RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Level I Identification for MI and DD

Name of applicant	Social security number - -	Application date - -
Date of birth - - ☐ Male ☐ Female	Marital status ☐Married ☐Divorced ☐Single ☐Separated ☐Widowed ☐Unknown	

Current location of applicant

☐ Psychiatric inpatient ☐ Acute hospital ☐ Home ☐ Residential group home ☐ Nursing facility ☐ Other: _____

Applicant's home address

Payment source

☐ Personal resources ☐ Medicaid approved ☐ Medicaid pending ☐ Commercial health insurance ☐ VA ☐ Medicare

Name and title of person facilitating application	Name and location of current facility

Guardian/legal representative, address and contact information (if applicable)

Primary care physician, address and contact information

Section I : Intellectual & Developmental Disabilities

Does this individual have an Axis II diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) diagnosed or manifested before the age of 22?

☐No ☐Yes

Does this individual have a possible related condition (RC)? ☐No ☐Yes (Specify) ☐Autism ☐Blindness ☐Deafness ☐Cerebral Palsy ☐Epilepsy

☐Head injury ☐Other: _____

Does this individual with a diagnosis of ID, DD or RC have substantial functional limitations with routine activities? ☐No ☐Yes (specify): ☐Self care

☐Understanding and use of language ☐Self direction ☐Mobility ☐Capacity for independent living ☐Learning ☐Decision making

Does this individual have evidence of an intellectual or developmental disability that has not yet been diagnosed? ☐No ☐Yes

Does this individual receive services now or in the past from an agency that serves people with ID and DD? ☐No ☐Yes (list agency):_____

***If any questions in this section are answered "yes" please contact the PASRR State Office of Developmental Disabilities for approval prior to NF admission.**

Section II : Mental Illness

1. Does this individual have a diagnosis of a major mental illness? ☐No ☐Yes (specify) : ☐Schizophrenia ☐Schizoaffective Disorder
   ☐Major Depression ☐Bipolar Disorder ☐Delusional/Psychotic Disorder ☐Paranoid Disorder
2. Does this individual have any of the following mental disorders? ☐No ☐Suspected (specify) ☐Yes (specify): ☐Anxiety ☐Panic ☐Personality Disorder
   ☐Depression (mild or situational) ☐Somatoform Disorder ☐Eating Disorder ☐Other: _____
3. Does the treatment history indicate a psychiatric hospitalization within the past two years? ☐No ☐Yes, date(s):_____
4. Did this individual have a disruptive life episode occurrence because of mental illness within the past two years? ☐No ☐Yes (specify):
   ☐Homelessness/Eviction ☐Law enforcement involvement ☐Altercations/difficulty interacting with others ☐Unstable employment ☐Social isolation
5. Has this individual now or in the past two years received any of the following mental health services? ☐No ☐Yes (specify):
   ☐Community mental health services ☐Inpatient psychiatric hospitalization ☐Psychiatric rehabilitative residence
6. Does this individual exhibit any of the following symptoms or behaviors now or in the past six months due to mental illness or suspected mental illness?
   ☐No ☐Yes (specify all): ☐Self injurious ☐Suicide attempt ☐Suicidal talk and/or gestures ☐History of suicide attempt ☐Physical violence
   ☐Physical threats (harmful) ☐Hallucinations/delusions ☐Illogical comments ☐Excessive irritability ☐Excessive sadness/tearfulness
   ☐Severe loss of appetite ☐Requires assistance with simple tasks ☐Unrealistic fears ☐Serious loss of interest ☐Unable to adapt to life changes
7. Does this individual have substance use disorder? ☐No ☐Yes; If yes, what type of substance? _____
   When did the substance use last occur? ☐Current use ☐Less than a month ☐Less than 1 year ☐Other _____

*** If the answer to question #1 or #2 is "yes" and any of the questions #3-6 is "yes", a PASRR Level II is required prior to approval of NF admission.**

Section II : Mental Illness Continued			
Psychotropic medication	Dosages/mg per day	Diagnosis	Discontinued in the past 6mo
			☐
			☐
			☐
			☐

Section III : Dementia

Does this individual have a primary diagnosis of dementia with collaborative testing results of the progression of dementia? ☐No ☐Yes

☐No, this individual has dementia but it is not a primary diagnosis

* If question above is answered "yes", a dementia exemption from PASRR will be reviewed and determined by the Department of BHDDH.

Section IV : Categorical Determination of Severe or Terminal Illness

Does this individual have a terminal illness with the prognosis of a life expectancy of <6 months and their psychiatric symptoms are stable? ☐No ☐Yes

Does this individual have a severe illness in which he/she could not participate in specialized care and is not a risk for harm to self or others? ☐No ☐Yes

Examples of severe illness include but are not limited to coma, brain stem injury, vent dependent, progressed ALS, progressed Huntington's disease.

*Medical Record documentation of terminal or severe illness needs to be submitted with this form. The nursing facility must update the ID Screen if the individual's medical state improves to the extent that s/he could benefit from services to address their MI or DD/RC needs.

Section V : Provisional Emergency and Delirium

Does this individual need emergency NF care **initiated by protective services** for seven days or less? ☐No ☐Yes(If yes, PS contact):_____

*The admitting NF must submit a "Notification of Need for Resident Review" to BHDDH within 7 days of admission for a Provisional Emergency.

Does this individual have a diagnosis of delirium which interferes with the ability to determine the diagnosis of MI or DD/RC? ☐No ☐Yes

*The NF must update the ID Screen as soon as the delirium clears, but not more than 30 days after admission. If indicated on the new ID Screen, a request for a "Notification of Need for Resident Review" for MI should be submitted on or before the 7th calendar day if the individual is expected to remain in the NF.

Section VI : 30 Day Respite or 30 Day Exemption

Does this individual with a diagnosis of MI or DD/RC require respite care for up to 30 calendar days to provide relief to the family or caregiver? ☐No ☐Yes

Does this individual with a diagnosis of MI or DD/RC require an admission directly from the hospital after receiving acute medical care, and the attending physician certifies that s/he will require less than 30 days of NF services? ☐No ☐Yes If yes, list acute medical diagnosis in this hospital admission that the individual will be treated for in the nursing facility:_____

*30 day exemption will only occur if the symptoms and behaviors are stable and there are no risks to self or others. 30 day exemptions or respite NF admissions will require an updated ID Screen by or before the 30th calendar day if the individual's stay will exceed 30 days.

The information used to screen this individual was obtained from the following resources (please check all that apply):

☐Doctor ☐Nurse ☐Social work ☐Case worker ☐Medical records ☐Family member ☐Friend ☐Applicant ☐Other_____

I certify that all information is true to the best of my knowledge, and I am aware that falsification of this screening will be investigated by the state Medicaid authority, Screener's signature: _____Title: _____Date:_____