North Carolina Department of Health and Human Services

Update Preadmission Screening and Review (PASRR) Process for Adult Care Homes licensed under G.S. § 131D, Article 1 and defined in G.S. § 131D-2.1

Preadmission Screening

The Preadmission Screening and Resident Review (PASRR) program is a required screening of any individual who is being considered for admission into a Medicaid Certified Adult Care Home regardless of the source of payment. As of March 1, 2013, the adoption of temporary rule 10A NCAC 14K .0101 requires that any adult care home licensed under G.S. 131D-2.4 must assure that PRIOR TO ADMISSION, any individual admitted to the home for care and services has a pre-admission screening using the North Carolina PASRR Medicaid Level I screening form, completed by an independent screener who is a healthcare professional.

The Level I screening form is used to identify individuals with serious mental illness (SMI). For individuals with no evidence or diagnosis of SMI, the initial Level I screen remains valid with no expiration unless there is a change in the individual's health or mental status or if they are moved to a higher level of care.

Who Is Subject to PASRR Screens

All individuals wishing to be admitted on or after March 1, 2013, to an Adult Care Home licensed under G.S. 131D-2.4, must be screened through the PASRR Level I Process.

Who can Complete the ACH PASRR Level I Screen

Any authorized community member who is not a legal representative of the individual being screened, and is not employed or paid by, or affiliated with a licensed ACH can complete the ACH PASRR Level I.

Adult Care Homes themselves **cannot** complete the Level I PASRR Screen. At the request of the Adult Care Homes, in order to expedite processing of the screenings, The N.C. Department of Health and Human Services (NCDHHS) has agreed to use a paper process in addition to the Web-based screening process to ensure that the Level I screenings are completed expeditiously. As a rule, the online tool will be utilized. However, in the event individuals have difficulty finding a provider who will use the online process, the paper process described below may be utilized. For example, as the person who knows an individual's medical history best, it is anticipated that primary care physicians will be requested to complete the PASRR. A physician's office may complete a paper form if desired and then the electronic submission of the form can occur at the Adult Care Home as long as a copy of the paper form with physician signature is uploaded along with the Web-based submission (see "Getting Started Paper Process" below for additional information).

Getting Help

The Division of Mental Health /Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) staff have been identified to provide technical assistance to screeners or physicians' offices with any aspect of completing the PASRR Level I screen. Beginning on Friday, March 1, 2013, the following staff persons are available:

- Barbara Flood – EAST - 919-218-3872, barbara.flood@dhhs.nc.gov
- Ed Crotts – WEST - 828-413-2686, ed.crotts@dhhs.nc.gov
- Patricia McNear – CENTRAL – 919-981-2580, patricia.mcnear@dhhs.nc.gov
- Bill Joyce – CENTRAL & FLOATING – 336-312-0212, bill.joyce@dhhs.nc.gov

Paper Process

The purpose of the paper based process is to supplement the online Uniform Screening Tool when access is not available or desired by a referring entity. To utilize the paper based process, please follow these steps:

Steps for Completing the Paper Form (Referring Entity)

- If the form is not already appended to this document, you can download and print the offline ACH PASRR Level I form our Getting Started page. http://www.ncmust.com/
- After downloading the form, open and print the document
- After supplying all of the required information, sign and date the form. This signature is an attestation that the person has filled it out to the best of their ability through either interview or records review. If the form is being filled out within a physician's office, the physician must also sign and date the form.
- Please note: The person filling out the form cannot fill in the form ahead of time with a legal representative or someone associated with, paid by, or employed by the adult care home and then request that a health care provider sign the form

Steps for Processing the Paper Form(Admitting Entity)

- The Referring Entity or person completing the form is required to provide a copy to the authorized entity or person who will enter and submit the data into the NC Uniform Screening Tool (MUST). Typically, the referring entity or person will send the form to one of these two authorized entities:
    1. Adult Care Home (ACH) or
    2. Local County Department of Social Services (DSS) when the DSS is the guardian and when the DSS has substantiated the need for Adult Protective Services.
- The authorized entity receiving the paper based form is responsible for entering the data into the online tool and uploading a scanned copy of the paper form upon request.
- If additional information is required though the processing of the form, the authorized entity who submitted the form is required to upload the requested documents. If the authorized entity does not have the requested information, it must be obtained from the referring entity. Such information may consist of the following: H&P; FL2 etc.
- Once all of the data and required documents are successfully submitted and upon completion, the tool will notify the person who entered the data.
- All required notification will be automatically mailed as well as made available online.

Support

- Technical support is available by contacting the PASRR help desk at 1-800-688-6696. Choose option 7 from the main menu and then option 2 for the technical help desk.
- One on one or group training is available online. Register Online now. http://www.ncmust.com/info

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nc department of health and human services

IMPORTANT: *The purpose of this form is to supplement the online Uniform Screening Tool when online access is not available or is not desired by a referring agency. The referring agency completing this form is required to provide a copy of this form to the Authorized Entity responsible for entering the information into the online tool. Once the Authorized Entity submits the information into the tool, you may be contacted and asked to supply additional information such as the H&P and FL2.*

*Refer to the Getting Started page located at **http://www.ncmust.com** for more information on how to prepare and process this paper based form.*

Screening Type

Adult Care Home (ACH) PASRR Level I	◯ Initial Request ◯ Change In Condition	Date

Screener Informtion

Last Name	First Name	Organization Name	
Organization Address		Organization City State Zip	
Telephone	Fax	Email	

Applicant Information

Applicant

Last Name	First Name	Middle Name

Permanent Mailing Address (where does applicant receive their mail?)

Street Address	City	State	Zip Code

Patients Current Location (where does applicant physically reside?)

Specify Location Type : Choose One ◯ Same As Screeners Organization ◯ Same As Permanent Mailing Address ◯ Other(enter below)

Facility Name (If Applicable)	Street Address		
City	State	Zip Code	County of Residence

Personal Details

Social Security Number	Date of Birth	Applicant's Home or Cell Phone Number	Gender	Marital Status
Medicare Number	Medicaid ID Number	Medicaid Status (Select only one) ◯ Card Active ◯ Medicaid Pending		Medicaid County of Residence

Legally Responsible Person

Name	Street Address			
City	State	Zip	Home or Cell Phone Number (999-999-9999)	Work Phone Number (999-999-9999)

Other Contact Person

Name	Type of Contact	Home/Cell Number (999-999-9999)	Work Phone Number (999-999-9999)
Street Address	City	State	Zip Code

Attending/ Primary Physician

Physician Name			
Street Address	Mailing Address (if Different from Street Address)		
City	State	Zip Code	Telephone Number (999-999-9999)

Physical Health Diagnoses

Substance Abuse

Has History Of, or Currently has a Substance Abuse Problem	Date of Last Use (MM/DD/YYYY)
◯ Yes ◯ No	

Terminal Prognosis

Is there a Terminal Prognosis?	Has a Doctor Certified a Terminal Prognosis?	Name of Physician	Date of Physician Certification
◯ Yes ◯ No	◯ Yes ◯ No		

Cognitive Impairment

Is there a Cognitive Impairment Diagnosis?
◯ Yes ◯ No

Cognitive Impairment Diagnoses (Check all that apply)	If Other Cognitive Impairment Diagnosis, Specify	Is Dementia the Primary Diagnosis ?
☐ Alzheimer's Disease ☐ Cerebral Atrophy ☐ Chronic or Organic Brain Syndrome ☐ Coma/Comatose ☐ Creutzfeldt-Jakob Disease ☐ Dementia ☐ Frontotemporal Dementia ☐ Huntingtons's Disease ☐ Lewy Body Dementia ☐ Multi-infarct Dementia ☐ Parkinson's Disease ☐ Pick's Disease ☐ Pre-Senile Dementia ☐ Wernicke-Korsakoff Syndrome (WKS) ☐ Other		◯ Yes ◯ No

Current Psychiatric Medications

Medication Name	Type of Medication
	◯ Formulary ◯ Over the Counter
If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication	

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	◯ Formulary ◯ Over the Counter
If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication	

Mental Health

Is there an MH Diagnosis?
◯ Yes ◯ No

If MH Diagnosis, specify Disorders/Diagnoses	If Other MH Diagnosis, Specify
☐ Anxiety/panic disorder ☐ Bipolar disorder ☐ Delusional disorder ☐ Eating disorder ☐ Major Depression ☐ Personality disorder ☐ Psychotic disorder ☐ Schizoaffective disorder ☐ Schizophrenia ☐ Somatoform disorder ☐ Other	

Intellectual/Developmental Disability (I/DD) Diagnosis

Is there an I/DD Diagnosis or Suspicion of I/DD?
◯ Yes ◯ No

If I/DD Diagnosis is Present/Suspected, Indicate the Severity Level	Age at Onset (years)	Are I/DD Services Being Provided?
◯ Mild ◯ Moderate ◯ Severe ◯ Profound ◯ Suspected Only		◯ Yes ◯ No

Conditions Related to Intellectual/Developmental Disability (I/DD) Diagnoses

Is there a RC Diagnosis?
◯ Yes ◯ No

Select All RC Diagnoses	If Other RC Diagnoses, Specify	Did the Condition Manifest Prior to Age 22?
☐ Autism ☐ Blindness ☐ Cerebral Palsy ☐ Closed Head Injury ☐ Deafness ☐ Epilepsy ☐ Other		◯ Yes ◯ No

Mental Health Behavioral Profile

Concentration / Task Limitations within the Past 6 Months	Adapting To Changes within the Past 6 Months
☐ Serious difficulty completing age related tasks ☐ Serious loss of interest in things ☐ Serious difficulty maintaining concentration/attention ☐ Numerous errors in completing tasks which she/he should be physically ☐ Requires assistance with tasks for which she/he should be physically capable ☐ Other	☐ Requires mental health intervention due to increased ☐ Requires judicial intervention due to symptoms ☐ Symptoms have increased as a result of adaptation ☐ Serious agitation or withdrawal due to adaptation ☐ Other
(Other) Concentration / Task Limitations within the Past 6 Months	(Other) Adapting To Changes within the Past 6 Months

Mental Health Treatments

Treatments Received within the Past 2 Years	Date Treatment was Received (MM/DD/YYYY)
☐ None	
☐ Inpatient Psychiatric Hospital	_____
☐ Partial Hospitalization/day treatment	_____
☐ Outpatient Treatment	_____

Mental Illness Interventions

Interventions to Prevent Hospitalization	Intervention Treatment Date (MM/DD/YYYY)	If Other MI Intervention, Specify
☐ None		
☐ Housing intervention	_____	
☐ Supportive Living	_____	
☐ Legal Intervention	_____	
☐ Other	_____	

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Orientation

Oriented to Time	Oriented to Person	Oriented to Place
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Mood and Behavior

☐ Socially Inappropriate/Disruptive Behavioral	☐ Wandering	☐ Physically Abusive	☐ Unrealistic Fears
☐ Resists Care	☐ Verbal Expressions of Distress	☐ Self Deprecation	☐ Negative Statements
☐ Anxious Non-Health Complaints Concerns	☐ Persistent Anger	☐ Repetitive Verbalizations	☐ Insomnia Disturbed Sleep Patterns
☐ Sad, Pained, Worried, Facial Expressions	☐ Crying/Tearfulness	☐ Unpleasant Mood In Morning	
☐ Reduced Social Interaction/Isolation	☐ Repetitive Physical Movements	☐ Withdrawal From Activities Of Interest	

Interpersonal Functioning

☐ Combative	☐ Dangerous to Self,Others or Property	☐ Altercations	☐ Homicidal
☐ Evictions Due To Socially Inappropriate Behavior	☐ Fear of Strangers	☐ Illogical Comments	☐ Paranoid Ideation
☐ Suicide Attempts/Ideation	☐ Social Isolation	☐ Excessive Irritability	☐ Hallucinations

Other Conditions

Categoricals

Is this a Request for a Short Term Nursing Facility Stay?	If Yes Then Indicate the Duration of the Nursing Facility Stay
◯ Yes ◯ No	

Communication

Makes Self Understood (Choose Only One)

- ◯ Understood
- ◯ Usually Understood
- ◯ Sometimes Understood
- ◯ Rarely/Never Understood

Understand/Use Of Language (Select all that apply)

- ☐ Uses Language/Speaks With No Difficulty
- ☐ Incomprehensible sounds
- ☐ Gestures
- ☐ Writing
- ☐ Assistive Devices
- ☐ Sign Language
- ☐ Does Not Understand/Use Language
- ☐ Understands Language But Does Not Use
- ☐ Speaks with Difficulty

Functional Limitations

Does the applicant have any functional limitations?

◯ Yes ◯ No

Select All That Apply

- ☐ Incapable of Self-Care
- ☐ Incapable of Self-Direction
- ☐ Immobile
- ☐ Incapable of Independent Living
- ☐ Incapable of Learning

Screener Certification

Who Supplied the Information?

- ☐ Applicant
- ☐ Family Member
- ☐ Friend of Family or Applicant
- ☐ Medical Record
- ☐ Doctor
- ☐ Nurse
- ☐ Case Manager
- ☐ Social Worker
- ☐ Other

By signing this form below, I certify that I have completed the above screening of the applicant to the best of my knowledge.

I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation.

Screener Name and Signature (Required)	Date	Physicians Name and Signature (If filled out at a physicians office)	Date
_____	_____	_____	_____
_____		_____	