



# PASRR LEVEL I SCREEN & Determination for Mental Illness, Mental Retardation & Other Related Conditions

Instructions: This PASRR Level I Screen contains 4 sections: **All 4 sections must be completed.**

Agency Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Fax#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Print Name and Title of Person Completing Form

Signature

## Section I: Identification and Background Information

1.	Applicant Name:	First: _____ (MI): _____ Last: _____
2.	Address:	Street: _____ City/Town: _____ State: _____ Zip: _____ County: _____ Phone: _____
3.	Social Security #:	_____ - _____ - _____
4.	MaineCare #:	_____
5.	Medicare #:	_____
6.	Date of Birth:	Month: _____ Day: _____ Year: _____
7.	Emergency Contact:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Relationship: _____ Phone: _____ Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Continuing Physician:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Phone: _____
9.	Anticipated or Current Nursing Facility:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Phone: _____ <b>This stay in a nursing facility is for... <input type="checkbox"/> SNF (skilled) or <input type="checkbox"/> LTC</b>
10.	Duration of Stay:	Estimated length of stay _____ days. Has physician documented that this applicant's stay in a nursing facility will be 30 days or less? <input type="checkbox"/> Yes <input type="checkbox"/> No

Any decision for a Level II Assessment or deferral/waiver of a Level II Assessment must be made by the  
**Department of Health & Human Services (DHHS) or designee.**



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## Section II: Level I Screen: Mental Illness (MI)

1.	Does the individual have a mental illness diagnosis?		
	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No		
2.	Diagnosis (Dx): _____ DSM Code: _____ (Number Required)		
2a.	This diagnosis has existed for how long? _____		
3.	Does the individual have a suspected mental illness as evidenced by any of the following:		
a.	Inability to communicate effectively with others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Inability to complete simple tasks unassisted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Serious difficulty interacting with others appropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Danger to self or others, aggressive, assaultive, suicidal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e.	Frequently isolates or avoids others or exhibits signs that suggest severe anxiety or fear of strangers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f.	Other major mental health symptoms that have emerged or worsened as a result of recent life changes and now ongoing symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Did the individual have any intervention <b>due to a mental illness</b> in the past two years, such as:		
a.	Hospitalization for psychiatric care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Supportive services at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Housing/law enforcement intervention?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Residential treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e.	Intensive community supports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The presence of **ANY** "Yes" answer for Questions 1, 3 or 4 meet PASRR criteria for the presence of mental illness or that the presence of mental illness is suspected.

If mental illness is present or its presence is suspected, fax to: APS Healthcare at 1-866-325-4752, Attention: PASRR Coordinator.

If answers to the above questions 1-4 are all "NO" **and** there is NO diagnosis or **only** a dementia diagnosis, this form must be faxed to the nursing facility and **not** to APS Healthcare.

*For questions re: PASRR MI or how to complete this section, CALL: 1-866-521-0027, PASRR Coordinator.*

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## Section III: Level I Screen: Other Related Conditions (ORC)

“Other Related Conditions” include physical, sensory or neurological disabilities which are manifested prior to age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self care.

The key to determining whether an individual has an ORC is the age of onset of the disability. It is the obligation of the person completing the PASRR to determine age of onset. If the clinical record does not clearly eliminate the possibility that the individual’s physical disability occurred prior to age 22, the hospital staff or nursing facility must ask the individual (or the individual’s representative if necessary) and document the response. This information must be available upon request to the representatives of the Department of Health and Human Services.

Instructions: An individual is considered to have an ORC, which is a severe developmental disability if he/she meets all of the conditions in Sections III-A through III-D, page 3.

### Section III-A: Other Related Conditions

1. Has the individual been diagnosed with or suspected of having one or more of the following conditions:

- Cerebral palsy:  Yes       No  
Epilepsy:       Yes       No

OR

Any other condition, other than a serious mental illness, found to be closely related to mental retardation, resulting in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with mental retardation, and requires treatment or services similar to those required for individuals with mental retardation?

- No  
 Yes - please specify: \_\_\_\_\_

*(If all 3 of these questions are “no”, stop here and go to Section IV (MR), page 4.)*

### Section III-B: Other Related Conditions

1. Were the ORC manifested before the individual reached the age of 22?  Yes     No

### Section III-C: Other Related Conditions

1. Are the ORC likely to continue indefinitely?  Yes     No

### Section III-D: Other Related Conditions

1. Does the ORC result in substantial functional limitations in 3 or more of the following areas of major life activity? (Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC).

- |                                       |                                     |
|---------------------------------------|-------------------------------------|
| ___ self care                         | ___ mobility                        |
| ___ understanding and use of language | ___ self-direction                  |
| ___ learning                          | ___ capacity for independent living |

If three or more of these functional limitations are checked, check  Yes  
otherwise, check  No

Questions III-A through III-D must **all** be “Yes” to meet PASRR criteria for diagnosis of an ORC.  
If “Yes” to an ORC, fax to APS Healthcare, 1-866-325-4752, Attention: APS Healthcare, PASRR Coordinator

If “No” to an ORC, fax this form to nursing facility.

*For questions re: PASRR ORC or how to complete this section, CALL: 1-866-521-0027, PASRR Coordinator.*

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# PASRR LEVEL I SCREEN & Determination for Mental Illness, Mental Retardation & Other Related Conditions

## Section IV: Level I Screen: Mental Retardation (MR)

An applicant is considered to have mental retardation, autism or a Pervasive Developmental Disorder (PDD) if the criteria listed below in IV-A and IV-B are met or the individual has previously been found eligible for services based on a diagnosis of mental retardation, autism or a PDD by DHHS. Documentation is not necessary to support the criterion as long as the individual is suspected to meet the criterion based on observations and knowledge about the individual. The individual completing this form is responsible for reporting information used in making the identification and should complete the Related Questions sections when applicable.

Instructions: If the answer to Section IV-A is "No", skip Section B and complete Sections IV-C and IV-D.  
If the answer to Section IV-A is "Yes", answer ALL questions in Section IV

### Section IV-A: Mental retardation, autism or PDD:

1. Has this individual ever been diagnosed with mental retardation, autism or a PDD, or is there suspicion of mental retardation, autism or a PDD?  Yes  No

Related Questions: Is intellectual functioning documented on a standardized general intelligence test?

No

Yes - please supply the following information regarding the test:

Test Name: \_\_\_\_\_ Test Date: \_\_\_\_\_

Tester's Name: \_\_\_\_\_ Tester's Prof. Qualifications: \_\_\_\_\_

### Section IV-B: The individual has impairments in adaptive behavior that show:

1. Significant limitation in meeting the standards of maturation, learning, personal independence and/or social responsibility for his/her age and cultural group:  Yes  No

2. Substantial functional limitation in three or more of the following areas of major life activities which are not related to the normal aging process (check all that apply)

\_\_\_ self care

\_\_\_ mobility

\_\_\_ receptive and expressive language

\_\_\_ self-direction

\_\_\_ learning

\_\_\_ capacity for independent living

(if three or more of these functional limitations are checked, check otherwise, check

Yes

No

3. Related Questions:

Are impairments in adaptive behavior documented by standardized testing?

No

Yes - please supply the following information regarding the test:

Test Name: \_\_\_\_\_ Test Date: \_\_\_\_\_

Tester's Name: \_\_\_\_\_ Tester's Prof. Qualifications: \_\_\_\_\_

### Section IV-C: Services:

1. Has the individual received services from a developmental services agency in the past, or been found eligible for services with the DHHS based on a diagnosis of mental retardation, autism or a PDD?

No  Yes - please identify DHHS region: \_\_\_\_\_

### Section IV-D: Facilities:

1. Has the individual ever been a resident of a mental retardation state facility (e.g. - state hospital, state school or state mental retardation facility)?

No  Yes - please identify facility: \_\_\_\_\_

**Questions IV-A and IV-B or IV-C or IV-D must have one "Yes" answer to meet PASRR criteria for diagnosis of mental retardation, autism or a PDD. If "YES" to mental retardation, autism or a PDD, fax to:**

- Androscoggin, Oxford & Franklin: 782-1753 (fax) 753-9100 (phone)
- Aroostook County: 493-4173 (fax) 493-4000 (phone)
- Cumberland & York Counties: 822-0295 (fax) 822-0270 (phone)
- Kennebec & Somerset Counties: 287-7186 (fax) 287-2205 (phone)
- Knox, Waldo, Lincoln & Sagadahoc Counties: 596-2304 (fax) 596-4302 (phone)
- Penobscot, Piscataquis, Hancock & Washington Counties: 941-4389 (fax) 941-4360 (phone)

**If "NO" to mental retardation, autism or PDD, fax this form to nursing facility.**

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