SCREENING FOR MENTAL ILLNESS, MENTAL RETARDATION/INTELLECTUAL DISABILITY, OR RELATED CONDITIONS

A. This section is to be completed by the Pre-admission Screening Team Or Acute Care Hospital Screening Team.
This form applies to NF Admissions ONLY.

Name: _____ Date of Birth: _____ Date PAS Request Received _____

Social Security No. _____ Medicaid No. _____ Responsible CSB _____

1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?

   Yes No (If NO< see DMAS-95 MI//IDD/RC Instructions.)

   a. Can a safe and appropriate plan of care be developed to meet all services and supports including medical/nursing/custodial care needs?

      Yes No

   If "Yes", this form must be completed AND the DMAS-96 form authorization is for Nursing Facility, this form **MUST BE COMPLETED**.

2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? Yes No
   (Check "Yes" only if answers a, b, and c below are "Yes". If "No", do not refer for assessment of active treatment needs for MI Diagnosis.)
   a. Is this major mental disorder diagnosable under DSM (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)?

      Yes No
   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? Yes No
   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? Yes No

3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF /INTERLLECTUAL DISABILITY (ID) WHICH WAS MANIFESTED BEFORE AGE 18?

   Yes No

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? Yes No
   (Check "Yes" only if each item below is Checked "Yes". If "No", do not refer for assessment of active treatment needs for related condition.)
   a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to IDD because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of IDD persons and requires treatment of services similar to those for these persons? Yes No
   b. Has the condition manifested before age 22? Yes No
   c. Is the condition likely to continue indefinitely? Yes No
   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? Yes (If yes, circle applicable areas) No

5. RECOMMENDATION (Either "a" or "b" must be checked.)
   a. Refer for secondary assessment. (NF Placement = Level II refer to Ascend Management)

      MI (# 2 above is checked "Yes")

      IDD or Related Condition (# 3 or # 4 is checked "Yes")

      Dual diagnosis (MI and IDD or Related Condition categories are checked)

** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded LTC until the secondary assessment has been completed.

   b. No referral for active treatment needs assessment required because individual:

      Does not meet the applicable criteria for serious MI or IDD or related condition

      Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of IDD

      Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI

      Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stern level, or other conditions which results in a level of impairment so sever that the individual could not be expected to benefit from specialized services.)

      Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: _____ Screening Committee: _____

Date: _____ Telephone #: _____ Street Address: _____

SCREENING FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, OR RELATED CONDITIONS - INSTRUCTIONS FOR COMPLETION

IDENTIFYING DATA

NAME: Enter the Individual's Full Name **DATE OF BIRTH**: MM/DD/YYYY
SOCIAL SECURITY NUMBER: Enter the 9-digit number **MEDICAID NUMBER**: Enter the 12-digit number
DATE PAS REQUEST RECEIVED: Enter the date that a request for a secondary assessment was made

I- Indicate whether the individual meets nursing facility criteria as described in the Virginia Medicaid Pre Admission Screening Manual. If "yes" is checked, complete the screening, If the individual does NOT meet nursing facility criteria, do not complete Level I screening and do not refer for a secondary assessment. If criteria is not met, the individual cannot be approved for Long-Term Care Services and Supports.

2. **Determination of Serious Mental Illness (MI)**: Check "yes" (that the individual has a current diagnosis of serious MI) only if *2* a, b, and c are checked "yes". Indicate the diagnosis if "yes' is checked. If "no" is checked for either a, b, or e below, **do not refer for** Level II for Ml.

   a. Check "yes' if the individual has a major mental disorder diagnosable under DSM(c g, schizophrenia (including disorganized, catatonic, and paranoid types), mood (including bipolar disorder (mixed manic, depressed, seasonal. NOS). major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder MOS, cyclothymia, dysthymia (primary/secondary or early/late onset). Paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder), panic or other severe anxiety disorder (including panic disorder with agoraphobia. agoraphobia with or without history of panic disorder, social phobia general wed anxiety disorder, obsessive compulsive disorder, past-traumatic stress disorder), somatoform disorder (includes somatization disorder. conversion disorder somatoform pain disorder, hypochondriasis. body dysmorphic disorder, undifferentiated somatotorm disorder, somatoform disorder NOS). Personality disorder (includes paranoid. schizoid. sehizotypal. histrionic, narcissistic, antisocial, borderline. avoidant, dependent. obsessive compulsive, passive aggressive, and NOS), other psychotic disorder (includes schizophreniform disorder. schizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical, NOS) or other mental disorder that may lead to a chronic disability)

   b. Check "yes" it the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning concentration, persistence, and pact, arid adaptation **to** change

   e Cheek "yes' tithe individual's treatment history indicates that he or she has experienced (I) psychiatric treatment more intense than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder

3. Determination of Intellectual Disability ID): Check "yes' if the **individual** has a level of retardation or disability **(mild,** moderate, **severe, or profound)** described in the American Association on Mental Retardation's Manual on Classification In Mental Retardation (19S3) that was manifested before **age 18**

4. **Determination of Related Conditions**: Check 'yes' only if each item in 4 a-d below is checked 11 'no" is checked, do not **refer for Level II** PAS for related conditions

   a. Check 'yes' if the condition is attributable to any other condition (e g, cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than Ml. found to be closely related to MR because this **condition** may result in impairment of general intellectual functioning or adaptive behavior similar to that of **IDD** persons and requires treatment or services similar to those for these persons
   b. Check 'yes" if the condition has manifested before **age 22**
   c. Cheek "yes" if the condition is likely to continue indefinitely
   d. Check "yes' ii the condition has resulted in substantial limitations in 3 or more of the following areas of major life activity self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living Circle the applicable areas

5. **RECOMMENDATION** (Either 5a or b MUST be checked)

   a. Cheek this category if Question 2 is checked 'yes' AND/OR either Question 3 or 4 is checked "yes' Indicate whether referral is for MI, MR or RC, the date the package is referred to the appropriate secondary screener, and where and to whom the package is sent. An individual for whom 5a has been checked may NOT he admitted to a LTC Services until the secondary assessments is completed.

   b. Check this "no referral needed" category ONLY if there is documented evidence as follows
   - Does not meet the 'applicable criteria For MI, IDD or a related condition.
   - Has a primary diagnosis of dementia (including Alzheimer's disease, (If there is a diagnosis of IDD this category does not apply).
   - Has a primary diagnosis of dementia (including Alzheimer's disease) AND a secondary diagnosis of MI.
   - Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other diagnoses, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. If the answer determines that an illness not listed here is so severe that the individual could not he expected to benefit from specialized services, documentation describing the severe illness must be attached for review).
   - Is terminally ill (note' a physician must have documented that individual's life expectancy is less than 6 months.

NOTE: WHEN A SCREENING HAS NOT BEEN PERFORMED PRIOR TO AN INDIVIDUAL'S ADMISSION TO A NF FEDERAL FINANCIAL PARTICIPATION (FFP) WILL NOT BE AVAILABLE UNTIL A SCREENING IS COMPLETE.

ASSESSOR INFORMATION

SIGNATURE: First Name, Middle initial, and Last Name
TITLE: Professional title of the assessor
SCREENING ENTITY: Name of entity who performed screening
DATE: Date screening was completed
TELEPHONE NUMBER: Telephone number, including area code
STREET ADDRESS: Complete Street address, including city-state and zip code