**CARE LEVEL II PRE-ADMISSION SCREENING**

***INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITIONS***

*All questions must be answered completely*

\*Date Referral to HIS       Date Referred to Assessor

Date of Assessment       \*Tracking #

Date Faxed to HIS       *\*This information will be provided to you by HIS*

Person requesting Level I screening:       Relationship to person being screened:

# SECTION I – IDENTIFICATION

**Name:**  Phone: (     )      -      DOB:

 Residential Address:

      ,

 County:

 SSN:      -     -      Gender:

 Medicaid Number:       County of Responsibility:

**Current Location:**       Ward/Unit:

 Current Address:

      ,

 County:

 Contact Person:       Admission Date:

 Phone: (     )      -      Fax: (     )      -      Email

**Attending Physician:**       Phone: (     )      -

 Physician’s Address:

      ,

 County:

**Proposed Facility (if applicable):**

 Contact Person:

 Address:

      ,

 County:

 Phone: (     )      -      Fax: (     )      -

 Proposed Date of Admission:

Please give the following information about any individuals serving as (**attach signature page of the court order**):

 [ ]  Guardian  [ ]  DPOA [ ]  Other Legal or Medical Representative

**Name:**

 Address:

      ,

 County:

 Home Phone: (     )      -      Work Phone: (     )      -      Email

Does the individual have another person involved in a significant way from whom we may be able to obtain additional information about the individual’s social, medical, emotional or environmental history and status?

 If “yes,” please provide the following information:

**Name**:

 Address:

      ,

 County:

 Home Phone: (     )      -      Work Phone: (     )      -

 Relationship to individual:

## SECTION II – DIAGNOSIS

1. List all diagnoses according to the current DSM manual. Please list diagnosis code as well as descriptions. If QDDP disagrees with diagnosis of record please discuss in clinical summary section, Question #23, at this time.

 **Diagnostic Code Description**

## SECTION III – VERIFICATION OF INTELLECTUAL/DEVELOPMENTAL DISABILITY /RELATED CONDITIONS

## AND APPLICABLE EXCLUSIONS

2. The current psychological report provides the following data:

 IQ Test:       Date:

 Results:

 Examiner Name/Credentials:

3. Was mental retardation (IQ of 70 or below) manifested prior to the age of 18?

4. a) Was the individual diagnosed with a intellectual/developmental disability related condition, as defined in the manual on page 7-9,

 prior to the age of 22?

 If **NO**, proceed to #5.

 If **YES**, list diagnosis, then continue:

 b) **Check all areas**, as defined in the manual on page 8 & 9, in which the individual has substantial functional limitations due to the Related Condition.

|  |  |  |
| --- | --- | --- |
| [ ]  Self-care | [ ]  Mobility | [ ]  Independent living skills |
| [ ]  Language | [ ]  Learning | [ ]  Self-direction |
| [ ]  Economic self-sufficiency |  |  |

 c) **Does the individual have substantial functional limitations**, in at least three of the areas, due to the related condition?

5. **If the answer to #3 AND #4a or #4c are “No,”** the individual *does not* require a Level II PASRR for Intellectual/developmental disability/Related Condition. Proceed to Sections VIII & IX. Otherwise, continue with the assessment.

1. Does the individual have a primary diagnosis of dementia or dementia related disorder?

**If the answer is “Yes,”** the Intellectual/developmental disability/Related Condition assessment is finished, proceed to Sections VIII & IX. You must provide documentation from the clinical record to support your response.

7. a) Does this individual have a medical condition which is:

 Permanent?

 Progressive?

 For the purpose of this assessment the following definitions apply.

 \***Permanent**: Permanent infirmities of aging are identified as the current primary factor causing the individual to need twenty-four hour nursing care **AND** the individual will no longer benefit from specialized services for persons with intellectual/developmental disability or related conditions.

 \***Progressive**: A medical condition of a progressive degenerative nature which, due to the current increasing deterioration directly related to the condition, is a primary factor determining the need of the individual **AND** the individual can no longer benefit from specialized services for persons with intellectual/developmental disability or related conditions.

 b) If the response to any of #7a is “Yes,” please describe the permanent or progressive medical condition and the treatment required.

 c) If both of the responses to #7a are marked “Yes,” the prescreening for ID/DD/Related Condition is finished. Proceed to to Sections VIII & IX, regarding Mental Illness.

## SECTION IV – PRESENTING PROBLEM

8. Why is this individual being referred for nursing facility admission at this time?

 a) Loss of community support system/caretaker?

 If **“Yes,”** please explain:

 b) Currently has significant medical needs or need for special treatments. (Check all that apply.)

 [ ]  Incontinence

 [ ]  Monitoring of special diet (e.g. Diabetic)

 [ ]  Monitoring of fluid intake

 [ ]  IV medications or feeding tube

 [ ]  Mobility Assistance

 [ ]  Other

 Please Explain:

 c) Currently displays challenging behaviors. (Check all that apply.)

 [ ]  Frequent/continuous yelling

 [ ]  Verbally Abusive or threatening

 [ ]  Damages/destroys property

 [ ]  Sexually aggressive/exposes self

 [ ]  Other

 Please explain:

 d) Currently exhibits (within the past 6 months) dangerous behaviors. (Check all that apply.)

 [ ]  Injuries to self ( including suicide attempts)

 [ ]  Injuries to others

 [ ]  Wandering without regard to safety

 [ ]  Fire setting

 [ ]  Isolates self (refuses basic nutrition, refuses contact with service providers)

 [ ]  Other:

 Please explain:

 e) Did any of the behaviors indicated in the check boxes marked above result in intervention by the following? (Check all that apply.)

 [ ]  Adult Protective Services

 [ ]  Law Enforcement

 [ ]  Hospitalization

 [ ]  Incarceration

 [ ]  Other:

 Please explain:

9. Has the individual received case management, residential day/support services, medication management, counseling/therapy, or other behavioral management assistance from a CDDO or other community agency in the past 6 months?

 If “No”, please explain why services were not provided, were discontinued or failed:

10. Does the individual have a documented history of services/support for ID/DD/RC?

 **If “Yes”**, please give name of CDDO or community service provider and provide dates of service:

11. Who is the current service provider?

 Name of current community service provider:

 Address:

      ,

 County:

 Provide dates of service:       thru

 Is there a person-centered support plan?

## SECTION V – MEDICAL HISTORY AND PHYSICAL

12. Please attach the most recent **MEDICAL HISTORY AND PHYSICAL**.

 *THIS ASSESSMENT CANNOT BE ACCEPTED WITHOUT THESE DOCUMENTS AND WILL BE COUNTED AS AN INCOMPLETE ASSESSMENT. IF YOU CANNOT OBTAIN THE HISTORY AND PHYSICAL, CONTACT YOUR KHS COORDINATOR IMMEDIATELY.*

13. List all medications the individual currently takes including over the counter medication, and indicate whether the medication is: S = Stable *OR* A = Being Adjusted.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | FREQ | **ROUTE** | **S/A** |
|       |       |       |       |       |
|       |       |       |       |       |
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14. List all medications the individual has taken during the last three months excluding those listed above unless there is a change in dosage.

| **MEDICATION** | **DOSAGE** | FREQ | **ROUTE** | **S/A** |
| --- | --- | --- | --- | --- |
|       |       |       |       |       |
|       |       |       |       |       |
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## SECTION VI – FUNCTIONAL ABILITIES

15. Describe the individual’s ability to self-administer and schedule medical treatments, self-monitor health and nutritional status.

16. Summarize the individual’s developmental abilities in the following areas. Please include any maladaptive or inappropriate behaviors observed or documented.

 a) Self-help:

 b) Sensorimotor:

 c) Speech and language:

 d) Social:

 e) Academic/educational:

 f) Independent living:

 g) Vocational:

 h) Affective:

**SECTION VII – LIVING ARRANGEMENT AND SUPPORT NETWORK**

17. Indicate the individual’s preferred living arrangement (individual’s choice, not service provider’s recommendation):

18. If there is a legal guardian, do they agree with the individual’s choice of living arrangement?

 Please explain:

19. Please check all boxes describing living situations in which the individual has resided since age 18, and indicate the approximate length of time resided and reason individual is not returning to/remaining in living situation.

 [ ]  Lived Alone in Own Apartment/House/Etc.

 [ ]  Lived with Relatives/Friends

 [ ]  Lived in Group Home/Transitional Living Center/ Assisted Living Facility

 [ ]  Lived in Nursing Facility

 [ ]  ICF/ID/DD

 [ ]  Other:

 Please explain:

20. The individual currently has residence available?

21. Individual’s Support Network includes: Check available supports and provide specific information (names, phone numbers, availability, etc. ) in space provided.

 [ ]  Family Members – Identify:

 [ ]  Case Manager -- Identify:

 [ ]  Guardian or Payee – Identify:

 [ ]  Others

 Please describe:

22. Support Services and Resources Needed: Check [x]  all that apply. Indicate whether they would be available, not available or unknown.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NEEDED** | **AVAILABLE** |  | NOTAVAILABLE |  | **UNKNOWN** |
| Affordable housing or housing subsidy | [ ]  |  | [ ]  |  | [ ]  |
| In-home support (estimated hrs per day or week      ) | [ ]  |  | [ ]  |  | [ ]  |
| Case management service to assist with goal planning, mobilizing community supports, problem-solving, assisting the individual to learn to use available resources and crisis intervention | [ ]  |  | [ ]  |  | [ ]  |
| Respite available as needed | [ ]  |  | [ ]  |  | [ ]  |
| Wellness monitoring | [ ]  |  | [ ]  |  | [ ]  |
| Meals on Wheels or other nutritional program | [ ]  |  | [ ]  |  | [ ]  |
| Natural supports: such as family, roommates, friends, church, etc. | [ ]  |  | [ ]  |  | [ ]  |
| Residential services | [ ]  |  | [ ]  |  | [ ]  |
| Day services | [ ]  |  | [ ]  |  | [ ]  |
| Recreational activities | [ ]  |  | [ ]  |  | [ ]  |
| Supported employment | [ ]  |  | [ ]  |  | [ ]  |
| Medical assistance | [ ]  |  | [ ]  |  | [ ]  |
| Nursing care (Visiting nurses in community) | [ ]  |  | [ ]  |  | [ ]  |
| **Other services (*please list* below)** |  |  |  |  |  |
|       | [ ]  |  | [ ]  |  | [ ]  |
|       | [ ]  |  | [ ]  |  | [ ]  |
|       | [ ]  |  | [ ]  |  | [ ]  |

## *Please list agency responsible for providing these services in #23*

## SECTION VIII – SUMMARY AND FINAL RECOMMENDATIONS

23. Clinical Summary:

24. Mark the appropriate placement/service recommendation:

 [ ]  Nursing facility level of care **is** needed/Specialized intellectual/developmental disability services **are not** needed

 [ ]  Nursing facility level of care **is not** needed/Specialized intellectual/developmental disability services **are** needed

 [ ]  Nursing facility level of care **is not** needed/Specialized intellectual/developmental disability services **are not** needed

 For purposes of this assessment:

 **Specialized Services** for individuals with Mental Retardation or Related Condition is defined as those services which necessitate the availability of trained MR personnel from an SRS licensed provider. These services can be provided in the following settings:

 1. Intermediate Care Facility for intellectual/developmental disability (ICF/ID/DD)

#####  OR

 2. Community setting if the services provided are equivalent to the level of services provided in an ICF/ID/DD.

 For the purpose of this assessment:

 **Nursing facility**: “any place or facility operating for not less than 25 hours in a week and caring for six or more individuals are related with the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 25 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.”

25. Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. Please give additional service recommendations that would be beneficial for this individual’s needs (regardless of above recommendations). What additional services, resources, or referrals would benefit this individual? Please be specific.

#### SECTION IX - DUAL DIAGNOSIS EVALUATION

26. Does the individual have a serious Mental Illness diagnosis?

 If NO, proceed to #30.

 If YES, proceed with the assessment.

27. Does the individual have a non-primary diagnosis of dementia or a dementia related disorder and is the primary diagnosis something other than a major mental disorder?

 If YES, proceed to #30.

 If NO, continue with the assessment.

28. Does the individual have a level of impairment resulting in functional limitations in major life activities, due to the mental illness, within the past 3 to 6 months (interpersonal functioning, concentration, persistence, and pace, adaptation to change)?

29. Does the recent treatment history indicate that the individual has experienced at least one of the following:

 a) Psychiatric treatment more intensive than outpatient care more than one time in the past two years (e.g., partial hospitalization or inpatient hospitalization.)

######  OR

 b) Within the last two years due to the mental disorder, an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home, or in the residential treatment environment, or which resulted in intervention by housing or law enforcement officials?

 If (#27 is NO) *and* (#26, #28 and #29 are YES), the individual does require a Level II PASRR for Mental Illness. This assessment is not complete until questions 7a, b, c and Sections III, IV,VI, VII, VIII, IX, X of the Level II Mental Illness PASRR form are completed. If individual does not require a Level II PASRR for Mental Illness, proceed to #32.

 *If the ID/DD assessment has been aborted,* and the individual needs a MI PAS completed, the assessment is not complete until questions 7a, b, c **AND** Sections III, IV, V, VI, VII, VIII, IX, and X are completed.

30. If a Level II PASRR for Mental Illness is required,

 a) Are you conducting a MI PAS?

 b) Are you referring to KHS for a MI PAS?

31. What is the county of responsibility?

32. What resources were utilized to gather information for this assessment? Include names of individual and title. If family member or guardian is not involved in the assessment, please explain why in the remarks section of this question.

 Date of interview with individual (face to face):

 Guardian should be included in the assessment!

 Guardian:       Date Interviewed:

 (indicate if interview was in person or by phone)

 Family Members:

 Health Care Professionals (must be interviewed and listed):

 Clinical Records:

 Minimum Data Set (MDS) Version 2.0:

 Remarks:

33. Please give exact location of where the assessment took place:

**SECTION X – QDDP SIGNATURE**

34. Assessor’s Name:
*Print your full name (first, middle initial, last) and title*

 Assessor’s phone number(s):

 Date:

 Assessor’s license type and number:

 Assessor’s Email address:

 Assessor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

35. Is this Level II a courtesy assessment?

 Date Faxed to responsible CDDO:

 Contact Person at responsible CDDO:

36. Time Documentation Summary:

 Screen Time:       Hours       Minutes

 Travel Time:       Hours       Minutes

 Total Time:       Hours       Minutes

***PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO MAKE SURE ALL NECESSARY REFERRALS ARE MADE***