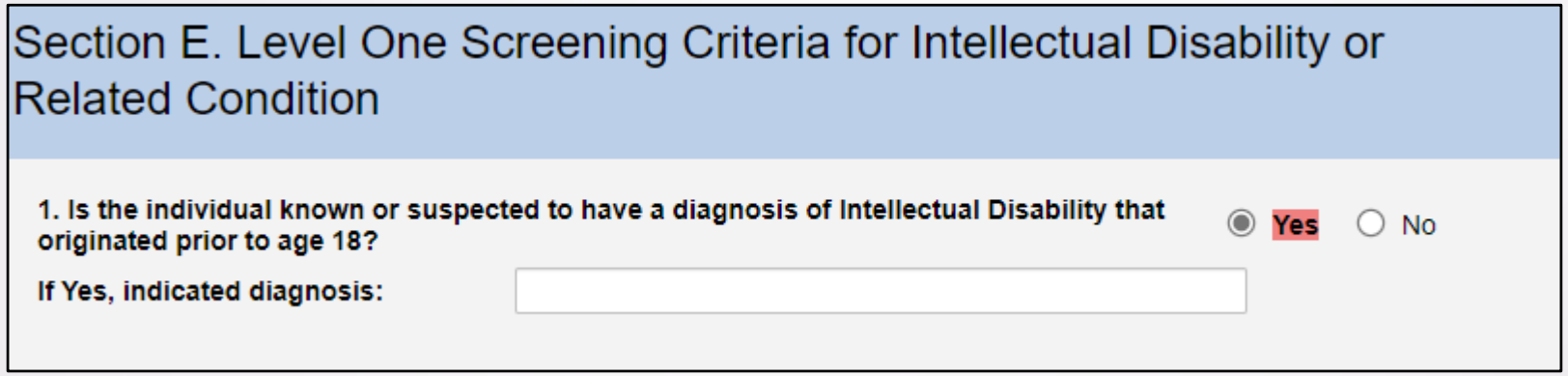
- Must be a documented diagnosis of current substance use **or** history of substance abuse
- A Level 2 screening is not automatically indicated if an individual has a substance related disorder

# Section D. Level One Screening Criteria for Serious Mental Illness



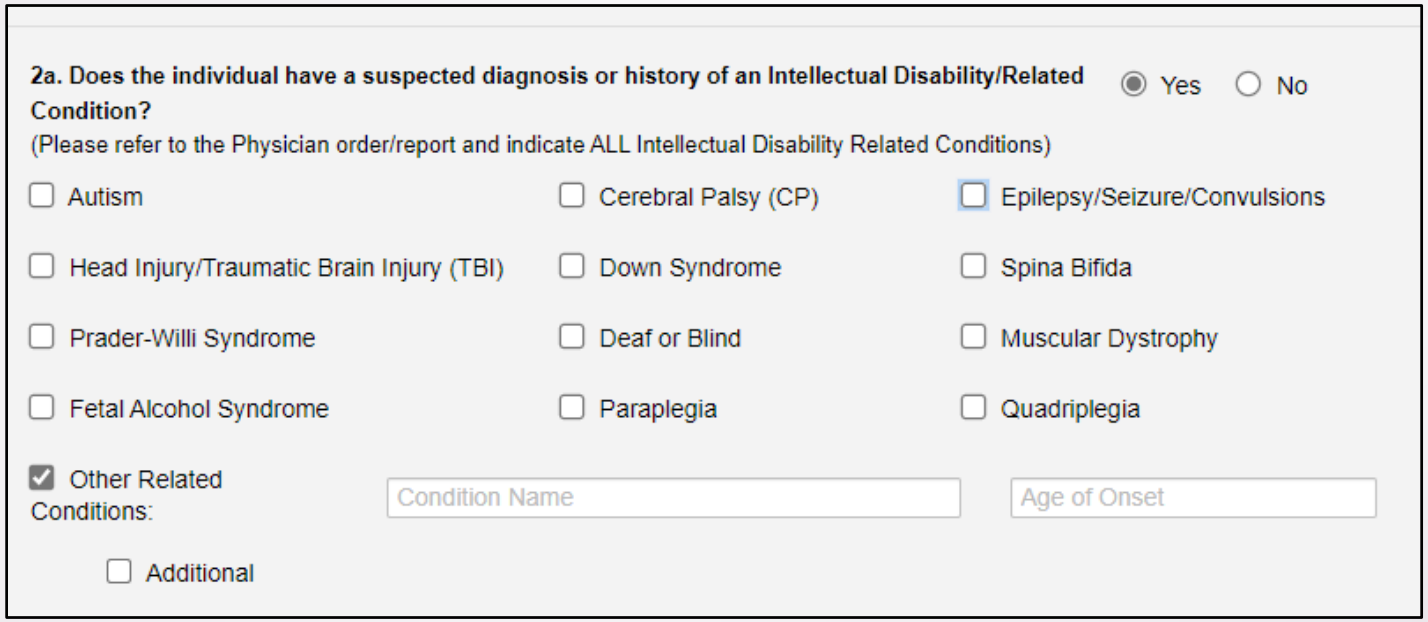

- If the individual does not have a diagnosis of Major Neurocognitive Disorder (MNCD) the additional questions in this section will disappear when answered "No".
- If the individual does have a diagnosis MNCD, then the following questions are required and should be completed to support the primary mental illness diagnosis.

# Section E. Level One Screening Criteria for Intellectual Disability or Related Condition




- If "Yes", does the individual have a Mild, Moderate, Severe, Profound, or Unspecified Intellectual Disability
- Related Conditions are not listed in this field

# Section E. Level One Screening Criteria for Intellectual Disability or Related Condition



**2a. Does the individual have a suspected diagnosis or history of an Intellectual Disability/Related Condition?** (●) Yes ( ) No

(Please refer to the Physician order/report and indicate ALL Intellectual Disability Related Conditions)

| | | |
|---|---|---|
| ☐ Autism | ☐ Cerebral Palsy (CP) | ☐ Epilepsy/Seizure/Convulsions |
| ☐ Head Injury/Traumatic Brain Injury (TBI) | ☐ Down Syndrome | ☐ Spina Bifida |
| ☐ Prader-Willi Syndrome | ☐ Deaf or Blind | ☐ Muscular Dystrophy |
| ☐ Fetal Alcohol Syndrome | ☐ Paraplegia | ☐ Quadriplegia |

☑ Other Related Conditions: Condition Name | Age of Onset

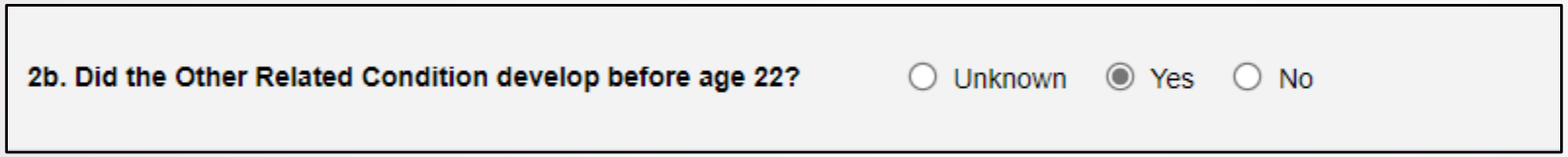
☐ Additional

- Does the individual have a diagnosis or history of a Related Condition?
  If "No" is indicated questions 2b thru 2d will disappear.

  If "Yes" is indicated, choose the diagnosis and provide the age of onset in the blank.
  If the diagnosis is not listed, click on "Other Related Condition" to type the diagnosis

- Mental Illness is **not** considered a "Related Condition"

# Section E. Level One Screening Criteria for Intellectual Disability or Related Condition




- Did the Other Related Condition develop before age 22?
  (Review the diagnosis and age of onset checked from question 2A)

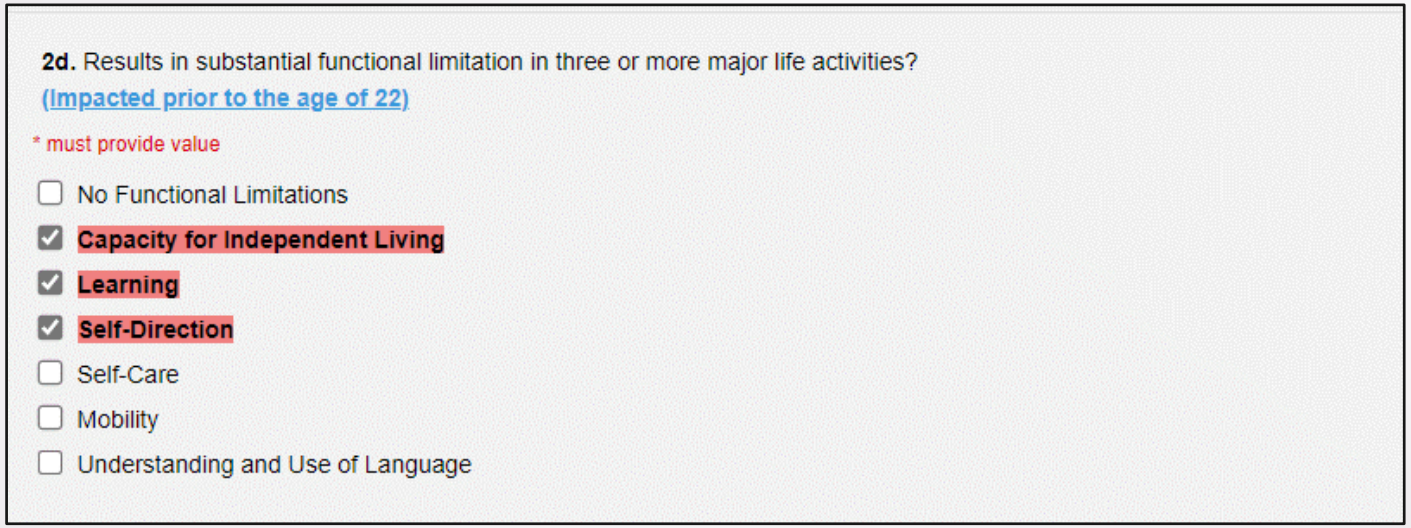
  If "No" is indicated questions 2C and 2D will disappear.

  If "Yes" or "Unknown" is indicated, please answer questions 2C and 2D (see next slides)

# Section E. Level One Screening Criteria for Intellectual Disability or Related Condition

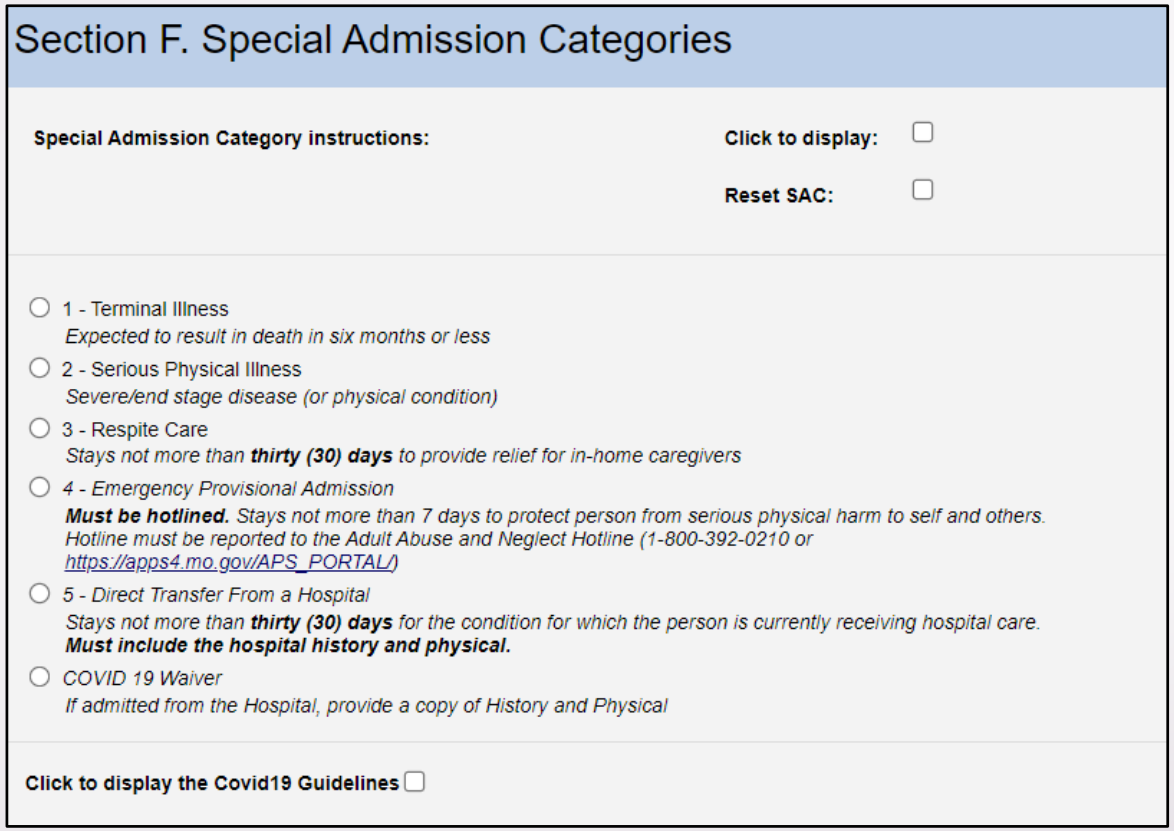
| | |
|---|---|
| **2c. Likely to continue indefinitely?** | ◉ Yes ○ No |

# Section E. Level One Screening Criteria for Intellectual Disability or Related Condition




- Results in substantial functional limitations in three or more major life activities?
  - Reminder: The functional limitation must have impacted the individual **prior to the age of 22**.
- A Level 2 screening would be indicated if the individual has a related condition prior to the age of 22 **and** 3 or more functional limitations.
- To assist with answering the questions in Section E, the submitter might have to ask the individual, guardian, or other sources as to whether or not the individual was receiving Developmental Disability Services (DD – DMH) in the community.

# Section F. Special Admission Category



Section F. Special Admission Categories

**Special Admission Category instructions:**

**Click to display:** ☐

**Reset SAC:** ☐

- ○ 1 - Terminal Illness
  *Expected to result in death in six months or less*
- ○ 2 - Serious Physical Illness
  *Severe/end stage disease (or physical condition)*
- ○ 3 - Respite Care
  *Stays not more than **thirty (30) days** to provide relief for in-home caregivers*
- ○ *4 - Emergency Provisional Admission*
  ***Must be hotlined.** Stays not more than 7 days to protect person from serious physical harm to self and others. Hotline must be reported to the Adult Abuse and Neglect Hotline (1-800-392-0210 or https://apps4.mo.gov/APS_PORTAL/)*
- ○ *5 - Direct Transfer From a Hospital*
  *Stays not more than **thirty (30) days** for the condition for which the person is currently receiving hospital care. **Must include the hospital history and physical.***
- ○ *COVID 19 Waiver*
  *If admitted from the Hospital, provide a copy of History and Physical*

**Click to display the Covid19 Guidelines** ☐

- A Special Admission Category (SAC) is **only** utilized if a individual triggers a Level 2 screening.
- The submitter does not have to choose a SAC for processing.
- SAC numbers 1 thru 5 must be **preapproved** by COMRU prior to admitting to SNF. Failure to preapprove these SACs may result in loss of Medicaid payment.

# Section F. Special Admission Category

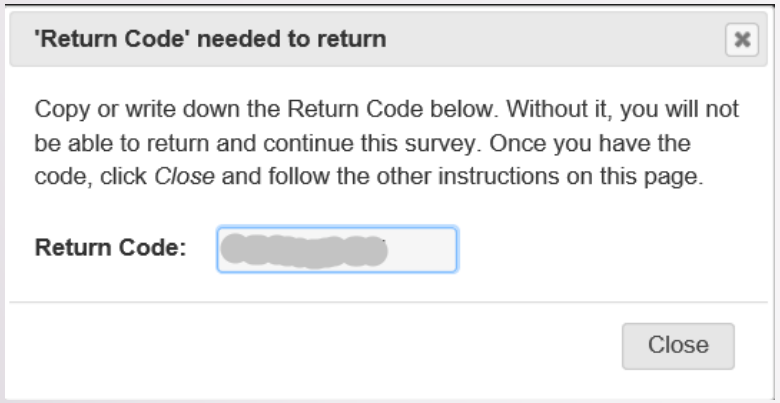
- The submitter will be able to view the determination of the SAC by logging back into the application (using the unique Return code).
- When SAC #3 or #5 is approved, it is the responsibility of the skilled nursing facility to subsequently notify COMRU via email **(**COMRU@health.mo.gov**)** if the individual will exceed the thirty-day special admission stay. In order to avoid loss of Medicaid payment, notice must be made to COMRU within the first 14-20 days of the individual's stay to allow time for the processing of the Level 2 screening.
- If the individual discharges, transfers, or leaves the nursing facility for any reason the SAC is considered completed and a new application request will need to be submitted to COMRU prior to the individual's return to any nursing facility.

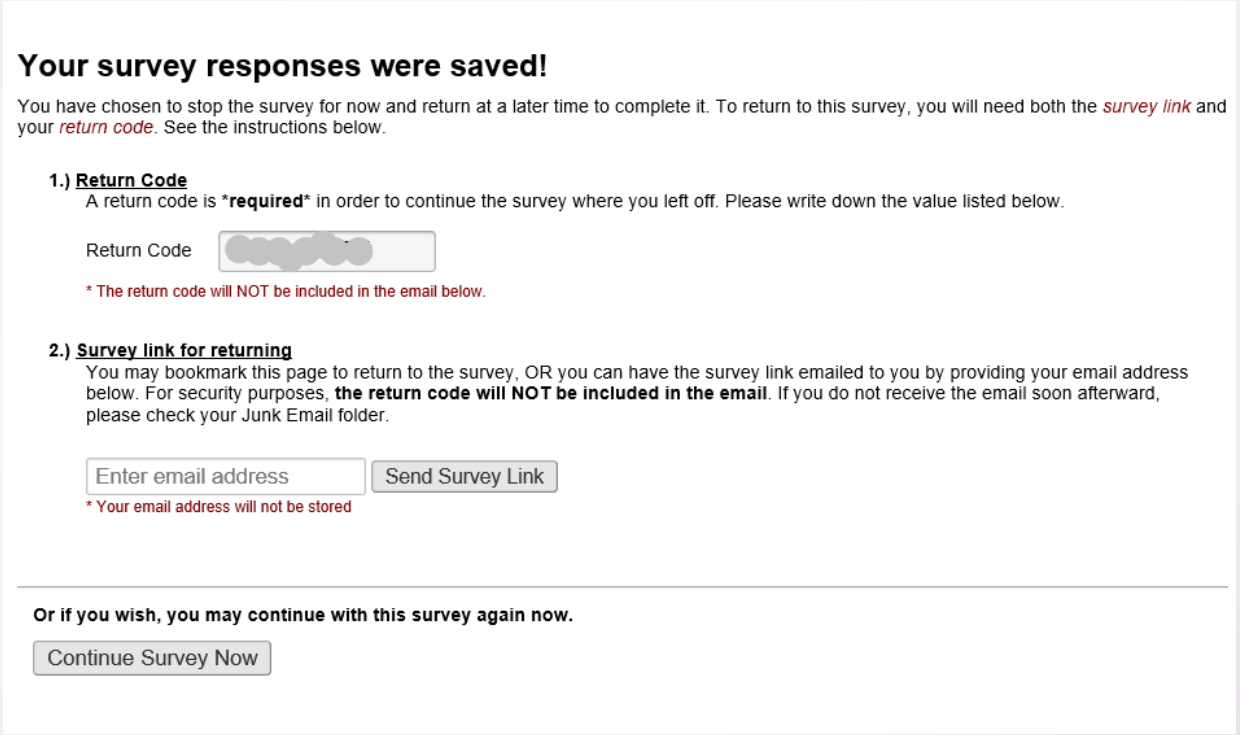
# Section G. Physician Signature



- Once the Level 1 form has been completed, it is then sent to the Physician for their signature.
- The submitter will need to scroll down to the end of the application and click the "Save and Return Later." button.

# Section G. Physician Signature



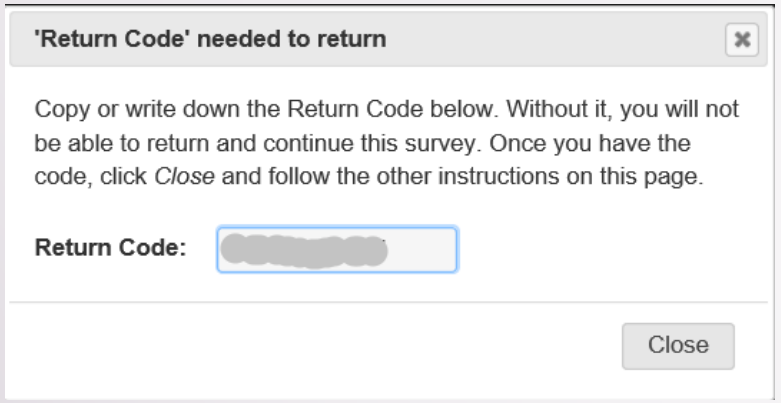

- The submitter will receive a Return Code.

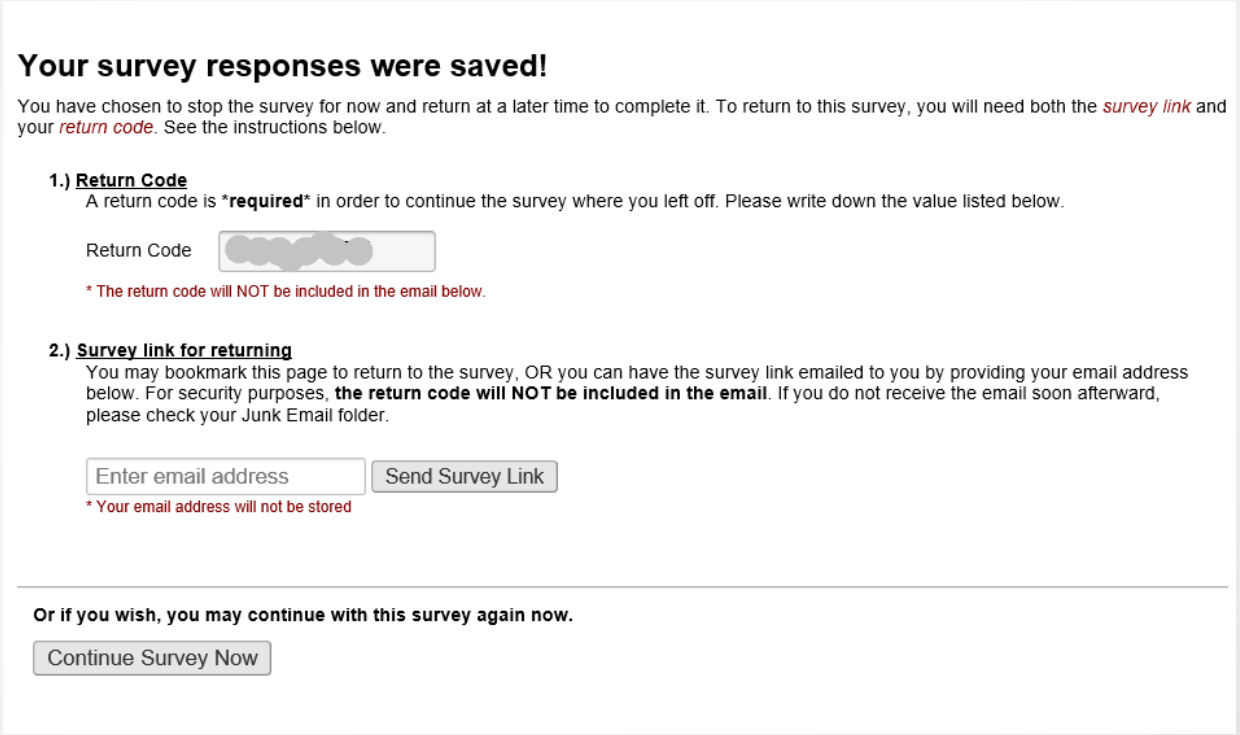
**IMPORTANT:** **Make sure to write the code down as the submitter will need this code to send to the physician. The submitter will utilize this Return Code throughout the process.**



- The code is able to be copied and pasted into a computer document if needed.
  (Using the mouse – highlight the Return Code and right click, then click on the "copy" option)

# Section G. Physician Signature

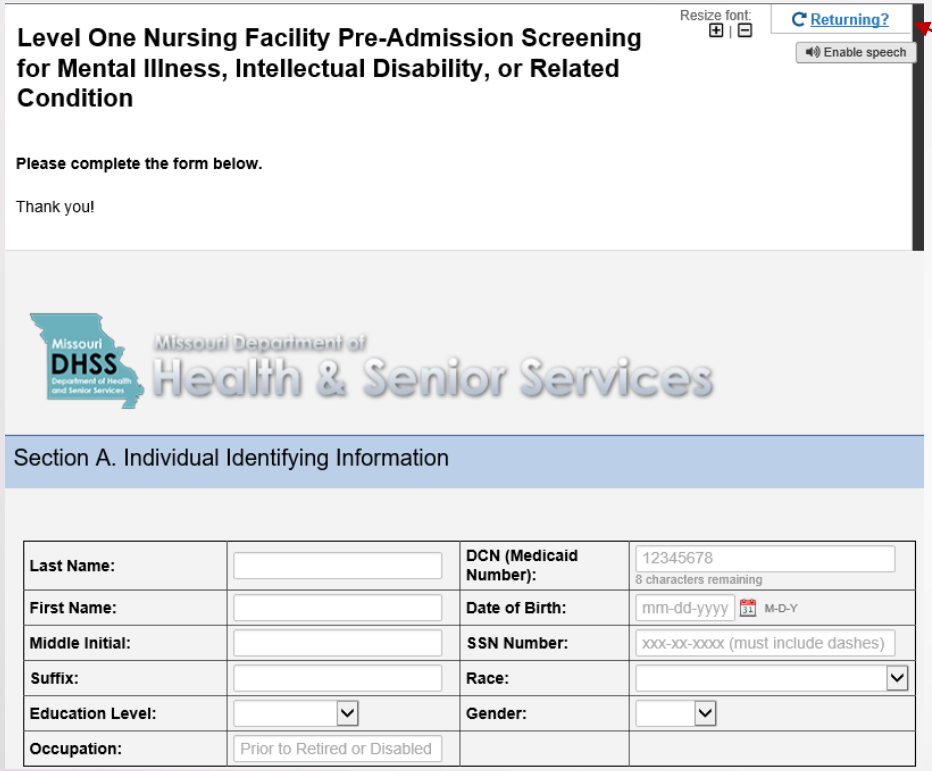


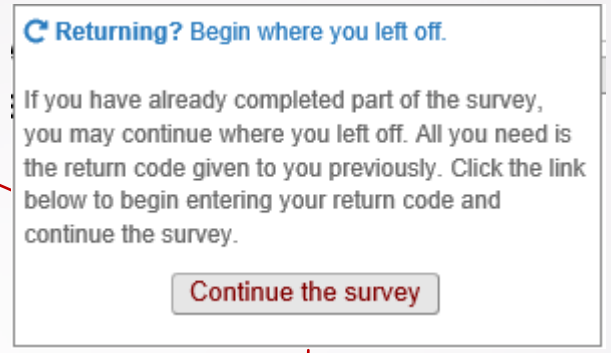



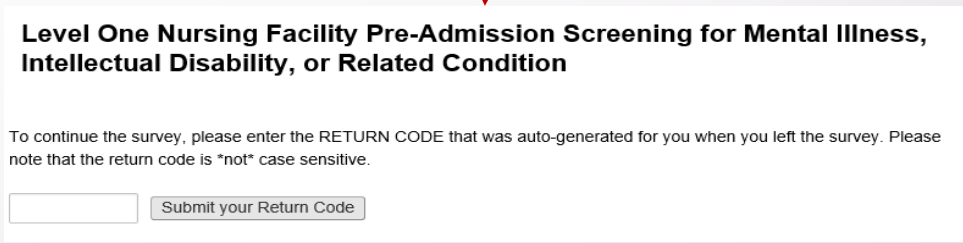

- When emailing the physician, it can be completed 2 ways:
  1. When the screen appears, enter the email address and click survey link.
     A second personal email will need to be sent from the submitter to the physician with the Return Code so they are able to access the application.

     **Or**
  2. The submitter sends a personal email to the physician with the code and the link to the application.
     The link to the this application will be located on COMRUs webpage.

# Other Information




- The physician opens the Application link and clicks on "Returning?". A box will appear and the physician will click on "Continue the survey".
- The physician logs back into the application (using the Return Code).
- When the physician has completed Section G, the physician scrolls to the bottom of the application and clicks "Save and Return Later". The physician can enter the submitter's email address and an email is returned indicating the application has been signed.

- The submitter can also log back into the application (using the Return Code) to verify the Physician has signed/completed the application. This is the same process as the previous slide.

- If the submitter is a hospital and the application **did not trigger** a Level 2 screening, the hospital can email the Return Code and Application link to the SNF for review. The SNF would complete the remainder of the application (Nursing Facility Level of Care Assessment) and submit to COMRU for processing.

- If the submitter is a hospital and the application **triggers** a Level 2 screening, the hospital would continue to complete the rest of the application for submission.

# Nursing Facility Level of Care Assessment

DHSS/COMRU

November 2022

# Key Points

- The new process is now automated – the link to complete the application will be located on COMRU's webpage: https://health.mo.gov/seniors/nursinghomes/pasrr.php.
- The Nursing Facility Level of Care Assessment (Level of Care Form) replaces the previous DA 124 A/B form.
- This new application will be required for any individual seeking admission into a Medicaid certified bed in a nursing facility on or after October 31, 2021.
- The automated system will give the submitter a Return Code that is unique to each individual application. Please ensure the submitter writes down this code as it will be utilized throughout the process.
- The LOC point count has changed from 24 points to 18 points
- The assessment criteria for the Level of Care (LOC) has been changed.
- The assessment criteria correlates with the Minimum Data Set (MDS) in most areas.

# Section A. Individual Identifying Information

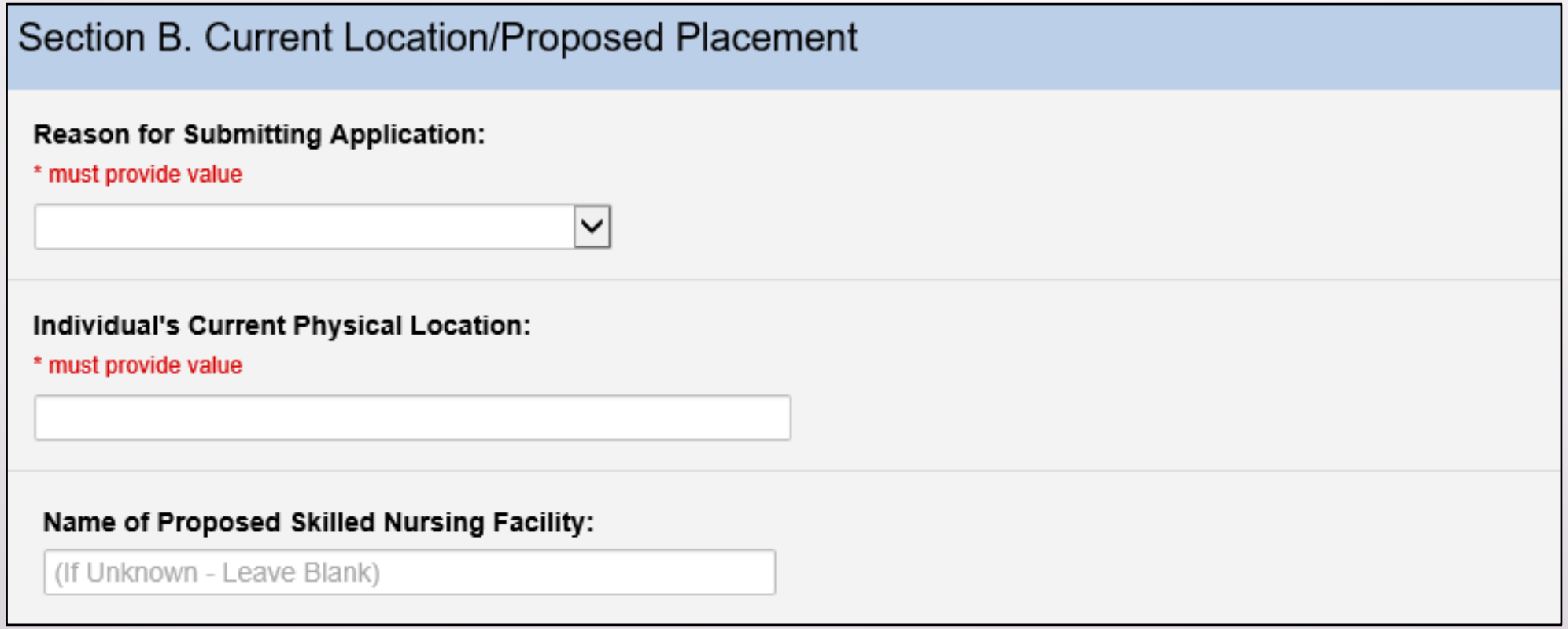
Nursing Facility Level of Care Assessment

Section A. Individual's Identifying Information

| | | | |
|---|---|---|---|
| **Last Name:** | _____ | **First Name:** | _____ |
| **Middle Initial:** | _____ | **Suffix:** | _____ |
| **DCN (Medicaid Number):** | _____ | **SSN Number:** | _____ |
| **Date of Birth:** | _____ | **Race:** | _____ |
| **Gender:** | _____ | | |

- This section is auto-filled based on the information completed on the Level One Nursing Facility Pre-Admission Screening for Mental Illness/ Intellectual Disability or Related Condition (Level One Form). The submitter will need to return to the Level One Form, Section A, if any corrections are required in this section.

# Section B. Current Location/Proposed Placement



# Section B. Current Location/Proposed Placement

**Reason for Submitting Application**

There is a drop down menu with the following options:

- New Admission **or** has been out of a SNF greater than 60 days

- Change in Status (MDS)

  Select this option if the individual had a previous level 2 screening completed and a significant change MDS has been completed by the SNF **or** if the individual did not trigger a Level 2 screening on the original application, but now triggers a Level 2 screening.

- Replacement Form

  Select this option if the SNF is unable to locate **any** of the following records:
  - The approved forms (DA 124s) processed prior to 2013.
  - The approved Level 2 screening completed over 1 year ago.

- Redetermination (DMH Requested)

  Select this option if the previous Level 2 screening indicates "The following community alternatives to nursing facility services may be considered - Short term NF Level of Services with transitions to community."

# Section B. Current Location/Proposed Placement

**Reason for Submitting Application**

There is a drop down menu with the following options:

- Mental Hospital

  Client is over the age of 65.

  Seeking Medicaid Reimbursement for Mental Hospital Placement.

  For Mental Hospital Reimbursement the following should be attached to the online application

  1. Psychiatric History
  2. Social History
  3. Medical Summary
  4. Treatment Plan

  Please place a comment in Section C (Recent Medical Incidents)

  Reiterating the client is seeking Mental Hospital

  The 18 point count criteria does not apply to Mental Hospital applications.

# Section B. Current Location/Proposed Placement

**Individual's Current Physical Location**

- Provide the address of where the individual is physically located.

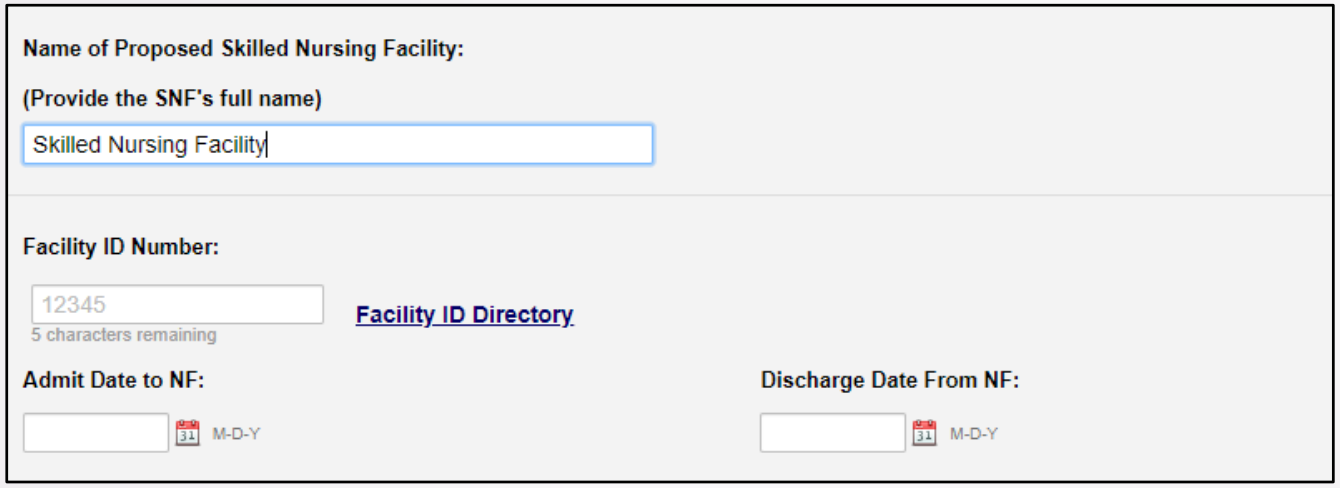
- This would be the address where Bock Associates will conduct the Level 2 screening if indicated.

**Name of Proposed Skilled Nursing Facility**

- If unknown – Leave blank

- If known – Please enter the correct Licensed Name of the SNF
  - When a SNF name is entered into this field 3 additional fields will appear Facility ID Number, Admit Date to NF, and Discharge Date from NF

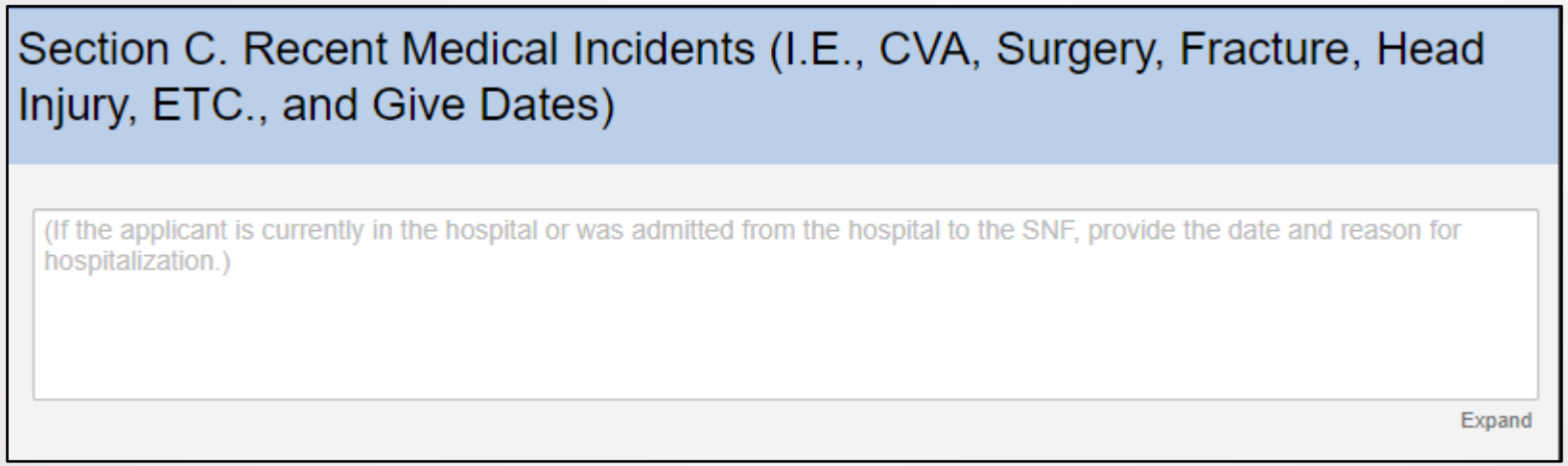
# Section B. Current Location/Proposed Placement




- If the Facility ID Number is unknown, click on the "Facility ID Directory" link .
  - This is a required field if the "Name of Proposed Skilled Nursing Facility" is answered.
  - This will link to the Missouri Long Term Care Facility Directory which is updated regularly.
    The facilities are listed in alphabetical order.
    In order to prompt the search option, the submitter can "right" click and choose "find".

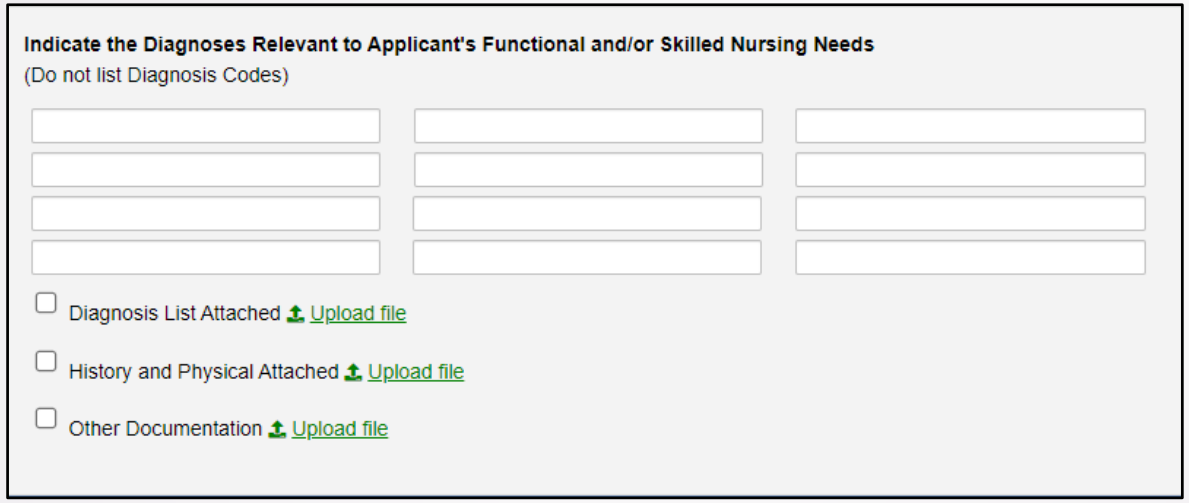
- Admit Date to NF and Discharge Date from NF:
  - If the individual has not admitted or discharged, this field is left blank.
  - If the individual admitted and/or discharged, please ensure these dates are accurate as they are linked to the Medicaid Payment.
  - This is entered in a "mm-dd-yyyy" format.

# Section C. Recent Medical Incidents




- The dates should be provided with the recent medical incidents.
- If the individual is currently in the hospital or admitted from the hospital, provide the date and reason for hospitalization.

# Section C. Recent Medical Incidents




- Diagnosis codes will **not** be accepted.

- The submitter can upload the Physician Order's instead of typing out the diagnoses.
  The file should be uploaded as a PDF under the "Diagnosis List Attached" link.
  The submitter can only upload one file in this section.

- The submitter can upload a History and Physical.
  The file should be uploaded as a PDF under the "History and Physical Attached" link.
  The Psychiatric Consult , Dementia testing, or other pertinent information can be uploaded here.
  The submitter can only upload one file in this section. The submitter would need to combine multiple documents to create one file when uploading.

# Section D. Assessed Needs

- There are **12 categories** under the Assessed Needs:
  Behavioral, Cognition, Mobility, Eating, Toileting, Bathing, Dressing and Grooming, Rehabilitative Services, Treatments, Meal Preparation, Medication Management and Safety

- Each category is **defaulted to O pts.**

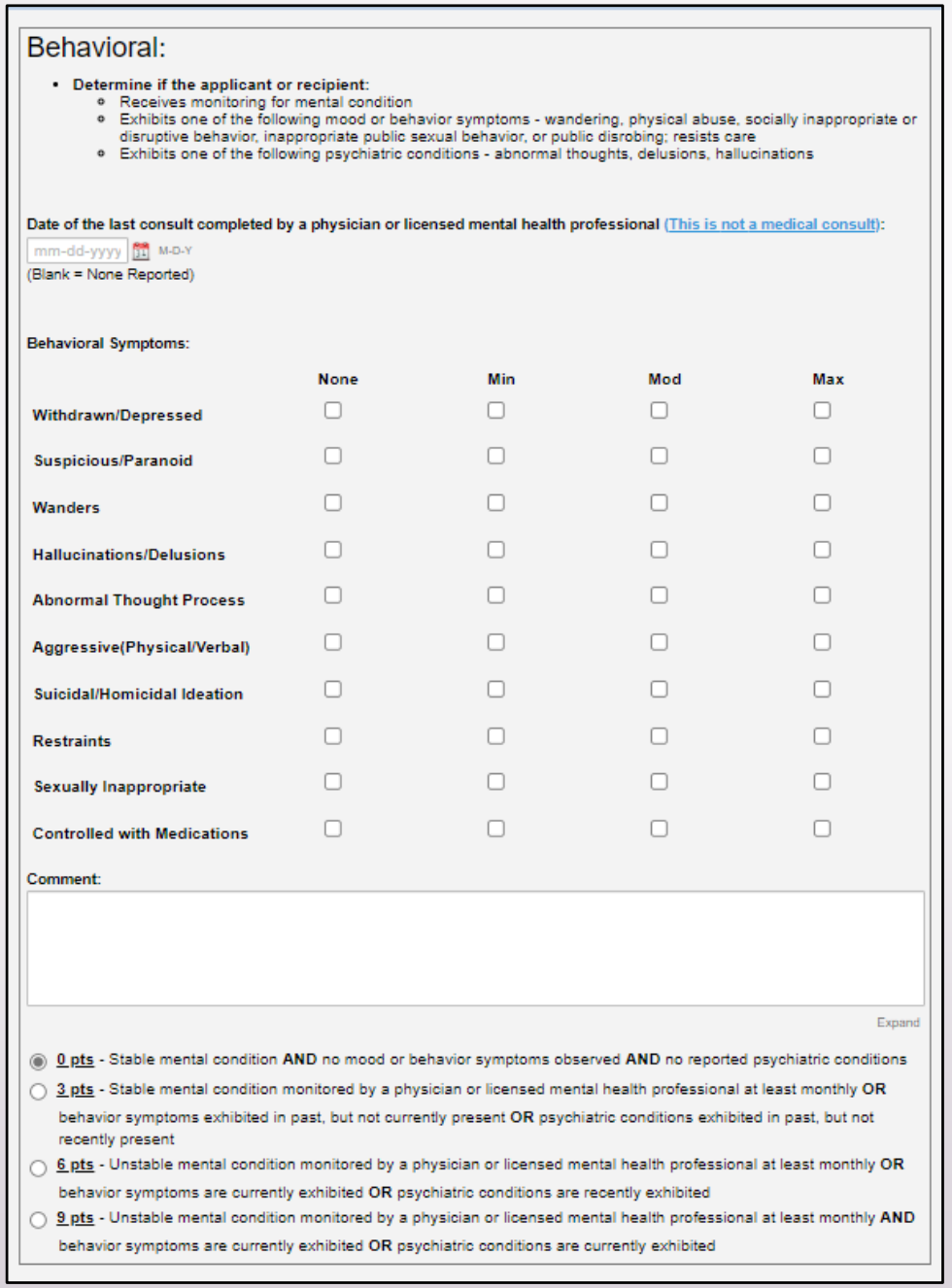
- The submitter must assess the individual in all categories to ensure an accurate point count.

- Each category has a "Comment" field for any additional information that might not have been captured for this individual in this category. This is **not** a required field.

- All categories (except for Meal Preparation and Medication Management) assessments should correlate with the individual's MDS.

- Reminder: The State Medical Consultants (SMC) base their point count on the submitted information provided on the application and supporting documentation.

# Behavioral:



## Behavioral:

- **Determine if the applicant or recipient:**
  - Receives monitoring for mental condition
  - Exhibits one of the following mood or behavior symptoms - wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior, or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions - abnormal thoughts, delusions, hallucinations

**Date of the last consult completed by a physician or licensed mental health professional** (This is not a medical consult):

mm-dd-yyyy M-D-Y

(Blank = None Reported)

**Behavioral Symptoms:**

| | None | Min | Mod | Max |
|---|---|---|---|---|
| **Withdrawn/Depressed** | ☐ | ☐ | ☐ | ☐ |
| **Suspicious/Paranoid** | ☐ | ☐ | ☐ | ☐ |
| **Wanders** | ☐ | ☐ | ☐ | ☐ |
| **Hallucinations/Delusions** | ☐ | ☐ | ☐ | ☐ |
| **Abnormal Thought Process** | ☐ | ☐ | ☐ | ☐ |
| **Aggressive(Physical/Verbal)** | ☐ | ☐ | ☐ | ☐ |
| **Suicidal/Homicidal Ideation** | ☐ | ☐ | ☐ | ☐ |
| **Restraints** | ☐ | ☐ | ☐ | ☐ |
| **Sexually Inappropriate** | ☐ | ☐ | ☐ | ☐ |
| **Controlled with Medications** | ☐ | ☐ | ☐ | ☐ |

**Comment:**

Expand

- ◉ **0 pts** - Stable mental condition **AND** no mood or behavior symptoms observed **AND** no reported psychiatric conditions
- ○ **3 pts** - Stable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms exhibited in past, but not currently present **OR** psychiatric conditions exhibited in past, but not recently present
- ○ **6 pts** - Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms are currently exhibited **OR** psychiatric conditions are recently exhibited
- ○ **9 pts** - Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **AND** behavior symptoms are currently exhibited **OR** psychiatric conditions are currently exhibited

# Behavioral:

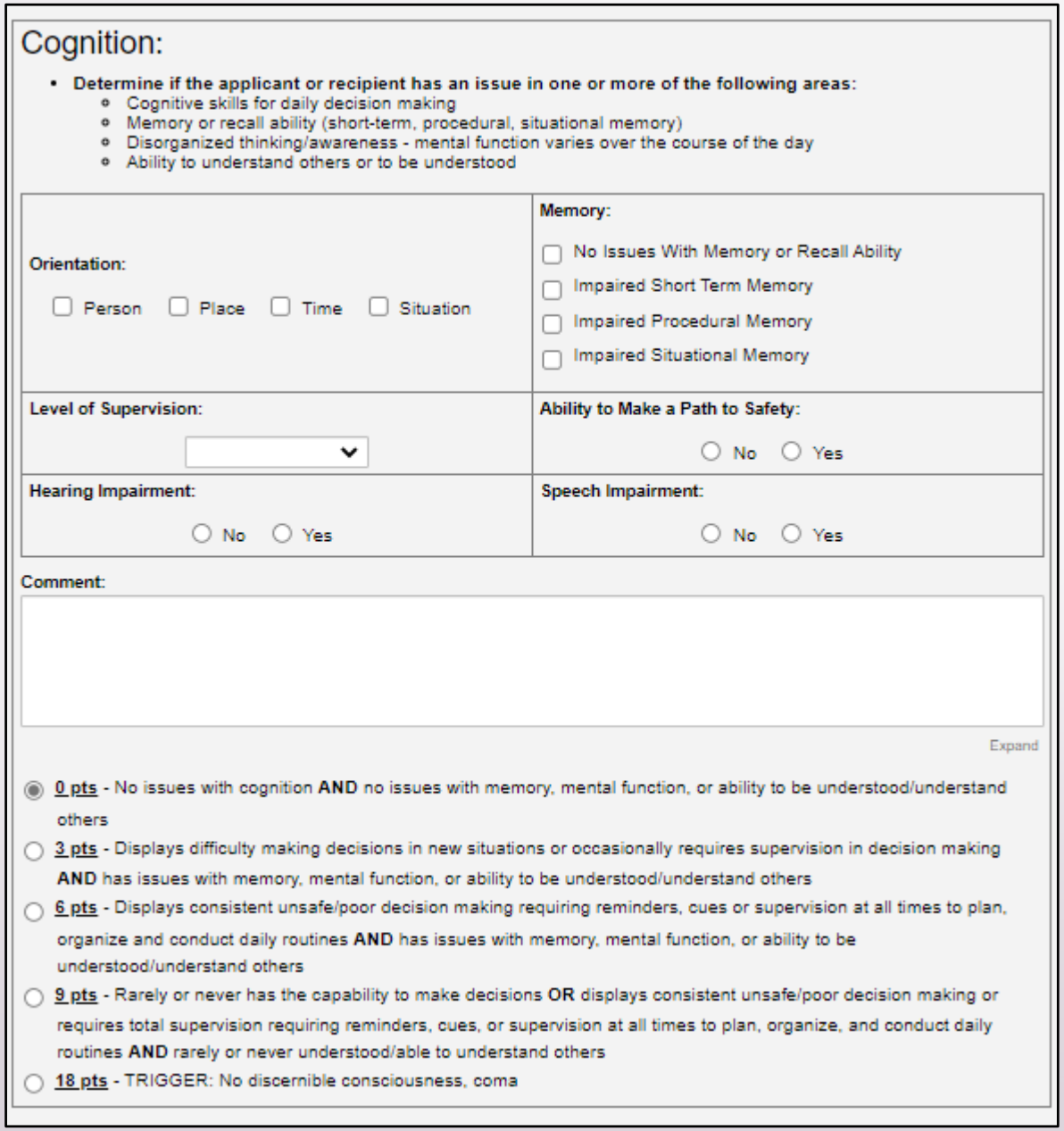
- Date of the last consult completed by a physician or licensed mental health professional
  This consult is in reference to the individual's behaviors.
  This is **not** a consult for a medical condition.

- A copy of the consult may be requested if the individual is exhibiting an unstable mental condition.

- Behavioral Symptoms:
  Is the individual currently exhibiting these behavioral symptoms?

- The submitter can provide additional information regarding the individual's behaviors in the "comment" field.

# Cognition:



## Cognition:

- **Determine if the applicant or recipient has an issue in one or more of the following areas:**
  - Cognitive skills for daily decision making
  - Memory or recall ability (short-term, procedural, situational memory)
  - Disorganized thinking/awareness - mental function varies over the course of the day
  - Ability to understand others or to be understood

| | |
|---|---|
| **Orientation:** ☐ Person ☐ Place ☐ Time ☐ Situation | **Memory:** ☐ No Issues With Memory or Recall Ability ☐ Impaired Short Term Memory ☐ Impaired Procedural Memory ☐ Impaired Situational Memory |
| **Level of Supervision:** | **Ability to Make a Path to Safety:** ○ No ○ Yes |
| **Hearing Impairment:** ○ No ○ Yes | **Speech Impairment:** ○ No ○ Yes |

**Comment:**

Expand

- ◉ **0 pts** - No issues with cognition **AND** no issues with memory, mental function, or ability to be understood/understand others
- ○ **3 pts** - Displays difficulty making decisions in new situations or occasionally requires supervision in decision making **AND** has issues with memory, mental function, or ability to be understood/understand others
- ○ **6 pts** - Displays consistent unsafe/poor decision making requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines **AND** has issues with memory, mental function, or ability to be understood/understand others
- ○ **9 pts** - Rarely or never has the capability to make decisions **OR** displays consistent unsafe/poor decision making or requires total supervision requiring reminders, cues, or supervision at all times to plan, organize, and conduct daily routines **AND** rarely or never understood/able to understand others
- ○ **18 pts** - TRIGGER: No discernible consciousness, coma

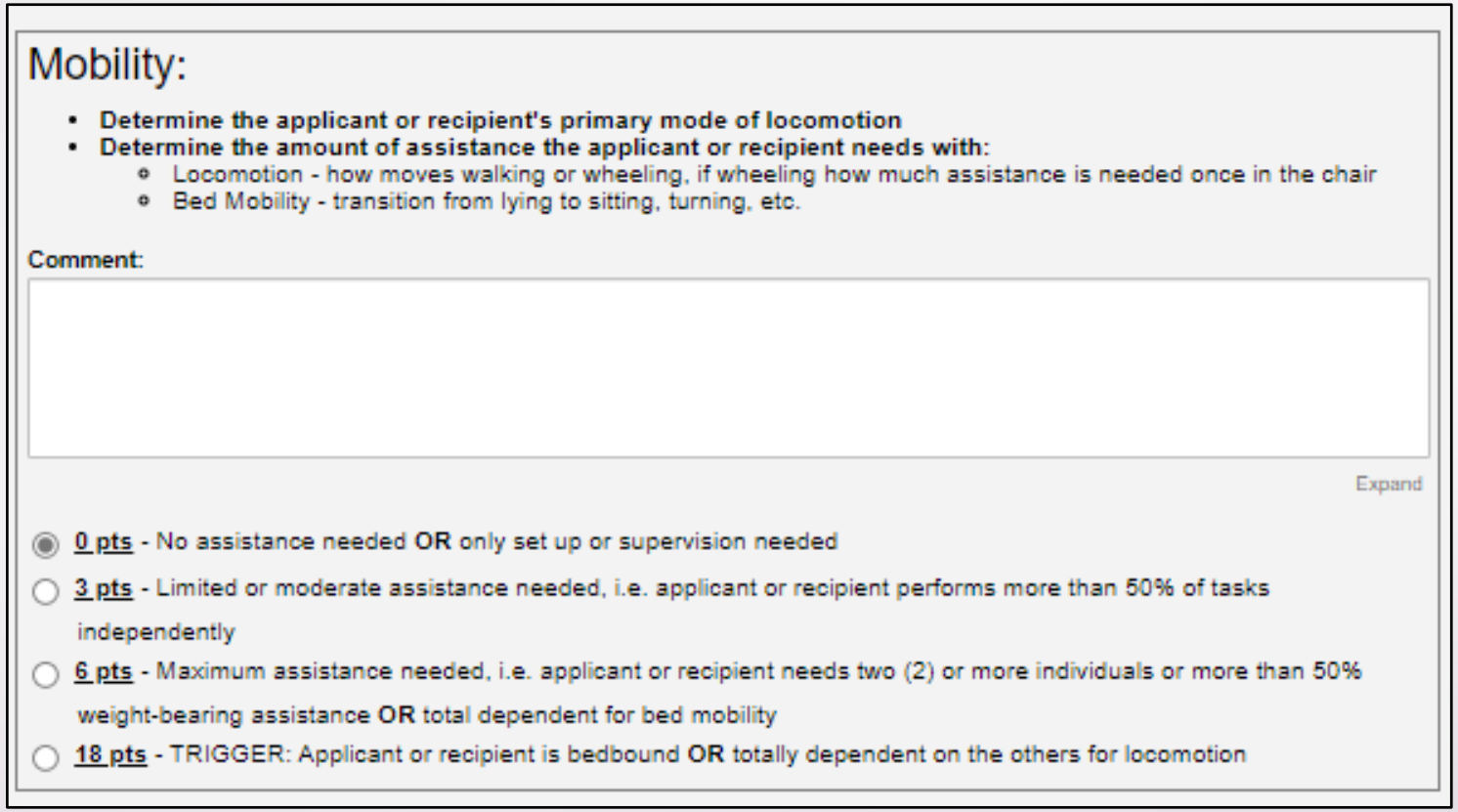
# Cognition:

- Level of Supervision
  There is a drop down menu with the following options:
  - 1:1 / Sitter
  - 15 minute checks
  - 2 hour checks
  - 2:1 / Sitter
  - Line of Sight
  - Video Camera
  - Elopement Risk
  - 30 minute checks

- If the "Level of Supervision" is not listed, please provide information in the "Comment" field.

- If Major Neurocognitive Disorder is indicated primary on the Level One Form, the information should reflect in this section.

# Mobility:



Mobility:

- **Determine the applicant or recipient's primary mode of locomotion**
- **Determine the amount of assistance the applicant or recipient needs with:**
  - Locomotion - how moves walking or wheeling, if wheeling how much assistance is needed once in the chair
  - Bed Mobility - transition from lying to sitting, turning, etc.

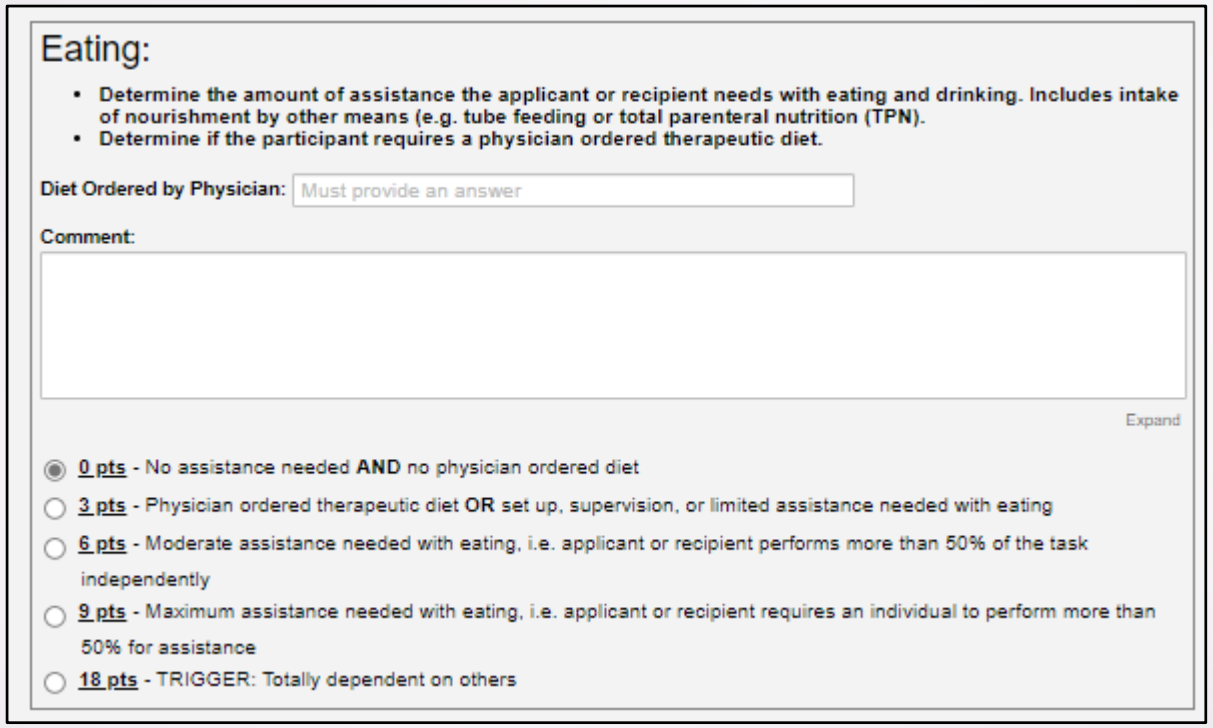
**Comment:**

Expand

- (●) **0 pts** - No assistance needed **OR** only set up or supervision needed
- ( ) **3 pts** - Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
- ( ) **6 pts** - Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals or more than 50% weight-bearing assistance **OR** total dependent for bed mobility
- ( ) **18 pts** - TRIGGER: Applicant or recipient is bedbound **OR** totally dependent on the others for locomotion

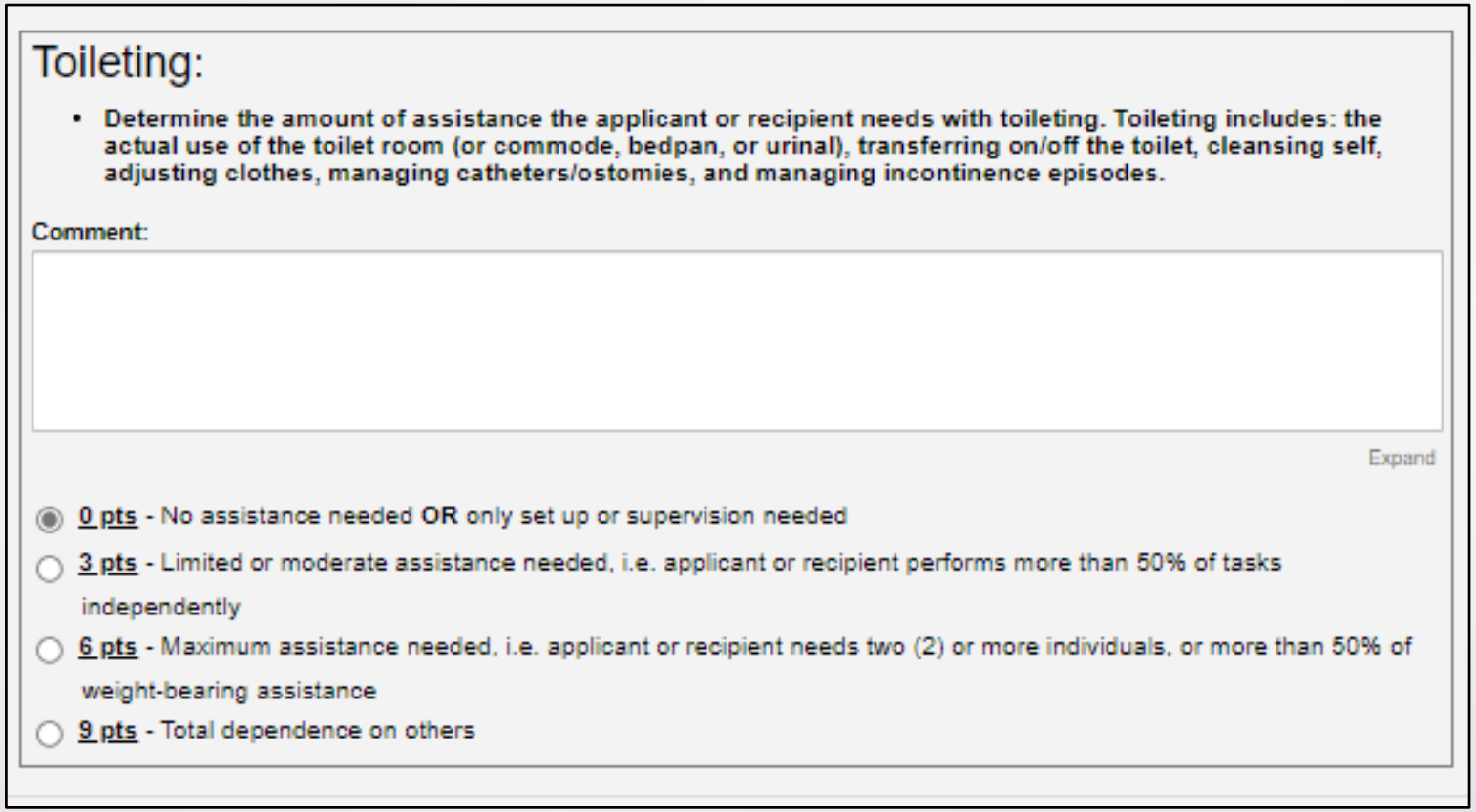
- Points should be given in this section based on a current assessment of the individual's mobility needs

# Eating:



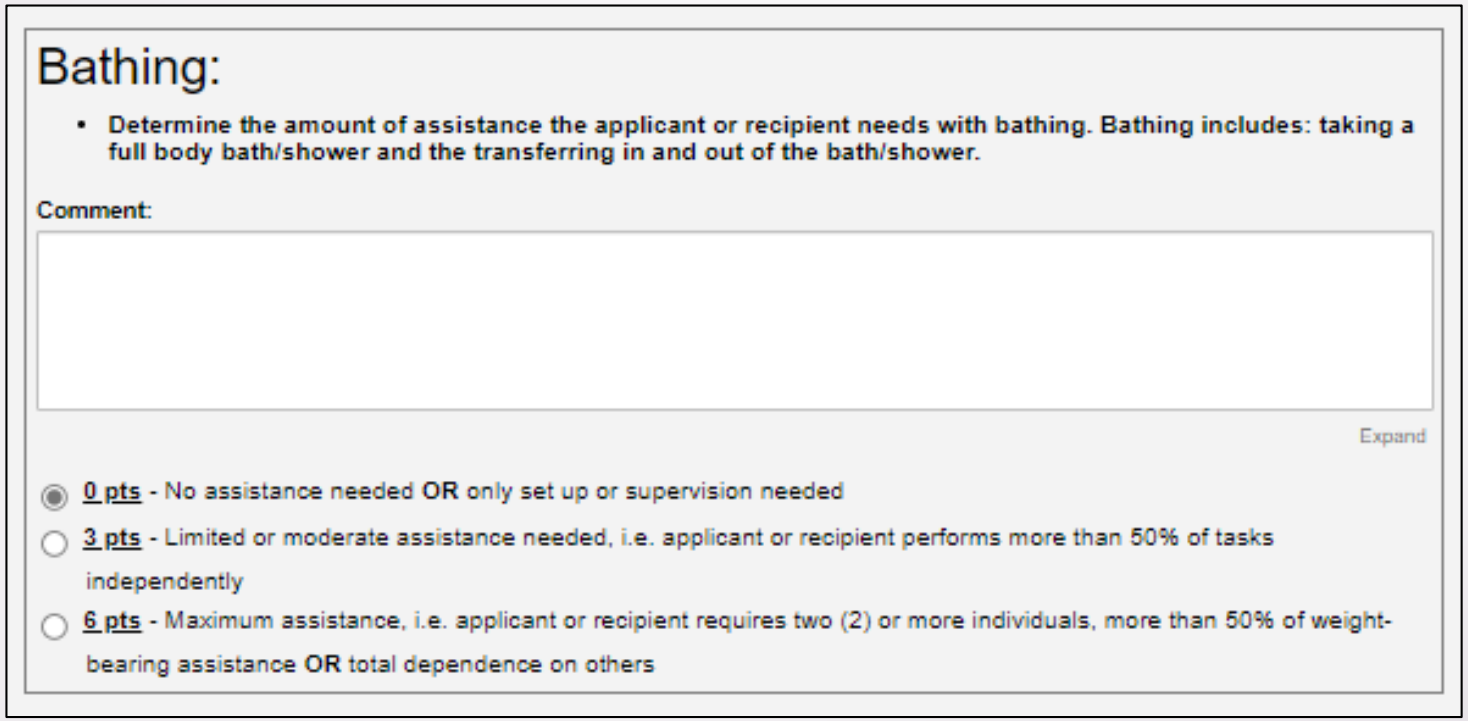

- The "Diet Ordered by Physician" is a required field.
- Points should be given in this section based on a current assessment of the individual's eating needs.

# Toileting:




- Points should be given in this section based on a current assessment of the individual's toileting needs

# Bathing:



Bathing:

- **Determine the amount of assistance the applicant or recipient needs with bathing. Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.**

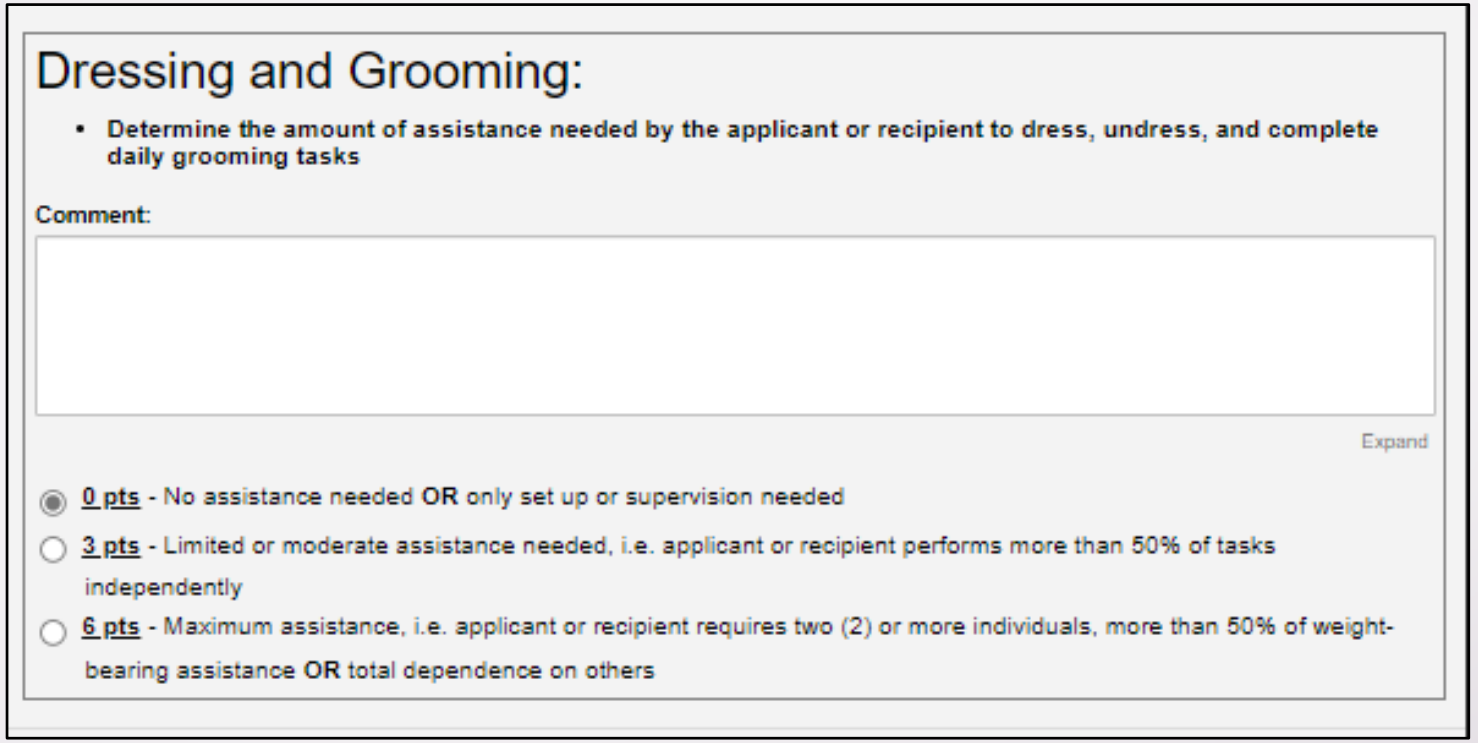
Comment:

Expand

- (●) 0 pts - No assistance needed **OR** only set up or supervision needed
- ( ) 3 pts - Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
- ( ) 6 pts - Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance **OR** total dependence on others

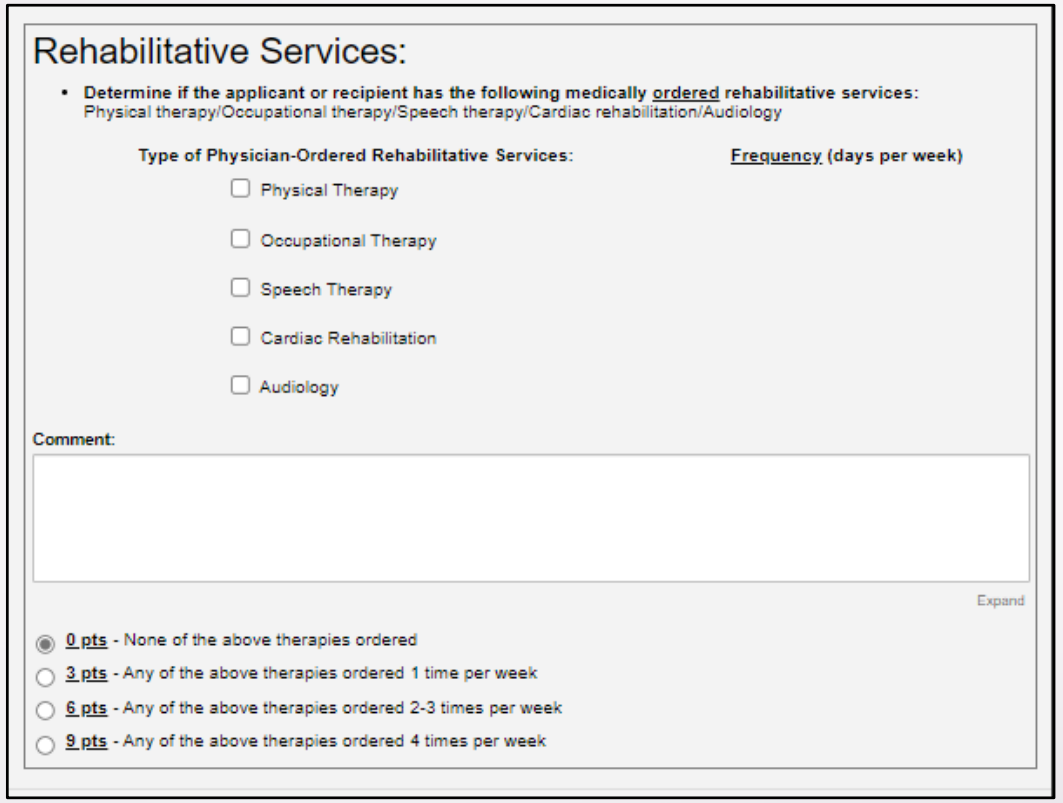
- Points should be given in this section based on a current assessment of the individual's bathing needs

# Dressing and Grooming:




- Points should be given in this section based on a current assessment of the individual's dressing and grooming needs

# Rehabilitative Services:



Rehabilitative Services:

- **Determine if the applicant or recipient has the following medically ordered rehabilitative services:**
  Physical therapy/Occupational therapy/Speech therapy/Cardiac rehabilitation/Audiology

**Type of Physician-Ordered Rehabilitative Services:** **Frequency (days per week)**

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Cardiac Rehabilitation
- ☐ Audiology

**Comment:**

Expand

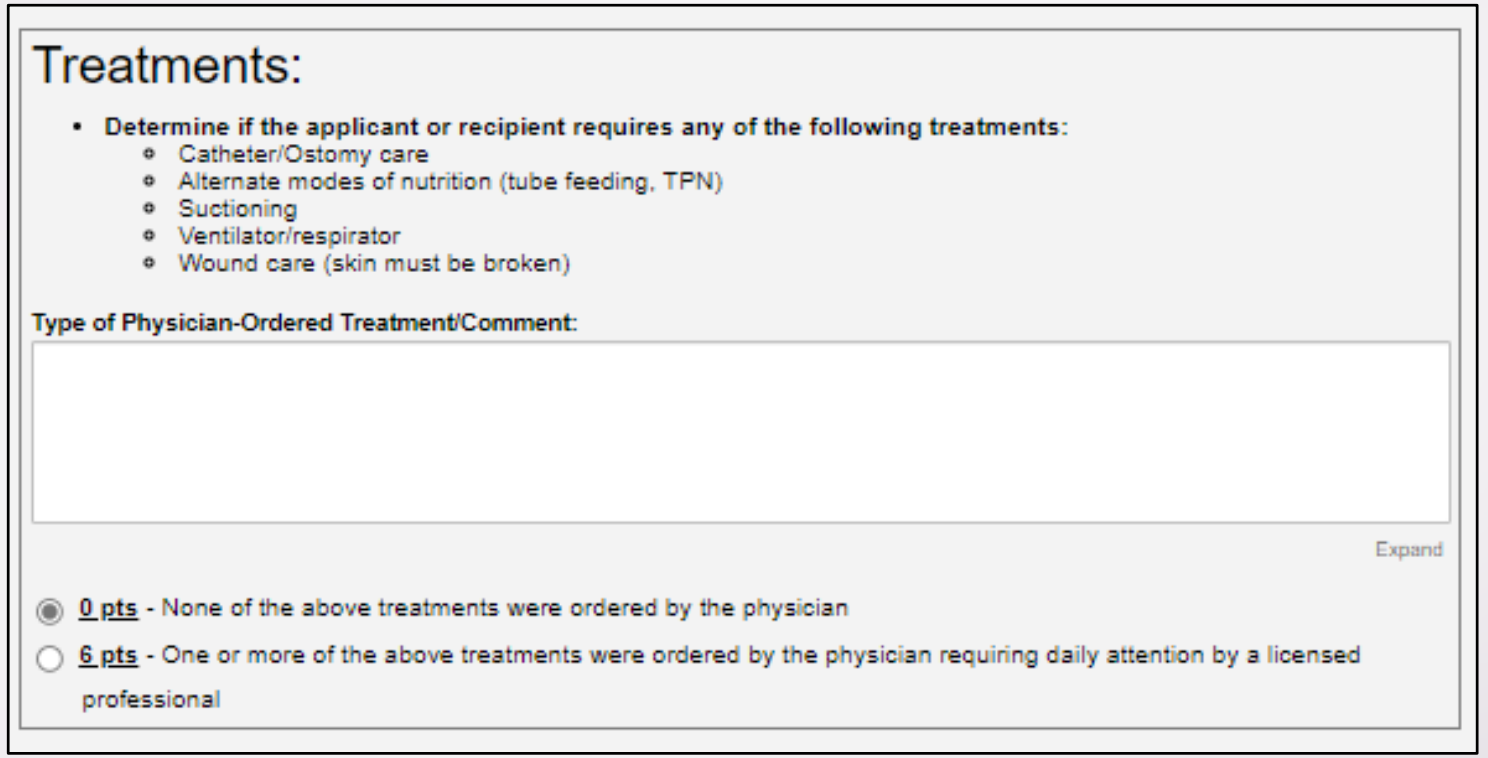
- ◉ 0 pts - None of the above therapies ordered
- ○ 3 pts - Any of the above therapies ordered 1 time per week
- ○ 6 pts - Any of the above therapies ordered 2-3 times per week
- ○ 9 pts - Any of the above therapies ordered 4 times per week

- A "Frequency" field will appear when any of the boxes are marked for Physician-Ordered Rehabilitative Services. The submitter would provide the frequency of the Rehabilitative Service the individual is currently receiving.
- A physician order for "evaluate and treat" will be evaluated as O pts.



- If multiple Rehabilitative Services are being received, the submitter would combine their frequency together to assess for a total point count.

# Treatments:



Treatments:

- **Determine if the applicant or recipient requires any of the following treatments:**
  - Catheter/Ostomy care
  - Alternate modes of nutrition (tube feeding, TPN)
  - Suctioning
  - Ventilator/respirator
  - Wound care (skin must be broken)

**Type of Physician-Ordered Treatment/Comment:**

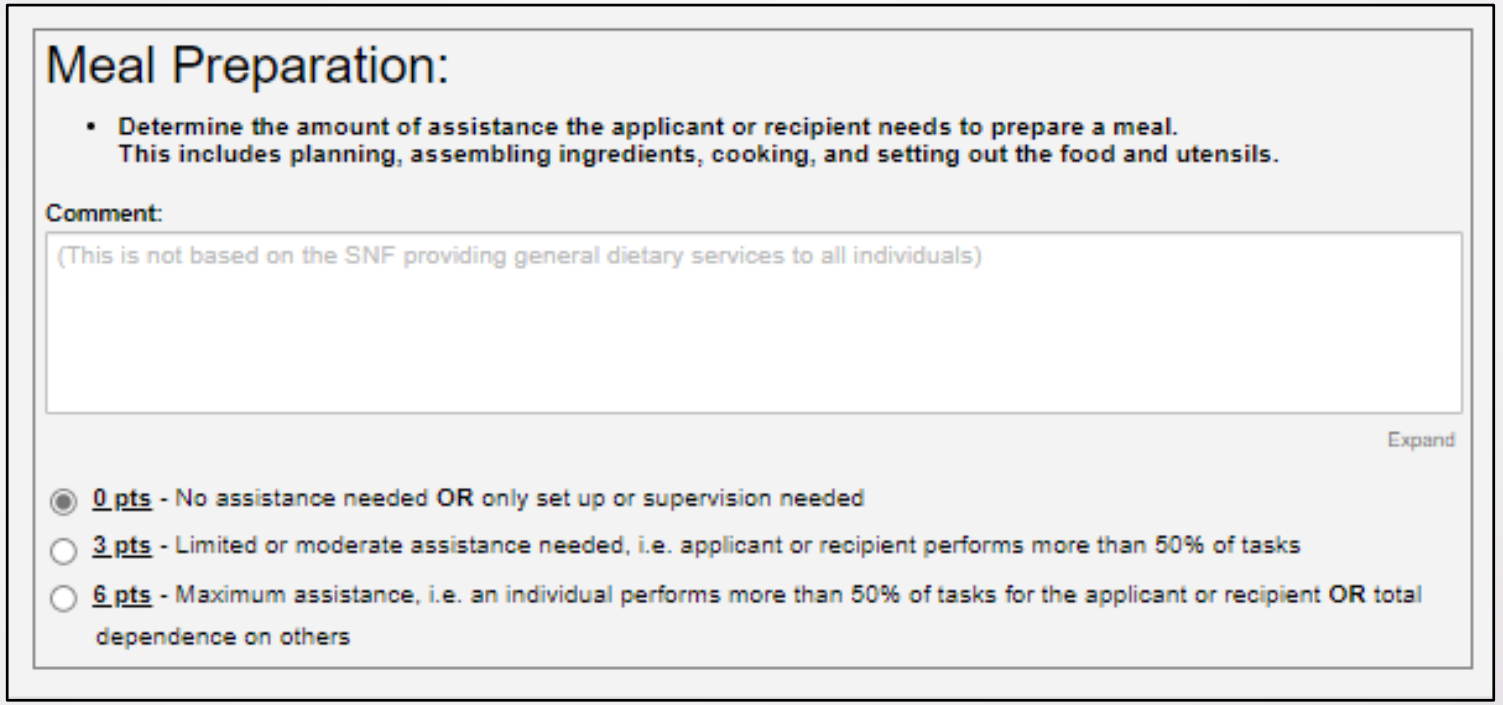
Expand

(•) **0 pts** - None of the above treatments were ordered by the physician

( ) **6 pts** - One or more of the above treatments were ordered by the physician requiring daily attention by a licensed professional

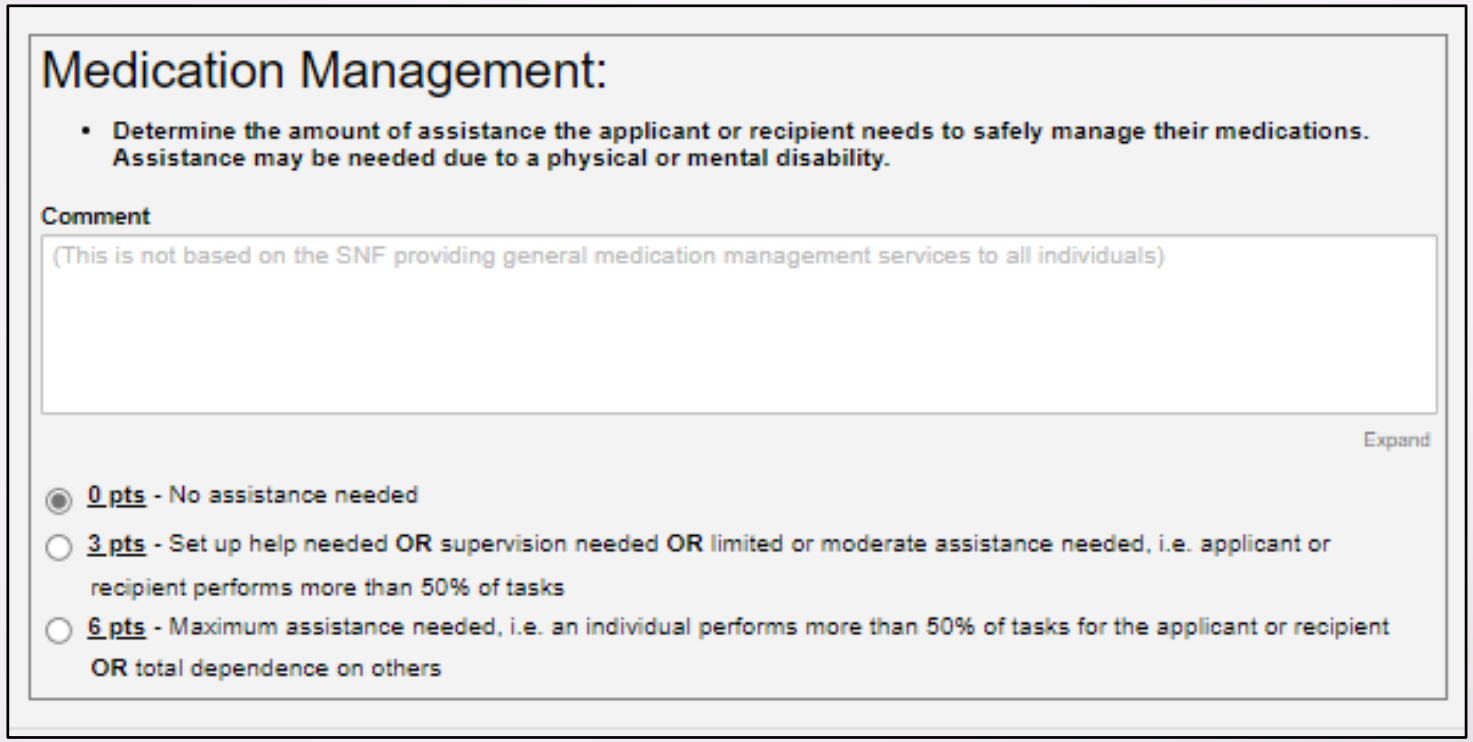
- Only the treatments **listed above** will be assessed for points in this category.
- The type of Physician-Ordered Treatment **must** be listed to obtain points in this category.

# Meal Preparation:



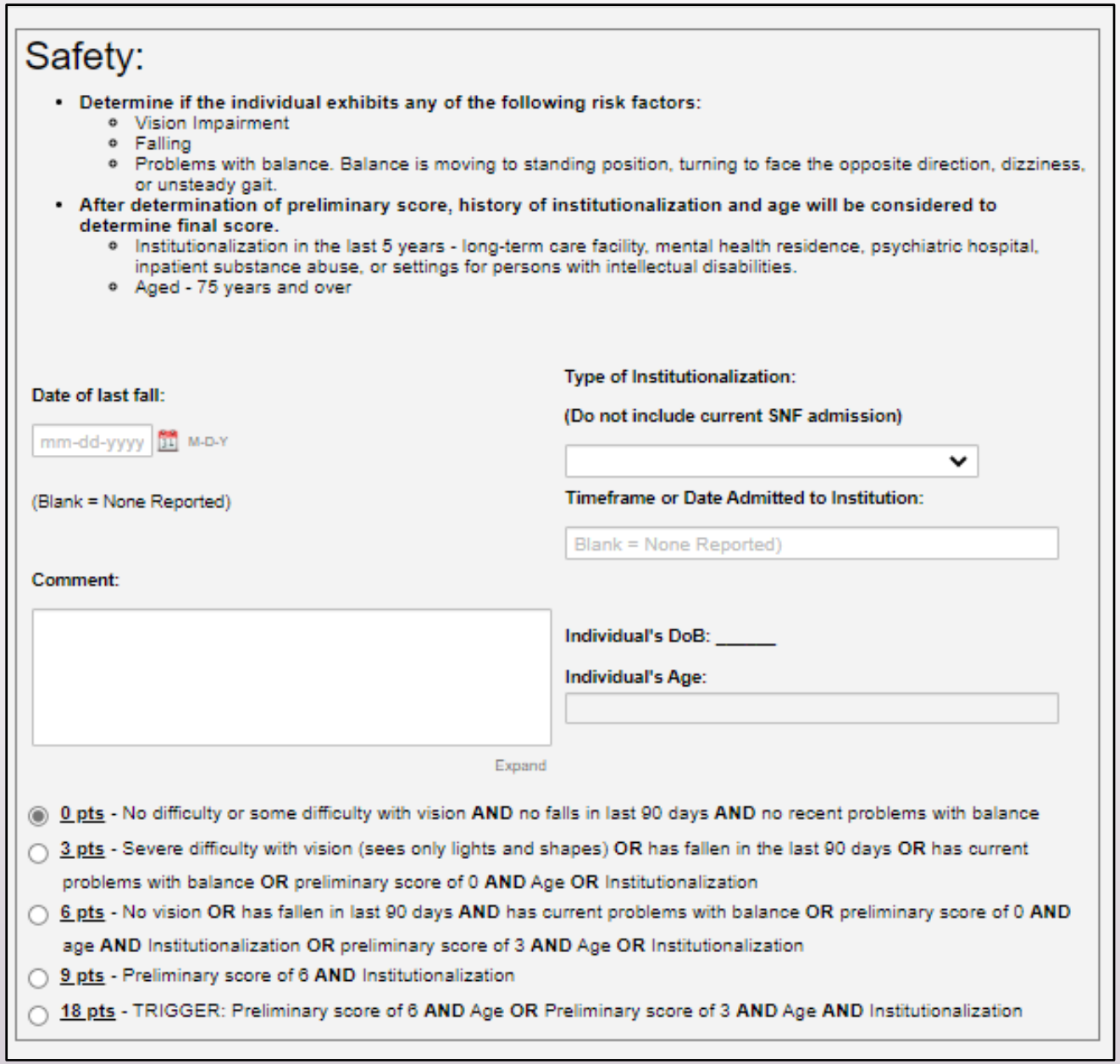

- This is <u>not</u> based on the SNF providing general dietary services to all individuals.
- The submitter must assess the individual's current ability to prepare their own meals.

# Medication Management:




- This is not based on the SNF providing general medication management services to all individuals.
- The submitter must assess the individual's current ability to safely manage their medications.

# Safety:



## Safety:

- **Determine if the individual exhibits any of the following risk factors:**
  - Vision Impairment
  - Falling
  - Problems with balance. Balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait.
- **After determination of preliminary score, history of institutionalization and age will be considered to determine final score.**
  - Institutionalization in the last 5 years - long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities.
  - Aged - 75 years and over

**Date of last fall:**

mm-dd-yyyy M-D-Y

(Blank = None Reported)

**Type of Institutionalization:**

**(Do not include current SNF admission)**

**Timeframe or Date Admitted to Institution:**

Blank = None Reported)

**Comment:**

Expand

**Individual's DoB: _____**

**Individual's Age:**

- ◉ **0 pts** - No difficulty or some difficulty with vision **AND** no falls in last 90 days **AND** no recent problems with balance
- ○ **3 pts** - Severe difficulty with vision (sees only lights and shapes) **OR** has fallen in the last 90 days **OR** has current problems with balance **OR** preliminary score of 0 **AND** Age **OR** Institutionalization
- ○ **6 pts** - No vision **OR** has fallen in last 90 days **AND** has current problems with balance **OR** preliminary score of 0 **AND** age **AND** Institutionalization **OR** preliminary score of 3 **AND** Age **OR** Institutionalization
- ○ **9 pts** - Preliminary score of 6 **AND** Institutionalization
- ○ **18 pts** - TRIGGER: Preliminary score of 6 **AND** Age **OR** Preliminary score of 3 **AND** Age **AND** Institutionalization

# Safety:

- Date of last fall
  If no reported fall, this field is left blank.

- Type of Institutionalization:
  There is a drop down menu with the following options:
  - None
  - DMH Psychiatric Hospital and Facilities
  - SNF (Skilled Nursing Facility)
  - ICF (Intermediate Care Facility)
  - RCF (Residential Care Facility)
  - ALF (Assisted Living Facility)
  - Mental Health Residence
  - Inpatient Substance Abuse Treatment
  - Psychiatric Hospital/Unit
  - Settings for Persons with Intellectual Disabilities

- Timeframe or Date Admitted to Institution:
  If submitter indicates additional points for Institutionalization, the timeframe or date must be provided.
  A response of "unknown" is **not** acceptable.

# Safety:

- Age

  The "Individual's DoB" (Date of Birth) will auto-populate based on the information completed on the Level One Form. The "Individual's Age" appears automatically.

- Points
  - Determination of preliminary score
    - Assess the individual's vision, falls status, and current balance problems
      Fall risk is not the same as having a current problem with balance.

  Which point count (0-3) best portrays the individual – (do not assess age or institutionalization)?

  After the preliminary score is obtained, the submitter will assess the age and institutionalization.

  **Example #1:** Yesterday, an 89-year-old individual admitted to the hospital for falls. The individual fell at home and reported they have issues with balance. The individual indicated no previous institutionalization. The individual has no issues with their vision.

  The individual would have a preliminary score of 6. Individual is 89-years-old (over 75) and no institutionalization.



**The submitter would choose 18 points, based upon a preliminary score of 6 and Age.**

# Safety:

**Example #2 :** Yesterday, A 45-year-old individual admitted to the psychiatric hospital for Schizophrenia. The Individual has been residing at a Residential Care Facility (RCF) for 2 years. The individual has no issues with vision. The individual has had no reported falls within the past 90 days nor issues with balance. The individual's record indicates fall risk due to receiving psychotropic medication.

The individual would have a preliminary score of 0. Individual is 45-years-old (under 75) and has been institutionalized (Psychiatric Hospital and RCF).

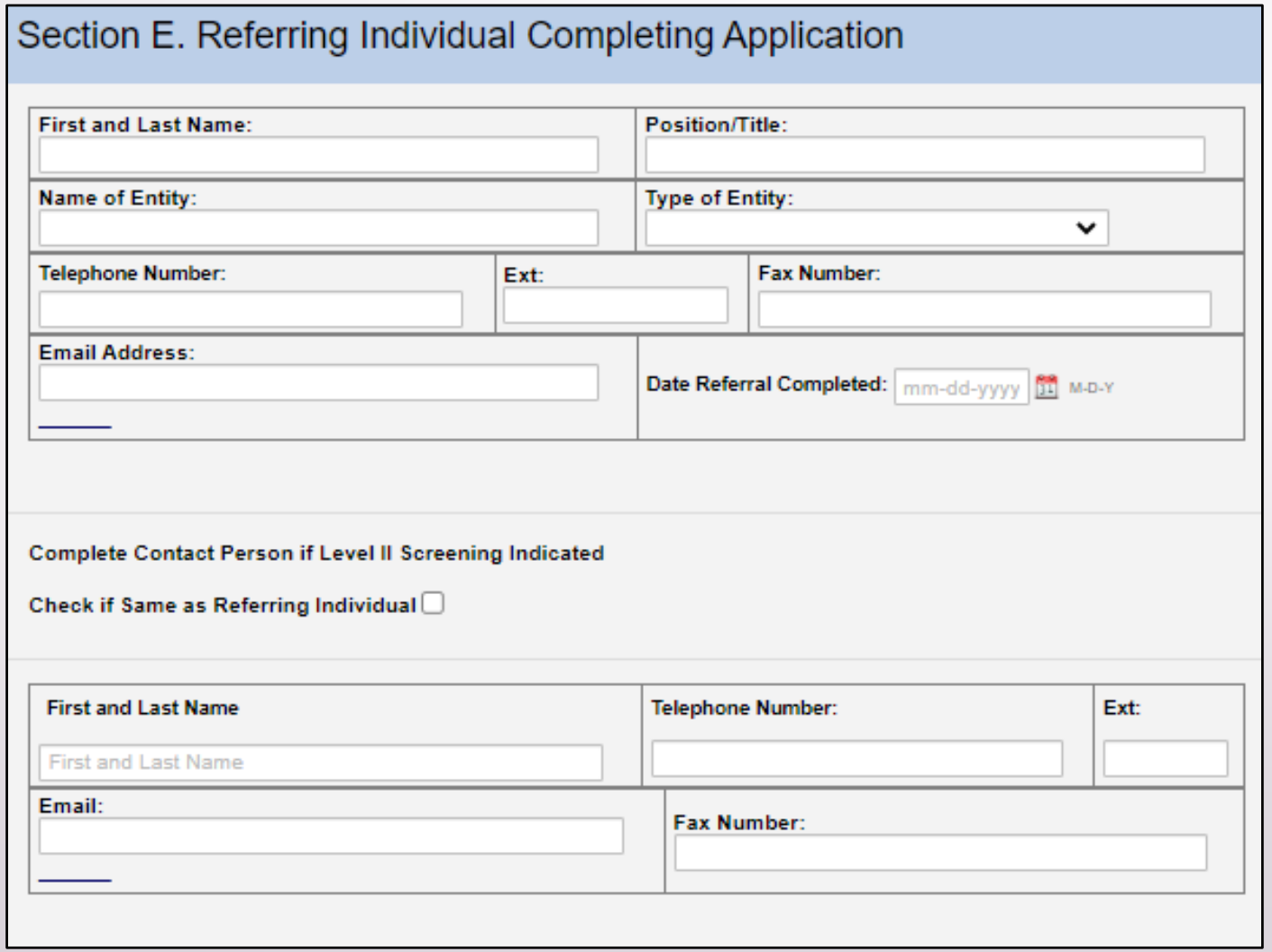
**The submitter would choose 3 points, based upon a preliminary score of 0 and Institutionalization.**

**Example # 3 –** Using Example #2 but changing the individual's age to 76.

The individual would have a preliminary score of 0. Individual is 76-years-old (over 75) and has been institutionalized (Psychiatric Hospital and RCF).

**The submitter would choose 6 points, based upon a preliminary score of 0 and Institutionalization and Age.**

# Section E. Referring Individual Completing Application



- Type of Entity

  There is a drop down menu with the following options:
  - DMH Group Home / Individualized Supported Living
  - Family / Legal Guardian
  - Hospital (Medical Unit)
  - Hospital (Psychiatric Unit)
  - Intermediate Care Facility (ICF)
  - Skilled Nursing Facility (SNF)
  - Residential Care Facility (RCF)
  - Assisted Living Facility (ALF)
  - DMH Psychiatric Hospital and Facilities
  - Other
  - ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disabilities)

- Complete Contact Person if Level II Screening Indicated

  If the "Referring Individual Completing Application" and "Contact Person" for the Level II Screening are the same, mark the box and the contact person information will disappear.

# Submitting the Application to COMRU


Central Office Use Only (DRL/COMRU)

Client: _____ _____

Level of Care Determination by DRL Central Office (COMRU)

Application Submitted to COMRU: _____

Application Accepted: _____ | Correction: _____

Meets level of care: _____

Application Type: _____

Point Count

There is a mandated 18 point count for SNF placement

_____ DHSS COMRU

_____ Submitter

Signature: _____

Date:

_____

If Level 2 indicated above:

Special Admissions Category: _____ | Valid: _____

Date Referred to DMH for Level 2 Screening: _____

Date Due from DMH: _____

DHSS Determination: _____

Level 2 Determination (DMH)

Mental Illness: _____

Intellectual Disability: _____

Previous Level 2 Determination: _____

Previous Level 2 Screening: _____

Application Status: _____

Bock Associates

Level 2 Evaluation

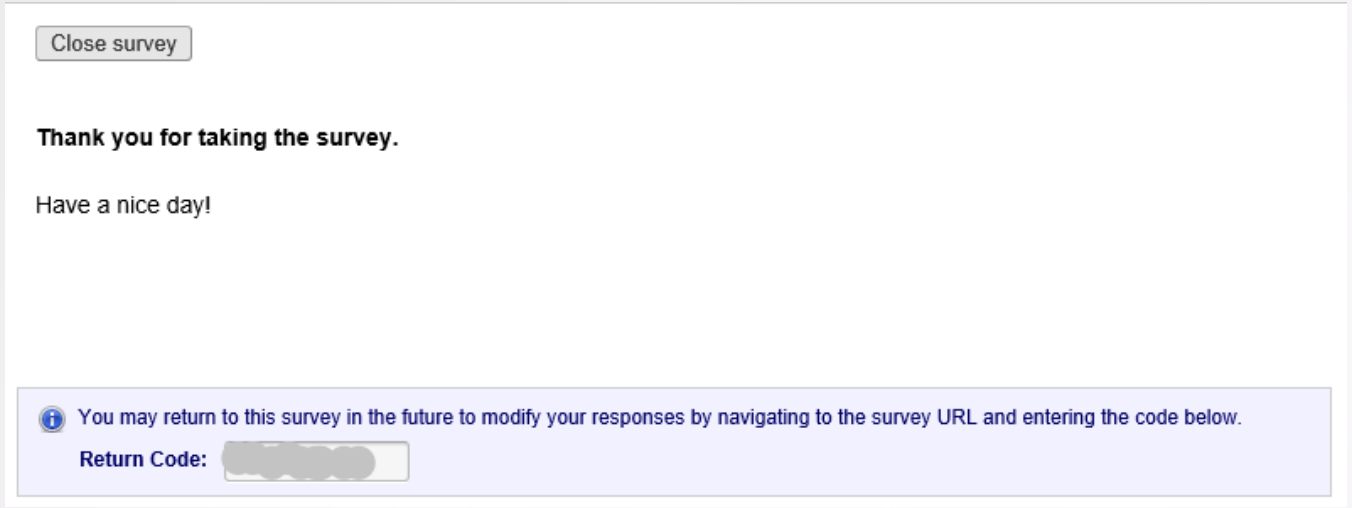
_____

Level 2 Determination

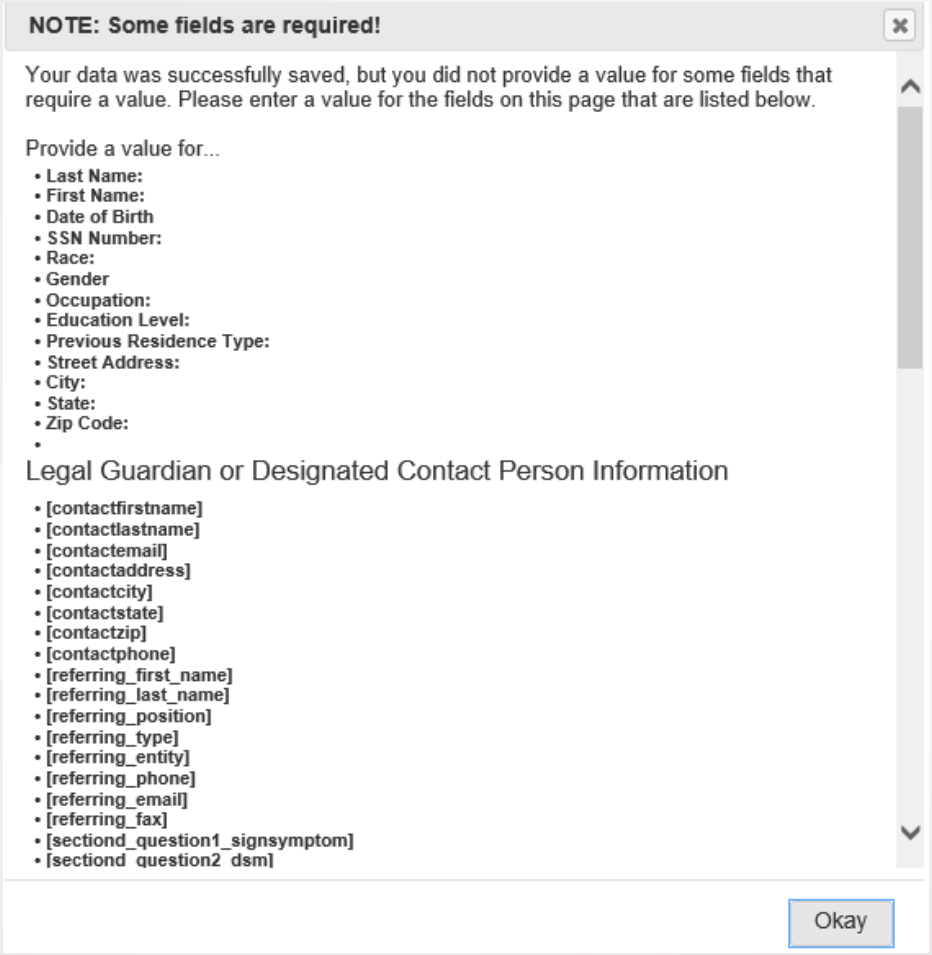
_____

Submit - Ready for Processing by COMRU

Save & Return Later




- The "Save and Return Later" button will allow the submitter to complete the application at different times.
- When the application is completed and ready to be processed by COMRU, the submitter will click "Submit."'
- The submitter will receive the above notification when the application is submitted to COMRU for review. The submitter needs to ensure that this screen appears before exiting the application.




- The submitter must ensure all required fields are answered. If the application is not complete, the submitter will receive an error message with the list of missing information.
- The missing information **does not** highlight in the application.
- The submitter will need to locate the section of the application that is referenced by the error message, correct it, and then click "Submit"

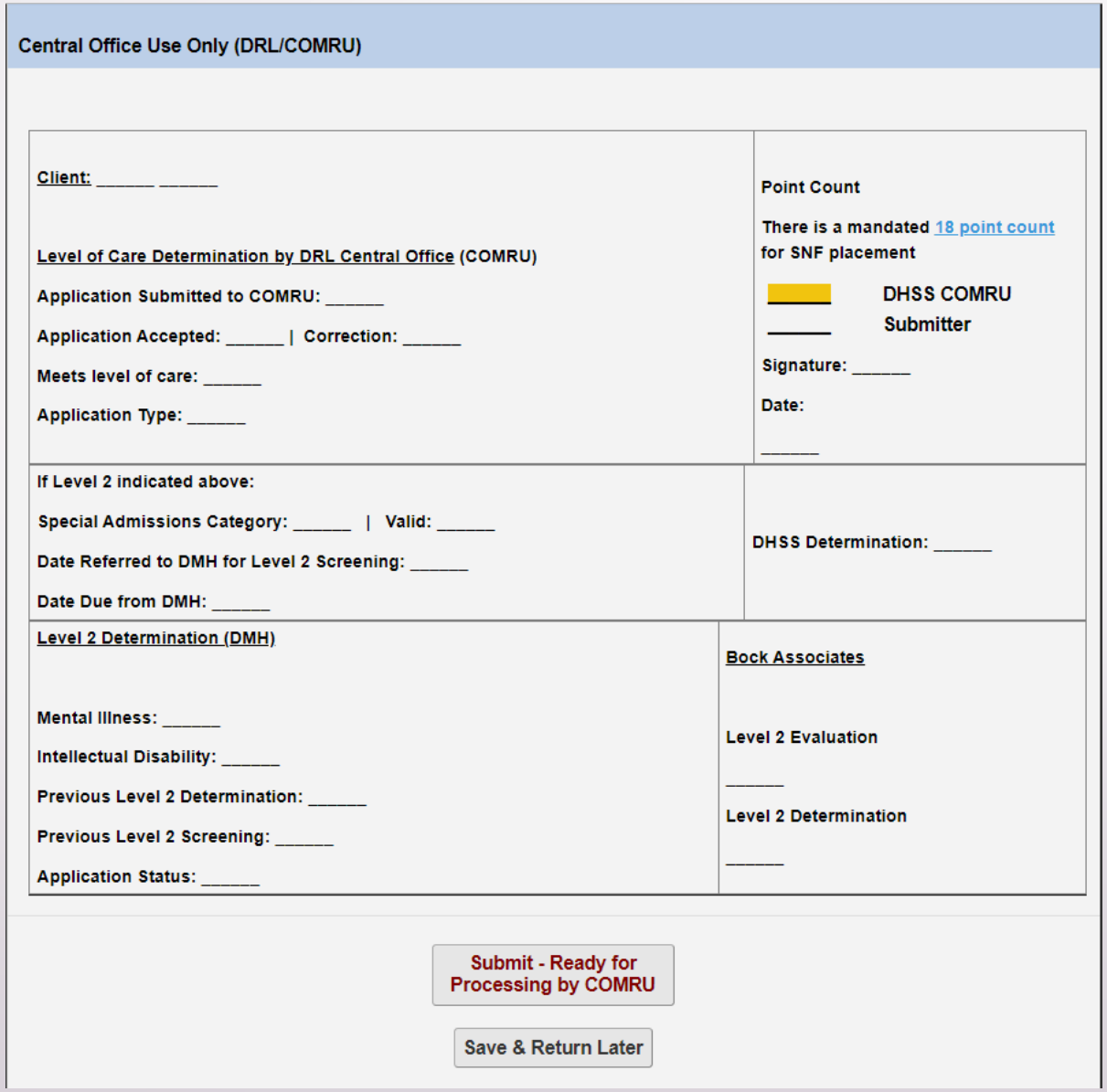
# Central Office Use Only (DRL/COMRU)

- The submitter can return to the application to check the status and see if it has been processed.

**Important:** If the application is already submitted and the submitter is checking status,
**Do Not** click the "Submit" or "Save and Return Later" buttons.
Close the application by clicking on the red "X" in the upper right hand corner

- The submitter must print the assessment.
- The assessment can also be saved to the submitter's computer depending on their program.

# Central Office Use Only (DRL/COMRU)



# Contact Information

Ammanda Ott
Registered Nurse Specialist/Supervisor
Division of Regulation and Licensure / COMRU

Telephone: 573-522-3092 (option 4)
Email: COMRU@health.mo.gov
Webpage: https://health.mo.gov/seniors/nursinghomes/pasrr.php