Chapter 514

Nursing Facility Services

Appendix 514 B

Pre-Admission Screening (PAS) 2000

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
PRE-ADMISSION SCREENING

Reason for Screening:
Check Only One

A. Nursing Home Only: Initial Transfer
B. Nursing Home Waiting Waiver: Yes
C. ADW Only: Initial Re-evaluation
D. Personal Care: Initial Re-evaluation

Facility/Agency/Person making referral:
NAME:
ADDRESS:
CONTACT PERSON:
PHONE: (____) _____ - _____
FAX: (_____) _____ - _____

1. DEMOGRAPHIC INFORMATION

1. Individual's Full Name	2. Sex F	2. Sex M	3. Medicaid Number	4. Medicare Number

5. Address (Including Street/Box, City, State & Zip)	6. Private Insurance

7. County	8. Social Security Number	9. Birth date (M/D/Y)	10. Age	11. Phone Number

12. Spouse's Name	13. Address (If different from above)

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)

_____
_____
_____

15. Name and Address of Provider, if applicable:

_____
_____
_____

16. Medicaid Waiver Recipient a. Yes b. No c. Aged/Disabled d. IDDW

17. Has the option of Medicaid Waiver been explained to the applicant? a. Yes b. No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Human Services or its representative.

_____ /
_____/_____
SIGNATURE - Applicant or Person acting for Applicant Relationship Date

19. Check if Applicant has any of the following:
a. Guardian
b. Committee
c. Medical Power of Attorney
d. Power of Attorney
e. Durable Power of Attorney
f. Living Will
g. Other _____

Name & Address of the Representative

_____
_____
_____

Phone: (_____) _____-_____

II. MEDICAL ASSESSMENT **Date** _____

Name _____

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

_____
_____
_____
_____
_____

21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate

22. Check if Abnormal:

a. Eyes	g. Breasts	m. Extremities	s. Musculo-Skeletal
b. Ears	h. Lungs	n. Abdomen	t. Skin
c. Nose	i. Heart	o. Hernia(s)	u. Nervous System
d. Throat	j. Arteries	p. Genitalia - male	v. Allergies (Specify)
e. Mouth	k. Veins	q. Gynecological	
f. Neck	l. Lymph System	r. Ano-Rectal	

Describe abnormalities and treatment:

_____
_____
_____
_____

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a. Angina-rest	e. Paralysis	i. Diabetes
b. Angina-exertion	f. Dysphagia	j. Contracture(s)
c. Dyspnea	g. Aphasia	k. Mental Disorder(s)
d. Significant Arthritis	h. Pain	l. Other (Specify)

24. Decubitus **a. Yes** **b. No** **If yes, check the following:**

A. Stage _____ **B. Size** _____ **C. Treatment** _____

Location: **a. Left Leg** **c. Right Leg** **e. Left Hip** **g. Right Hip**
b. Left Arm **d. Right Arm** **f. Left Buttock** **h. Right Buttock**

Other _____ **Developed at:** **a. Home** **b. Hospital** **c. Facility**

25. In the event of an emergency, the individual can vacate the building: (check only one)

a. Independently **b. With Supervision** **c. Mentally Unable** **d. Physically Unable**

DATE: _____

NAME: _____

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a.__ Eating (not meal prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.__ Bathing				
c.__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d.__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e.__ Cont./Bladder	Self/Prompting	Physical Assistance	Total Care	
f. __ Cont./Bowel	Continent	Occas. Incontinent*	Incontinent	Catheter
g.__ Orientation				
h.__ Transferring	Continent	Occas. Incontinent*	Incontinent	Colostomy
i.__ Walking		*less than 3 per wk.		
j.__ Wheeling	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
k.__ Vision	Independent	Supervised/Assistive	One Person Assistance	Two Person Assist.
l.__ Hearing		Devise	One Person Assistance	Two Person Assist.
m.__ Communication	Independent		Situational Assistance	Total Assistance
	No Wheelchair	Supervised/Assistive	(Doors, etc.)	
	Not Impaired	Devise	Impaired/Not Correctable	Blind
	Not Impaired	Wheels Independently	Impaired/Not Correctable	Deaf
	Not Impaired	Impaired /Correctable	Understandable with Aids	Inappropriate/None
		Impaired/Correctable		
		Impaired/Understandable		

27. Professional and technical care needs (check all that apply).

a. Physical Therapy	f. Ostomy	k. Parenteral Fluids
b. Speech Therapy	g. Suctioning	l. Sterile Dressings
c. Occupational Therapy	h. Tracheostomy	m. Irrigations
d. Inhalation Therapy	i. Ventilator	n. Special Skin Care
e. Continuous Oxygen	j. Dialysis	o. Other _____

28. Individual is capable of administering his/her own medications (check only one).

a. Yes b. With Prompting/Supervision c. No Comment:_____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

30. Current Diagnoses (Check all that apply)

a. None
b. Mental Retardation
c. Autism
d. Seizure Disorder (Age at onset: _____)
e. Cerebral Palsy
f. Other Developmental Disabilities (Specify: _____)
g. Schizophrenic Disorder
h. Paranoid Disorder
i. Major Affective Disorder
j. Schizoaffective Disorder
k. Affective Bipolar Disorder
l. Tardive Dyskinesia
m. Major Depression
n. Other related conditions (Specify:_____)

Date of last PASARR Level II Evaluation_____

31. Has an individual ever received services from an agency serving persons with intellectual/ developmental disability and/or mental illness? □ Yes □ No
If yes, specify agency

Name_____
Address_____
Admission Date _____ **Discharge Date** _____

32. Has the individual received any of the following medications on a regular basis within the last two years? □Yes □ No
33. Was this medication used to treat a neurological disorder? □Yes □ No

□ Chlorpromazine	□ Thorazine	□ Perphenazine	□ Trilafon	□ Haloperidol	□ Haldol
□ Promazine	□ Sparine	□ Fluphenazine	□ Prolixin	□ Molindone	□ Moban
□ Trifupromazine	□ Vesprin	□ Fluphenazine HCl	□ Permitil	□ Loxapine	□ Loxitane
□ Thioidazine	□ Mellaril	□ Trifluphenazine	□ Stelazine	□ Clozapine	□ Clozaril
□ Mesoridazine	□ Serentil	□ Chlorprothixene	□ Taractan	□ Procholorperazine	
□ Actiphenazine	□ Tindal	□ Thiothixene	□ Navane	□ Compazine	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

a. Substance Abuse (Identify_____)
b. Combative
c. Withdrawn/Depressed
d. Hallucinations
e. Delusional
f. Disoriented
g. Bizarre Behavior
h. Bangs Head
i. Sets Fires
j. Displays Inappropriate Social Behavior
k. Seriously Impaired Judgment
l. Suicidal Thoughts, Ideations/Gestures
m. Cannot Communicate Basic Needs
n. Talks About Their Worthlessness
o. Unable to Understand Simple Commands
p. Physically Dangerous to Self and Others, if Unsupervised
q. Verbally Abusive
r. Demonstrates Severe Challenging Behaviors
s. Specialized Training Needs
t. Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? □ Yes □ No
Other (Specify)
_____

IV. PHYSICIAN RECOMMENDATION **DATE:** _____

NAME: _____

35. Prognosis - Check one only: a___ Stable b___ Improving c___ Deteriorating d___ Terminal

Other _____

36. Rehabilitative Potential (Check one only) a ___ Good b ___ Limited c___ Poor

37. Diagnosis:

a. Primary _____

b. Secondary _____

c. Other medical conditions requiring services _____

38. Physician Recommendations

A. FOR NURSING FACILITY PLACEMENT ONLY
On the basis of present medical findings, the individual may eventually be able to return home or be discharged.

a ___ Yes b___ No

If yes, check one of the following:

a. Less than 3 months
b. 3-6 months
c. Over 6 months
d. Terminal illness

B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

a. Nursing Home
b. Nursing Home waiting A/D Waiver
c. A/D Waiver
d. Personal Care

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

_____

Physicians Signature MD/DO

_____

Date This Assessment Completed:

TYPE OR PRINT Physicians name/address below:

_____

_____

_____

_____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan. NOTE: Information gathered from this form may be utilized for statistical/data collection.

V. ELIGIBILITY DETERMINATION **DATE:** _____

NAME: _____

DEPARTMENT USE ONLY

LEVEL I (Medical Screen)

Medical and other professional personnel of the Medicaid Agency or its designees MUST evaluate each individual's need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

a. Diagnosis of dementia (Alzheimer's or related disorder)?	**Yes**	**No**
b. Thirty days of respite care?	**Yes**	**No**
c. Serious Medical Condition?	**Yes**	**No**

41. Medical Eligibility Determination:

a. Nursing Facility Services/Aged/Disabled Waiver **b. Personal Care Services**

c. No Services Needed **d. Optional Services**

42. PASARR Determination:

a. Level II required **b. Level II not required**

_____ _____

Nurse Reviewers Signature - Title **Date** **Control Number**

Printed Name_____

WAIVER ONLY: Level of Care:_____ **Number of Hours:**_____

DEPARTMENTAL USE ONLY

LEVEL II (MI/IDD Screen)

(Completed by PASARR Provider)

43. DETERMINATION:

a. Nursing facility services needed - Specialized services not needed.
b. Nursing facility services needed - Specialized services needed.
c. Alzheimer's or related disorder identified.
d. 30-day Respite care needed.
e. Terminal illness identified.
f. Serious illness identified.
g. Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

a. Nursing Facility Services/Aged/Disabled Wavier
b. Psychiatric Hospital (21 years or under)
c. ICF/IID or I/DD Waiver
d. Other-Identify:_____

_____

_____

PASARR Reviewers Signature **Title** **Printed Name**

_____ _____

Agency Name **Date**

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS