MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE

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LEVEL ONE NURSING FACILITY PRE-ADMISSION SCREENING FOR MENTAL ILLNESS/INTELLECTUAL DISABILITY OR RELATED CONDITION

SECTION A. INDIVIDUAL'S IDENTIFYING INFORMATION

NAME (LAST, FIRST, MIDDLE, INITIAL, SUFFIX)	DATE OF BIRTH
DCN (MEDICAID NUMBER)	SSN NUMBER
RACE	GENDER
EDUCATION LEVEL	OCCUPATION

SECTION B. INDIVIDUAL'S CONTACT INFORMATION

PREVIOUS RESIDENCE TYPE

STREET ADDRESS

CITY	STATE	ZIP CODE

LEGAL GUARDIAN OR DESIGNATED CONTACT PERSON INFORMATION

☐ None ☐ Legal Guardian ☐ Designated Contact Person

RELATIONSHIP	FIRST NAME	LAST NAME

E-MAIL

STREET ADDRESS

CITY	STATE	ZIP	TELEPHONE

SECTION C. REFERRING INDIVIDUAL COMPLETING APPLICATION

FIRST NAME	LAST NAME
POSITION/TITLE	TYPE OF ENTITY
NAME OF ENTITY	PHONE NUMBER
EMAIL ADDRESS	FAX NUMBER

SECTION D. LEVEL ONE SCREENING CRITERIA FOR SERIOUS MENTAL ILLNESS

1. Does the individual show any signs or symptoms of a Major Mental Illness? ☐ Yes ☐ No

   Signs/Symptoms: _____

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

   ☐ Schizophrenia
   ☐ Psychotic Disorder
   ☐ Dysthymic Disorder
   ☐ Conversion Disorder
   ☐ Somatic Symptom Disorder
   ☐ Anxiety Disorder
   ☐ Schizoaffective Disorder
   ☐ Major Depressive Disorder
   ☐ Panic Disorder
   ☐ Personality Disorder
   ☐ Dissociative Identity Disorder
   ☐ Delusional Disorder
   ☐ Bipolar Disorder
   ☐ Obsessive-Compulsive Disorder
   ☐ PTSD
   ☐ Mood Disorder
   ☐ Anorexia Nervosa or other eating disorders
   ☐ Other Mental Disorder in the DSM: _____

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

☐ 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.

☐ 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.

☐ 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.

4. Within the last 2 years has the individual: (Record YES if Either/Both of the two subcategories below are checked) ☐ Yes ☐ No

☐ 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.

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

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

When did the most recent substance abuse occur?
☐ N/A ☐ 1-30 days ☐ 31-90 days ☐ Unknown

6. Does the individual have a diagnosis of Major Neurocognitive Disorder (MNCD) i.e., dementia or Alzheimer's? ☐ Yes ☐ No

Were any of the following criteria used to establish the basis for the MNCD: ☐ N/A ☐ Yes ☐ No

Standardized Mental Status Exam (type)_____ Date Completed _____ Score _____

☐ Neurological Exam
☐ History and Symptoms
☐ Other Diagnostics: Specify _____

Has the Physician documented MNCD as the primary diagnosis OR that MNCD is more progressed than a co-occurring mental illness diagnosis? (Provide documentation if answered yes) ☐ N/A ☐ Yes ☐ No

SECTION E. LEVEL ONE SCREENING CRITERIA FOR INTELLECTUAL DISABILITY OR RELATED CONDITION

1. Is the individual known or suspected to have a diagnosis of Intellectual Disability that originated prior to age 18? ☐ Yes ☐ No

If Yes, indicated diagnosis: _____

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

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

2b. Did the Other Related Condition develop before age 22? ☐ N/A ☐ Unknown ☐ Yes ☐ No

Age/Date: _____
(Please provide the date/age of onset for each Related Condition indicated)

2c. Likely to continue indefinitely? ☐ N/A ☐ Yes ☐ No

2d. Results in substantial functional limitation in three or more major life activities (Impacted prior to the age of 22)?

- ☐ No Functional Limitations
- ☐ Capacity for Independent Living
- ☐ Learning
- ☐ Self-Direction
- ☐ Self-Care
- ☐ Mobility
- ☐ Understanding and Use of Language

SECTION F. SPECIAL ADMISSION CATEGORIES

☐ **1 — Terminal Illness**

Expected to result in death in six months or less

Diagnosis: _____

Currently on Hospice: ☐ Yes (Provide hospice order) ☐ No

☐ **2 — Serious Physical Illness**

Severe/end stage disease (or physical condition)

Diagnosis: _____

☐ **3 — Respite Care**

Stays not more than thirty (30) days to provide relief for in-home caregivers

The client is going to be short term: ☐ Yes ☐ No

Reason for Respite Care: _____

☐ **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/)

Reason for Hotline: _____

☐ **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

The client is going to be short term: ☐ Yes ☐ No

Reason for Transfer: _____

What is the plan after 30 days? _____

SECTION G. PHYSICIAN'S AUTHORIZATION AND SIGNATURE

I attest that the information on these forms is complete and correct as known to me.

☐ Applicant is not currently a danger to self and others ☐ Applicant is currently a danger to self and others

PHYSICIAN SIGNATURE	DATE
DISCIPLINE	LICENSE NUMBER