



Applicant/Resident Name	Medicaid Number
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**SECTION C: DEMENTIA QUESTIONS**

<input type="checkbox"/> YES	<input type="checkbox"/> NO	1) Does the individual have a documented PRIMARY diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-IV TR (or most recent version)?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	2) Does the individual have a SECONDARY diagnosis of dementia, Alzheimer's disease, or some other organic mental disorder as defined in DSM-IV TR (or most recent version)?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	3) Does the individual have a PRIMARY diagnosis of one of the mental disorders listed in Question D (1) below?

*If this is a Resident Review, please complete the remainder of this section (Check NA if this request is a PAS).*

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA	4) Is the diagnosis for this resident review request different from the diagnosis submitted at admission?
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Please list below diagnosis at admission if different from the resident review request diagnosis.

Diagnosis 1 _____	Diagnosis 2 _____	Diagnosis 3 _____
Diagnosis 4 _____	Diagnosis 5 _____	Diagnosis 6 _____

**SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS**

1) Does the individual have a diagnosis of any of the mental disorders listed below?     YES     NO

*Check all that apply.*

<input type="checkbox"/> a) Schizophrenia <input type="checkbox"/> b) Mood Disorder <input type="checkbox"/> c) Delusional (Paranoid) Disorder <input type="checkbox"/> d) Panic or Other Severe Anxiety Disorder <input type="checkbox"/> e) Somatoform Disorder	<input type="checkbox"/> f) Personality Disorder <input type="checkbox"/> g) Other Psychotic Disorder <input type="checkbox"/> h) Another Mental Disorder Other Than MR that may lead to a <b>chronic disability</b> . If so, describe _____ _____
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2) Within the past two (2) years, DUE TO THE MENTAL DISORDER

a) Has the individual utilized intensive psychiatric services more than once?     YES     NO

**Indicate the number of times the individual utilized each service over the last 2 years. If service was not utilized, enter "0".**

	Ongoing case management from mental health agency? ("1" if continuously receiving over 2 years. If not, "0").
	Emergency mental health services?
	Number of admissions to the inpatient hospital settings for psychiatric reasons?
	Number of admissions to partial hospitalization treatment programs for psychiatric reasons?
	Number of admissions to Residential Care Facilities (RCFs) providing mental health services by a mental health agency?

\_\_\_\_\_ TOTAL SCORE

*If total score equals 2 or more, answer YES to Question D (2). Regardless of score answer Question D (2) (b).*

**OR**

b) Had a disruption to his/her usual living arrangement e.g., arrest, eviction, inter or intra-agency transfer, locked seclusion?

YES     NO

*If YES, answer YES to Question D(2).*

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3) Within the past 6 months, DUE TO THE MENTAL DISORDER, has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis?  YES  NO

*Check all that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> a) Maintaining Personal Hygiene              | <input type="checkbox"/> g) Performing Household Chores         |
| <input type="checkbox"/> b) Dressing Self                             | <input type="checkbox"/> h) Going Shopping                      |
| <input type="checkbox"/> c) Walking/Getting Around                    | <input type="checkbox"/> i) Using Available Transportation      |
| <input type="checkbox"/> d) Maintaining Adequate Diet                 | <input type="checkbox"/> j) Managing Available Funds            |
| <input type="checkbox"/> e) Preparing/Obtaining Own Meals             | <input type="checkbox"/> k) Securing Necessary Support Services |
| <input type="checkbox"/> f) Maintaining Prescribed Medication Regimen | <input type="checkbox"/> l) Verbalizing Needs                   |

4) Within the past 2 years, has the individual received SSI or SSDI due to a mental impairment?  YES  NO

5) Does the individual have indications of Serious Mental Illness?  YES  NO

*NOTE: The individual has indications of Serious Mental Illness if the individual answered YES to AT LEAST two questions of D(1), D(2), or D(3) OR if the individual answered YES to question D(4).*

### SECTION E: INDICATIONS OF MR OR RELATED CONDITION

1) Does the individual have a diagnosis of mental retardation (mild, moderate, severe or profound) as described in the AAMR manual "Mental Retardation: Definition, Classifications and Systems of Support" (2002 or more recent version)?  
 YES  NO

2) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR?  YES  NO

*If NO, go to Question E(6). If YES, please specify*

3) Did the disability manifest before the individual's 22<sup>nd</sup> birthday?  YES  NO

4) Is the disability likely to continue indefinitely?  YES  NO

5) Did the disability result in functional limitations, prior to age 22, in 3 or more of the following major life activities?

*Check all that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> a) Self Care                       | <input type="checkbox"/> e) Mobility                          |
| <input type="checkbox"/> b) Economic Self-Sufficiency       | <input type="checkbox"/> f) Understanding and Use of Language |
| <input type="checkbox"/> c) Self Direction                  | <input type="checkbox"/> g) Learning                          |
| <input type="checkbox"/> d) Capacity for Independent Living |   |

6) Does the individual currently receive services from a County Board of DD?  YES  NO

7) Does the individual have indications of MR or related condition?  YES  NO

*The individual has indications of MR or related condition if the individual received*

- Yes to Question E (1); OR
- Yes to all of the following in this Section: Questions, 2, 3, 4 AND 5; OR
- Yes to Question E (6)

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**SECTION F: RETURN TO COMMUNITY LIVING REFERRAL**

1) Did you share with the individual the service and support alternatives to the nursing facility admission (for PAS) or continuation of the nursing facility stay (for RR)?  Yes  No

If service and support alternatives are not appropriate due to care needs, **please explain why alternatives are not appropriate at this time**

2) Does this individual expect to return to live in the community either following the short term stay in the nursing facility or at some point in the future?  
 Yes  No

3) Do you believe that this individual could benefit from talking to someone about returning to the community following the short term stay in the nursing facility (for PAS) or during the continued stay in the nursing facility (for RR)?  
 Yes  No

4) Was this individual employed prior to the nursing facility placement?  
 Yes  No Occupation, if applicable :

5) Does the individual need assistance obtaining and/or returning to employment upon return to a community setting?  
 Yes  No

6) What challenges or barriers do you believe could impede this individual's return to the community?  
*Check all that apply and provide a brief description*

<input type="checkbox"/> a) Care needs are likely greater than community capacity	<input type="checkbox"/> e) Affordable housing limited
<input type="checkbox"/> b) Limited or no family/friend support available	<input type="checkbox"/> f) Accessible housing limited
<input type="checkbox"/> c) Guardian/Family likely to not support community living	<input type="checkbox"/> g) Limited income to support community living
<input type="checkbox"/> d) Lost housing during NF stay	<input type="checkbox"/> h) Other, please describe below

Brief Description

**Does the Individual Need Help Returning to Community Living?**

If the individual already has, or is likely to have prior to discharge from the facility, a combined stay in the hospital/nursing facility/ICF-MR facility of 6 months or longer and could benefit from community transition assistance, a referral to the HOME Choice Transition Program is recommended. Please visit <http://jfs.ohio.gov/OHP/consumers/HCconsumers.stm> to submit an application or call 1-888-221-1560 for more information regarding program benefits and application procedures.

Application submitted on \_\_\_\_\_ (mm/dd/yy)

Ohio's twelve area agencies on aging offer free long-term care consultations. As requested, a consultant (most often a nurse or social worker) will meet with the individual and their family for a free evaluation of the current situation and future options. The consultant will explain services available, discuss eligibility requirements and financial resources required and help determine needs and wishes. Call toll-free 1-866-243-5678 to be connected to the area agency on aging serving your community.

Long Term Care Consultation requested on : \_\_\_\_\_ (mm/dd/yy) Request sent to \_\_\_\_\_ Area Agency on Aging

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**SECTION G: REQUEST FOR RESIDENT REVIEW APPROVAL FOR A SPECIFIED PERIOD**  
***Complete only when seeking an RR for a Specified Period of Time***

1) If seeking a resident review approval for a specified period of time, how much time is needed?  
 a) Number of Days \_\_\_\_\_

2) Reason for Request:  
 a) Individual requires more rehabilitation following the recent hospital stay. *Describe* \_\_\_\_\_  
**OR**  
 b) More time is needed to ensure a safe and orderly discharge due to:  
*Check all that apply->*  
 i) Accessible housing barrier. *Describe* \_\_\_\_\_  
 ii) Affordable housing barrier. *Describe* \_\_\_\_\_  
 iii) Service and support limitations in the community. *Describe* \_\_\_\_\_  
 iv) Lack of sufficient income. *Describe* \_\_\_\_\_  
 v) Other. *Describe* \_\_\_\_\_

3) If seeking a resident review approval extension, how much time is needed?  
 a) Number of Days \_\_\_\_\_

4) Reason for Request:  
 a) Individual requires more rehabilitation following the recent hospital stay. *Describe* \_\_\_\_\_  
**OR**  
 b) More time is needed to ensure a safe and orderly discharge due to:  
*Check all that apply->*  
 i) Accessible housing barrier. *Describe* \_\_\_\_\_  
 ii) Affordable housing barrier. *Describe* \_\_\_\_\_  
 iii) Service and support limitations in the community. *Describe* \_\_\_\_\_  
 iv) Lack of sufficient income. *Describe* \_\_\_\_\_  
 v) Other. *Describe* \_\_\_\_\_

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**SECTION H: MAILING ADDRESSES**

**Please place an 'x' in the box  next to the address and phone number of the person to be contacted for a Level 2 PAS/RR evaluation by ODMH and/or ODODD.**

**1) What address should be used for mailing results of the PAS/RR evaluation to the applicant/resident?**

In Care Of			
Street Address			
City	State	Zip	Ohio County of Residence ( <i>First 4 letters</i> )
Telephone No.			

**2) Please provide the following information about the individual's attending physician:**

Last Name		First Name	
Street Address			
City	State	Zip	Telephone No.

**3) If the individual has a guardian or legal representative, please provide the following information about the guardian/legal representative:**

Last Name		First Name	
Street Address			
City	State	Zip	Telephone No.

**4) If the individual is an applicant to or resident of a nursing facility, please provide the name and address of the nursing facility:**

Name of Nursing Facility			
Street Address			
City	State	Zip	Ohio County of Residence ( <i>First 4 letters</i> )
Telephone No.			

**5) If the individual is being discharged from a hospital, and the submitter is not employed by the discharging hospital, please provide the name of a contact person and the name and address of the discharging hospital:**

Last Name		First Name	
Street Address			
City	State	Zip	Telephone No.

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**SECTION I: SUBMITTER INFORMATION/CERTIFICATION**

In order to process the screen, the submitter must provide his/her name and address and sign below. Complete the form fully and with accuracy. Incomplete forms may be returned with a request for further information. **The nursing facility may not admit or retain individuals with indications of Serious Mental Illness and/or MR or a related condition without further review by ODMH and/or DODD (OAC rules 5101:3-3-15.1 and 5101:3-3-15.2).**

Last Name		First Name	
Street Address			
City	State	Zip	Telephone No.
I understand that this screening information may be relied upon in the payment of claims that will be 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.			
Signature		Title	Date (mm/dd/yy)
Employer			

**Additional Instructions and Documentation Requirements**

**Use black ink and print clearly. Please complete all sections of the form unless otherwise specified. For any RR-ID, a copy of the screen must be placed in the resident's chart at the nursing facility. The screen should accompany the resident in the event of transfer to another nursing facility.**

Section A: Include date of birth and social security number and specify whether the applicant/resident is a Medicaid recipient including whether the applicant/resident is enrolled on a managed care plan.

Section B: Check the box that corresponds with the request. If Code #7 is checked, please identify what has changed.

Section C: If the diagnosis at the Resident Review request is different than the admitting diagnosis under the preadmission screen or hospital exemption, please attach supporting documentation of the admission diagnosis and the resident review diagnosis.

Section F: When requesting a preadmission screen or a resident review, please assess the individual's potential to return to a community setting and indicate whether a referral has been made to the HOME Choice Transition Program or for a Long Term Care Consultation.

Section G:

For resident review approvals for a specified period of time.

\*The nursing facility is required to submit the following documentation:

\*For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.

\*For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.

For extensions of resident review approvals for a specified period of time.

\*Please note the number of the extension request in the space provided.

\*The nursing facility is required to submit the following documentation:

\*For purposes of extended rehabilitation, attach the doctor's order, rehabilitation progress notes for the first 30 day nursing facility stay, and clinical prognosis.

\*For purposes of discharge planning, attach a detailed report of discharge planning activities as of the date of the resident review request including contacts made with services, benefits, and housing providers. The detailed report should also include the action items underway to ensure a safe and orderly discharge by the end of the requested resident review timeline. Attach medical and social reports as needed to support the request.