GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
PASRR LEVEL I APPLICATION (DMA-613)
RESIDENT IDENTIFICATION SCREENING INSTRUMENT

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 are permanent documents to be placed in the resident's chart and made readily available for professional review. Georgia Medicaid will not reimburse the admitting nursing facility for claims prior to the completion date of all proper documentation; this includes Level II PASRR documentation that was not completed prior to the Medicaid or non-Medicaid eligible resident's admission into the nursing facility (NF). The nursing facility is responsible for ensuring that the form is complete and accurate before admission.

The Physician's Recommendation Concerning Nursing Facility Care **DMA-6 signed by the physician**
□ Yes □ No

Does the individual applying for admission, directly from a 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 Date of Certification_____

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

_____ _____ _____
Physician's Name on DMA-6 **Date Signed** **Physician's Telephone #**

_____ _____ ___-___-____
Name of applicant / Sex: □ M □ F **Date of birth** **Social Security Number**

_____
Applicant Medicaid ID # or System Generated ID #

_____ _____
Facility or Office Name Submitting Application **FAX #**

_____ _____ _____
Name, Title of Representative Submitting Application **Submission Date** **Telephone#**

Has the applicant been admitted into the Nursing Facility? □ Yes □ No

Admitting Nursing Facility: _____ **Facility Provider number:** _____

Anticipated Date of Admission: _____

Current location of applicant: ◘ Acute hospital ◘ Psychiatric inpatient ◘ Residential Nursing Facility

◘ Home Address_____ Contact Person_____ Phone_____

◘ Other_____

Check all that apply to the applicant/resident:

◘ New admission

◘ Readmission to NF from acute hospital

◘ Transfer between NF's

◘ Respite care, less than 30 days

◘ Significant status change

◘ Other: _____

◘ Readmission to NF from psychiatric hospital

◘ Transfer from residence to NF

◘ Emergency, Requiring Protective Services

◘ Out-of-state resident **(OOS)**

◘ Referral from ID/DD agency/DBHDD

***Resident's OOS PASRR Contact information:**

_____

Name **Telephone #**

CHECK ALL DIAGNOSES THAT APPLY TO PATIENT

1. **Does the individual have a primary diagnosis of Dementia?**
   ◘ **Yes** ◘ **No** **ICD-10 Diagnosis**_____ **Date of Onset, if known**_____

   a. **If yes, check the type of Dementia, due to:**

   ◘ Alzheimer's Disease
   ◘ Parkinson's Disease
   ◘ Huntington's Disease
   ◘ HIV
   ◘ Other_____
   ◘ Head Trauma
   ◘ Vascular changes
   ◘ Pick's Disease
   ◘ Creutzfeldt-Jakob (ABE)

   b. **If no, is there presenting evidence to indicate Dementia as a/an:**

   1. Undiagnosed condition? ◘ **Yes** ◘ **No** **or** **2. Suspected diagnosis?** ◘ **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 any services or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services, which result in the implementation of an individualized plan of care that 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.

Please specify the Physical Illness: _____

ICD-10 code(s), if known _____ **Date of Onset, if known**_____

- Severe 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 which includes a medical prognosis that his/her life expectancy is 6 months or less?** ◘ **Yes** ◘ **No**

Diagnosis_____ **Date of Onset, if known**_____

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CHECK ALL DIAGNOSES THAT APPLY TO PATIENT

4. **Does the individual have a Primary Diagnosis of Serious Mental Illness or Mental Disorder?** ◘ **Yes** ◘ **No**

Diagnosis_____ **Date of Onset, if known**_____ **ICD-10 code(s)** _____

If yes, check all that apply:

□ Schizophrenia, Paranoid Type

□ Schizophrenia, Disorganized Type

□ Depressive Disorder

□ Schizophrenia, Catatonic Type

□ Bipolar Disorder

□ Schizophrenia, Undifferentiated Type

□ Anxiety Disorder

□ Schizophrenia, Residual Type

□ Somatoform Disorder

□ Substance Use Related Disorder

□ Other Mental Disorder

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) In-patient psychiatric treatment/crisis stabilization unit within 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, lack concentration or persistence.
¤ **Yes** ¤ **No**

(3) Adapting 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: _____

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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**

a. Diagnoses 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_____ **Date of Onset, if known**_____ **ICD-10 code(s)** _____

The individual is a "**PERSON WITH RELATED CONDITIONS**" having a severe, chronic disability that **meets 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) 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:

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Do not admit the applicant to the nursing facility until the DMA Medical Management Vendor and/or the PASRR Determination Unit approves this admission and issues the PASRR authorization code number. ***Admissions into a facility prior to the issued authorization code will result in the Department's denial of payment prior to the date that the PASRR authorization code is issued.** The authorization code must be documented on the applicant's DMA-6 form, in the appropriate 9A or 9B section.

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 a related condition of mental illness, intellectual disability or developmental disability. If there is no further evidence to indicate the possibility

of mental illness, intellectual disability or related condition, prior to admission into the nursing facility, the nursing facility may admit this applicant. If the nursing facility admits the applicant and discovers information that was not disclosed to the PASRR screeners, the nursing facility is required to contact the DMA Medical Management Vendor immediately.

Admission to the facility does not constitute approval for Title XIX patient status.

A copy of this form, as well as a copy of the DMA-6, must be placed in each resident's file in the facility.

Comments:

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I understand that this form may be considered in the payment of claims from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.