PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613)

Please provide the required information for this PA request on this page. When you have completed entering the data for this PA request, select the Review Request link to view the information entered.
I understand that submission of this application is in accordance with Section 1919(b)(3)(f) of the Social Security Act, which requires that a Medicaid certified nursing facility can neither admit nor retain any individual with serious mental illness and/or intellectual disability unless a thorough evaluation indicates that such placement is appropriate and that services will be provided. The Level I screen is part of the Preadmission Screening/Resident Review (PASRR), and identifies whether an applicant to a nursing facility has indicators for mental illness, intellectual disability, developmental disability or a related condition. The nursing facility is not authorized to admit initial applicants without completion of this preadmission nursing facility policy procedure which includes physician certified completion of the DMA-6 for a level of care determination. Both the DMA-6 and the DMA-613

DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE
DO NOT PROCEED IF PHYSICIAN HAS CERTIFIED THAT NF SERVICES ARE FOR 30 DAYS OR LESS

Physician Information

Physician's Name on DMA-6 :			Office or Hospital :	Phone :	
Address 1 :		Address 2 :		City :	State :
Zip :		County :		Physician Signed?	Yes No	Date Signed :	

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Contact Information

Contact First Name :		Last Name :		Title of the Contact Person :	
Name of Contact Facility :		Contact Facility Type :		Date Level I Requested :	
* Phone :		* Fax :		E-mail :	
Address :		City :		State :	Zip Code :

Nursing Facility Information

Has the patient been admitted to the nursing facility? ○ Yes ○ No

Date of Admission to Nursing Facility :

Name of Nursing Facility :

Nursing Facility Provider ID :

Does the individual applying for admission, **directly from hospital discharge, require NF services for the condition received while in the hospital** and whose attending physician has certified that the NF stay is likely to require **less than 30 days**? ○ Yes ○ No

Member Information

Member ID :		Last Name:		First Name :	Middle Initial :
Social security Number :		Date of Birth :		Gender :	
Current location of applicant :				Requesting Provider:	

If 'Other' is selected, please explain. If 'Home' is selected, please list address, contact person, contact phone number.

Check all that apply to the applicant/resident

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☐ New admission	☐ Readmission to NF from psychiatric hospital	☐ Readmission to NF from acute hospital	☐ Respite care, less than 30 days
☐ Transfer from residential to NF	☐ Transfer between NF's	☐ Emergency, requiring Protective Services	☐ Out of State resident(OOS)
☐ Significant Status Change	☐ Referral from ID/DD agency/DBHDD	☐ Other	

If 'Other' is selected, please explain.

***Resident's OOS PASRR Contact Information:** (if Out of State resident is selected)

OOS Contact Last Name : | OOS Contact First Name : | Contact Phone # :

1. Does the individual have a primary (Axis I) diagnosis of dementia? ○ Yes ○ No

If Yes, check the type of dementia, due to:

☐ Alzheimer's Disease ☐ Vascular Changes ☐ HIV ☐ Head Trauma ☐ Huntington's Disease ☐ Creutzfeldt-Jakob (ABE) ☐ Pick's Disease

☐ Parkinson's Disease ☐ Other Other Diagnosis if known : Date of onset if known :

If 'Other' is selected, please explain.

If No, is there presenting evidence to indicate :

Undiagnosed condition: ○ Yes ○ No Suspected Diagnose: ○ Yes ○ No

2. Is there current and accurate data found in the patient record to indicate that there is a **severe physical illness** that is so severe that the patient could not be expected to benefit from *specialized services? ○ Yes ○ No

* Specialized Services under Georgia's PASRR Program are services in combination with nursing facility services results in the implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities which necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, Skills training with Rehab supports& therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.

If Yes, specify the physical illness :

☐ Coma, Functioning at a brain stem level ☐ Congestive Heart Failure ☐ Chronic Obstructive Pulmonary Disease ☐ Ventilator dependence

☐ Delirium ☐ Parkinson's Disease ☐ Huntington's Disease ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

☐ Other Diagnosis if known Date of onset if known :

If 'Other' is selected, please explain.

Physical illness likely to continue ? ○ Yes ○ No

Likely to interfere with mental/cognitive capacity/function ? ○ Yes ○ No

3. Does the individual have a **terminal illness** as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less? ○ Yes ○ No

Diagnosis if known : Date of onset if known:

4. Does the individual have a Primary Diagnosis of Serious Mental illness, developmental disability or related condition? ○ Yes ○ No

If Yes, specify the physical illness :

☐ Schizophrenia, Paranoid Type ☐ Schizophrenia, Disorganized Type ☐ Schizophrenia, Catatonic Type ☐ Schizophrenia, Undifferentiated Type

☐ Schizophrenia, Residual Type ☐ Bipolar Disorder ☐ Depressive Disorder ☐ Somatoform Disorder

☐ Other mental Disorder if known ☐ Substance Use Related Disorder

Date of onset if known:

Comments :

a. Does the treatment history indicate that the individual has received, is receiving, or has been referred to receive services from an agency for a serious mental illness or mental disorder? ○ Yes ○ No

b. Does the treatment history indicate the individual has experienced **at least ONE of the following?**

(1) Inpatient psychiatric treatment/crisis stabilization within the past 5 years. ○ Yes ○ No

(2) An episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ○ Yes ○ No

c. The disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has AT LEAST ONE of the following characteristics on a continuing or intermittent basis:

(1) Interpersonal Symptoms. The individual may have serious difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others ○ Yes ○ No

(2) Completion of Tasks. The individual may have serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks, requires assistance with tasks, lacks concentration or persistence. ○ Yes ○ No

(3) Adaptating to change. This individual may be self-injurious, self-mutilating, suicidal, or have episodes of physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, or withdrawal. ○ Yes ○ No

Comments (Limit of 3500 characters, for longer comments, please attach a file):

5. The individual has a Diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) [prior to age 18] or a Related Condition [prior to age 22] ○ Yes ○ No

If Yes,

a. Diagnosis of any of the following **disabilities** MAY indicate a **RELATED CONDITION:** Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

Diagnosis, if known : Date of onset, if known :

The individual is a **"PERSON WITH RELATED CONDITIONS"**having a severe, chronic disability **that meet ALL of the following conditions**:

(1) It is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required by these persons.

(2) It is manifested before the person reaches age 22.

(3) It is likely to continue indefinitely.

(4) It results in substantial functional limitations in THREE or more of the following areas of major life activities:

self-care;

understanding and use of language;

learning;

mobility;

self-direction; and

capacity for independent living.

b. If No, is there presenting evidence to indicate a suspected diagnosis for an undiagnosed condition as indicated by substantial functional limitations in THREE or more of the following areas of major life activities: (Refer to Section (4) Above) ○ Yes ○ No

c. Does the treatment history indicate that the individual has received, is receiving, or has been referred to services for ID/DD/RC from DBHDD or another agency? ○ Yes ○ No

(1) Has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ○ Yes ○ No

(2) Has received Inpatient residential treatment ○ Yes ○ No

Comments (Limit of 3500 characters, for longer comments, please attach a file):

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