PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA
CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES

State Form 45277 (R2 / 7-02) / Form 450B/PASRR2A - Sections IV and V, Part A

This form is **CONFIDENTIAL** according to IC12-15-2 *et seq.*, IC 12-10-10 *et.seq.*, IC 12-21 and 470 IAC 1-3-1.

This form **MUST** be completed for **ALL** persons prior to nursing facility admission in accordance with 42 CFR 483.106. All of the following questions must be answered as indicated.

Name of applicant / resident	Name of facility / city

Current location of applicant ☐ Residential ☐ Home ☐ Nursing facility ☐ Psychiatric bed ☐ Acute hospital ☐ Other:

Please check any of the following that applies to the applicant / resident:

☐ New admission ☐ Readmission to NF from psychiatric hospital stay ☐ Transfer between NF's ☐ Out-of-state resident
☐ Transfer from residential to NF ☐ Other: ______

SECTION IV

Question	Answer
1. Does the individual have a documentable diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) based on criteria in DSM-IV, without a concurrent primary diagnosis of a major mental illness or a diagnosis of mental retardation or developmental disability?	☐ Yes ☐ No
2. Does the individual have a diagnosis of major mental illness *[limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability]?*	☐ Yes ☐ No
3. a. Does the person have a diagnosis of mental illness not listed above? List diagnosis:	☐ Yes ☐ No
b. Has the individual been prescribed *(within the past 1 year)* a major tranquilizer or psychoactive drug on a regular basis for a mental health condition? *(If given for another purpose, explain by listing the name of the drug and the purpose of the prescription; for example, Mellaril for dementia. When explained and documented in the individual's medical record, check "No".)* ** A Yes answer to 3a and / or 3b DOES NOT ALONE trigger a Level II.*	☐ Yes ☐ No
4. Has the person had any recent (*within the last two years*) history of in patient / partial hospitalization care? Explain:	☐ Yes ☐ No
5. Does the individual have a diagnosis of mental retardation, developmental disability (*MR / DD*) or other related condition?	☐ Yes ☐ No
6. Is there any history of a MR / DD or related condition in the individual's past?	☐ Yes ☐ No
7. Is there any presenting evidence (*cognitive or behavior characteristics*) that may indicate the person has MR / DD or related condition? (*Explain*)	☐ Yes ☐ No

Signature of authorized assessor	Title / Position	Date signed

SECTION V - PART A

PASRR Determination Criteria - Level II Exemption: See back of form for explanation. *(Exemption **MUST** be certified by a physician's signature.)*

NOTE: Exemption applies only to initial nursing facility admission, not to RR or transfers.

EXEMPTED HOSPITAL DISCHARGE: An individual may be admitted to a nursing facility directly from a hospital after receiving acute inpatient care *(non-psychiatric)* at the hospital if: (1) the individual requires nursing facility services for the condition for which he/she received care in the hospital; and (2) the attending physician certifies before the admission that the individual is likely to require less than 30 days nursing facility care.

In accordance with the requirements above, I certify that this individual requires less than 30 days of care in a nursing facility.

Signature of physician	Printed name of physician	Date signed
If applicable, hospital or other affiliation:	City	

NOTE: If the individual requires care beyond the initial 30 day period, the nursing facility must notify the PAS agency prior to the expiration of 30 days and provide a written explanation of the reason continued residence is required and the anticipated length of stay. Admission under the above exemption does not exempt the nursing facility from providing services to an individual who has mental health or MR/DD or related needs and would benefit from services. Refer to II B on back for complete instructions

CERTIFICATION OF LEVEL II REFERRAL

PASARR LEVEL II ASSESSMENT REFERRAL NEEDED	PAS: ☐ Yes ☐ No	
Signature of PAS agency respresentative	Title / Position	Date signed