



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:



North Carolina Department of Health and Human Services

- Patricia McNear – CENTRAL – 919-715-7774, 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>



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 Information

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) <input type="radio"/> Card Active <input type="radio"/> 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 <input type="radio"/> Yes <input type="radio"/> No	Date of Last Use (MM/DD/YYYY)
--	-------------------------------

Terminal Prognosis

Is there a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No	Has a Doctor Certified a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No	Name of Physician	Date of Physician Certification
--	--	-------------------	---------------------------------

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? <input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Alzheimer's Disease Cerebral Atrophy <input type="checkbox"/> Chronic or Organic Brain Syndrome Coma/Comatose <input type="checkbox"/> Creutzfeldt-Jakob Disease Dementia <input type="checkbox"/> Frontotemporal Dementia Huntington's Disease <input type="checkbox"/> Lewy Body Dementia Multi-infarct Dementia <input type="checkbox"/> Parkinson's Disease Pick's Disease <input type="checkbox"/> Pre-Senile Dementia Wernicke-Korsakoff Syndrome (WKS) <input type="checkbox"/> Other		

Current Psychiatric Medications

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter
-----------------	--

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter
-----------------	--

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter
-----------------	--

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter
-----------------	--

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter
-----------------	--

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

Medication Name	Type of Medication <input type="radio"/> Formulary <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	If MH Diagnosis, specify Disorders/Diagnoses <input type="checkbox"/> Anxiety/panic disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Delusional disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Somatoform disorder <input type="checkbox"/> Other	If Other MH Diagnosis, Specify
Bipolar Disorder <input type="radio"/> Bipolar I disorder, Current or most recent episode depressed <input type="radio"/> Bipolar I disorder, Current or most recent episode manic <input type="radio"/> Bipolar I disorder, Current or most recent episode hypomanic <input type="radio"/> Bipolar II Disorder	Major depressive disorder, Recurrent episode <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> With psychotic features	Schizoaffective Disorder <input type="radio"/> Bipolar type <input type="radio"/> Depressive type
Bipolar I Disorder, Current or most recent episode depressed, Please indicate severity <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> With psychotic features <input type="radio"/> Unspecified	Bipolar I Disorder, Current or most recent episode Manic, Please indicate severity <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> With psychotic features	Bipolar II Disorder <input type="radio"/> With manic features <input type="radio"/> With manic- or hypomanic-like episodes <input type="radio"/> With mixed features

Intellectual/Developmental Disability (I/DD) Diagnosis		
Is there an I/DD Diagnosis or Suspicion of I/DD? <input type="radio"/> Yes <input type="radio"/> No		
If I/DD Diagnosis is Present/Suspected, Indicate the Severity Level <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Profound <input type="radio"/> Suspected Only	Age at Onset (years)	Are I/DD Services Being Provided? <input type="radio"/> Yes <input type="radio"/> No

Conditions Related to Intellectual/Developmental Disability (I/DD) Diagnoses		
Is there a RC Diagnosis? <input type="radio"/> Yes <input type="radio"/> No		
Select All RC Diagnoses <input type="checkbox"/> Autism <input type="checkbox"/> Blindness <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head Injury <input type="checkbox"/> Deafness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other	If Other RC Diagnoses, Specify	Did the Condition Manifest Prior to Age 22? <input type="radio"/> Yes <input type="radio"/> No

Mental Health Behavioral Profile	
Concentration / Task Limitations within the Past 6 Months <input type="checkbox"/> Serious difficulty completing age related tasks Serious loss of interest in things <input type="checkbox"/> Serious difficulty maintaining concentration/attention Numerous errors in completing tasks which she/he should be physically <input type="checkbox"/> Requires assistance with tasks for which she/he should be physically capable <input type="checkbox"/> Other	Adapting To Changes within the Past 6 Months <input type="checkbox"/> Requires mental health intervention due to increased Requires judicial intervention due to symptoms <input type="checkbox"/> Symptoms have increased as a result of adaptation Serious agitation or withdrawal due to adaptation <input type="checkbox"/> 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)
<input type="checkbox"/> None <input type="checkbox"/> Inpatient Psychiatric Hospital <input type="checkbox"/> Partial Hospitalization/day treatment <input type="checkbox"/> Outpatient Treatment	_____ _____ _____

Mental Illness Interventions

Interventions to Prevent Hospitalization	Intervention Treatment Date (MM/DD/YYYY)	If Other MI Intervention, Specify
<input type="checkbox"/> None <input type="checkbox"/> Housing intervention <input type="checkbox"/> Supportive Living <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other	_____ _____ _____	

Orientation

Oriented to Time <input type="radio"/> Yes <input type="radio"/> No	Oriented to Person <input type="radio"/> Yes <input type="radio"/> No	Oriented to Place <input type="radio"/> Yes <input type="radio"/> No
--	--	---

Mood and Behavior

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

Interpersonal Functioning

<input type="checkbox"/> Combative	<input type="checkbox"/> Dangerous to Self, Others or Property	<input type="checkbox"/> Altercations	<input type="checkbox"/> Homicidal
<input type="checkbox"/> Evictions Due To Socially Inappropriate Behavior	<input type="checkbox"/> Fear of Strangers	<input type="checkbox"/> Illogical Comments	<input type="checkbox"/> Paranoid Ideation
<input type="checkbox"/> Suicide Attempts/Ideation	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Excessive Irritability	<input type="checkbox"/> Hallucinations

Other Conditions

Categoricals

Is this a Request for a Short Term Nursing Facility Stay? <input type="radio"/> Yes <input type="radio"/> No	If Yes Then Indicate the Duration of the Nursing Facility Stay
---	--

Communication

Makes Self Understood (Choose Only One)	Understand/Use Of Language (Select all that apply)
<input type="radio"/> Understood <input type="radio"/> Usually Understood <input type="radio"/> Sometimes Understood <input type="radio"/> Rarely/Never Understood	<input type="checkbox"/> Uses Language/Speaks With No Difficulty <input type="checkbox"/> Incomprehensible sounds <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Sign Language <input type="checkbox"/> Does Not Understand/Use Language <input type="checkbox"/> Understands Language But Does Not Use <input type="checkbox"/> Speaks with Difficulty

Functional Limitations

Does the applicant have any functional limitations? <input type="radio"/> Yes <input type="radio"/> No	Select All That Apply
	<input type="checkbox"/> Incapable of Self-Care <input type="checkbox"/> Incapable of Self-Direction <input type="checkbox"/> Immobile <input type="checkbox"/> Incapable of Independent Living <input type="checkbox"/> Incapable of Learning

Screener Certification			
Who Supplied the Information?		By signing this form below, I certify that I have completed the above screening of the applicant to the best of my knowledge.	
<input type="checkbox"/> Applicant <input type="checkbox"/> Family Member <input type="checkbox"/> Friend of Family or Applicant <input type="checkbox"/> Medical Record <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Case Manager <input type="checkbox"/> Social Worker <input type="checkbox"/> Other		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)		Physicians Name and Signature (If filled out at a physicians office)	
Date		Date	
_____		_____	
_____		_____	