

PASRR/MI Level II Evaluation

For BOCK use only

RedCap _____

Pre-Admission Screening

Resident Review

PASRR Outcome: SMI Unable to verify SMI Primary Dementia

Specialized Services? No Yes

Re-evaluation required? No 180 days Other: _____

SECTION I: Identification

1. Name (Last, First, MI) _____ 2. Date of Birth _____ 3. Gender Male

4. DCN _____ 5. Evaluation Date _____ 6. Type: On-Site Telehealth Female

7. Current Location: NF Hospital Home RCF/ALF ISL Other _____

8. Facility Name _____ Admit Date _____

City _____

Contact _____ Phone _____

9. Does the individual have a **LEGAL GUARDIAN?** No If Yes, complete the following:

Name _____

Address _____

City _____ State _____ Zip Code _____

Relationship: _____ Phone _____

SECTION II: Psychosocial Assessment

1. Is English the individual's primary language? Yes No

If No, primary language is: _____ Were interpretive services used during evaluation? Yes No

2. Marital Status: _____

3. Describe current **family** state. What kind of support system/resource is the family? Who are the primary contacts?

4. Describe historical/past and most recent **living situation**.

SECTION II: Psychosocial Assessment (continued)

5. Prior medical and support systems (check all that apply):

- None
- Home health
- Family assistance
- Medication supervision/set-up/administration
- Personal care/ADL assistance
- Housekeeping
- Meal preparation/home delivered meals
- Shopping assistance
- Respite services
- Adult day care program
- Financial management
- Other (church, friends etc): _____

6. Specify reason for NF application, admission or continued stay(check all that apply)

- Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)
- Assistance needed for transfers, ambulation, fall prevention
- Rehabilitation services needed (physical, occupational, speech therapy)
- Medical treatment and/or monitoring for acute conditions
- Medical treatment and/or monitoring for chronic conditions
- Dementia symptoms requiring 24 hr monitoring/management
- Behavioral difficulties and/or mental illness symptoms requiring 24 hr monitoring/management
- Lack of community/family supports to maintain functioning at home
- Alternative care options are unavailable (waiting lists, etc)
- Other _____

7. Highest level of education attained: _____

8. Previous employment/position held: _____

Current employment status: _____

SECTION III: Psychiatric Assessment/History

1. Please list all documented historical and current psychiatric and ID/DD **diagnoses** (include date of diagnosis if available).

2. Describe any **medical conditions** that could exacerbate, mimic, be related to mental illness symptoms, or be considered a DD related condition.

SECTION III: Psychiatric Assessment/History (continued)

3. Does the individual have a history of traumatic experiences which may include physical, emotional or sexual **abuse**, domestic violence, neglect, or exploitation? If Yes, specify: No

4. Describe **historical symptoms** or behaviors indicating a psychiatric disorder and time of onset.

5. Describe any **previous psychiatric treatment** including hospitalizations, outpatient treatment, etc. Include services received through the Missouri Department of Mental Health.

6. Does the individual have a history of **alcohol and/or drug use**? No

If Yes, describe use and treatment/services including services received through the Missouri Department of Mental Health.

Describe current/recent use: _____

SECTION III: Psychiatric Assessment/History (continued)

7. **Current** psychiatric support/services. **Mark all that apply.**

- Psychiatric follow-up/consultation
- Inpatient psychiatric treatment
- Medication administration/management/monitoring
- Supported community living/Independent supported living
- Secured/behavioral unit
- Safety precautions (specify): _____
- Other (specify): _____
- None
- Day program/partial hospital program
- Individual therapy/counseling
- Sheltered workshop
- Group therapy/counseling
- ECT

8. Any history OR current thoughts/plans/acts/ideation or intention of **suicide or self injury**? No Unknown If yes, describe:

9. Any history OR current thoughts/plans/acts/ideation or intention of **homicide, aggressive/assaultive or violent** behavior? No Unknown If yes, describe:

SECTION IV: Behavioral Assessment

1. Overt Behaviors None If yes, please indicate which of the following behaviors are problematic for the individual within the last 30 days based on the individual's medical record or staff comments.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Unsafe smoking behavior | <input type="checkbox"/> Impatient/demanding | <input type="checkbox"/> Cursing/swearing | <input type="checkbox"/> Suspicious of others |
| <input type="checkbox"/> Refuses medications | <input type="checkbox"/> Wandering | <input type="checkbox"/> Disturbs other residents | <input type="checkbox"/> Lies purposefully |
| <input type="checkbox"/> Refuses activities | <input type="checkbox"/> Alcohol/drug use | <input type="checkbox"/> Physically threatening | <input type="checkbox"/> Steals deliberately |
| <input type="checkbox"/> Refuses to eat | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Strikes others provoked | <input type="checkbox"/> Talks of suicide/ideation |
| <input type="checkbox"/> Uncooperative with diet | <input type="checkbox"/> Exposes self | <input type="checkbox"/> Strikes others unprovoked | <input type="checkbox"/> Passive death wish |
| <input type="checkbox"/> Uncooperative with hygiene | <input type="checkbox"/> Sexually aggressive | <input type="checkbox"/> Elope/leave facility | <input type="checkbox"/> Suicide threats |
| <input type="checkbox"/> Self induced vomiting | <input type="checkbox"/> Verbally abusive | <input type="checkbox"/> Seclusiveness | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Frequent/continuous yelling | <input type="checkbox"/> Verbally threatening | <input type="checkbox"/> Injures self | <input type="checkbox"/> Verbalizations or crying out |
| <input type="checkbox"/> Intrusive/invades others space | <input type="checkbox"/> Uncooperative with medical/nursing care or treatments | | |
| <input type="checkbox"/> Other (specify): _____ | | | |

2. Describe frequency and intensity of behaviors and staff response to behaviors noted above. NA

SECTION IV: Behavioral Assessment

3. Placement in Seclusion/Restraints. In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior?

No If yes, describe:

4. Typical **Daily Activities**. Per individual and/or staff report describe how the individual spends most of her/his time (important activities, hobbies, interests).

SECTION V: Level of Functioning

Coding: I = Independent V = Verbal assist, supervision, or set up P = Physical assist

1. Personal care and independent living skills:

- | | | |
|------------------------------|---------------------------------|--------------------------------------|
| ___ Toileting | ___ Selects appropriate clothes | ___ Scheduling of medical treatments |
| ___ Personal hygiene | ___ Dressing/undressing | ___ Monitoring of health status |
| ___ Brushing teeth/oral care | ___ Bathing | ___ Handling money |
| ___ Eating | | |

2. Mobility/Gait (**mark all that apply**)

- Normal/Fully independent Aids (cane/walker) Unsteady Staff assist
 Wheelchair unassisted Wheelchair assisted Bedfast Other: _____

3. Describe the individual's **communication** and interaction with others.

SECTION VI: Medical History and Physical Assessment

1. Does the individual have any medication allergies? No

If Yes, specify: _____

2. Describe **previous medications** used to treat mental illness symptoms, including current or recent use of medications that could mask or mimic mental illness symptoms.

Unknown

SECTION VI: Medical History and Physical Assessment (continued)

3. Has the client been compliant with medication instructions in the past? Unknown No Yes

4. Current Medications. Record current meds, excluding convenience meds or attach current MAR/Physician Orders/POS

Current MAR /Physician Orders/POS attached Date: _____

Drug Name	Dosage	Frequency	Start Date

5. Describe individual's response to hypnotics, anti-psychotics, mood stabilizers and anti-depressants, anti-anxiety/sedative agents, and anti-Parkinson agents. NA

6. Describe the individual's ability to self-administer physician-prescribed medications: _____

7. Has the individual had any significant medication changes in the last 30 days? No If yes, describe:

8. Has the individual received an emergency (STAT) or PRN administration of medications to control behavior in the last 30 days?

No If Yes, describe:

SECTION VI: Medical History and Physical Assessment (continued)

9. List all current and historical medical diagnoses as documented in the individual's record

Current Diagnosis List/History & Physical Attached Date: _____

Diagnoses	Status

10. Level of Impact medical/physical health conditions and treatments have on individual's independent functioning

None Mild Moderate Severe

11. Height _____ 12. Weight: _____ 13. Weight trend past six months: _____

14. Appetite: _____

15. Sleep Pattern (**mark all that apply**)

Normal Problems falling asleep Problems staying asleep
 Receives medication Severely disturbed pattern Hypersomnia/daytime sedation
 Other: _____

16. **Neurological Assessment.** Complete Neurological Assessment or attach current neurological report from medical record.

Completed by PASRR Assessor (Addendum A Attached) **OR** Neurological functioning addressed in existing medical records

Provider: _____ Date: _____

17. Summarize Neurological results and describe any abnormal results in motor functioning, sensory functioning, gait, deep tendon reflexes and cranial nerves.

SECTION VI: Medical History and Physical Assessment (continued)

18. **Review of Systems.** Complete Review of Systems or attach current History & Physical with Review of Systems from medical record.

- Completed by PASRR Assessor (Addendum B Attached) **OR** Review of Systems addressed in existing medical records

Provider: _____ Date: _____

19. Summarize Review of Systems/H&P and describe any abnormal results/provide additional comments as necessary:

20. Does the individual currently receive any special **medical treatments**/supports?

- No If Yes, please indicate which of the following treatments the individual receives (**mark all that apply**)

- | | | |
|--|--|---|
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Foot care | <input type="checkbox"/> Monitoring of Vital Signs |
| <input type="checkbox"/> Bowel and bladder/Incontinence care | <input type="checkbox"/> Fracture care | <input type="checkbox"/> Oral suction |
| <input type="checkbox"/> Catheterization care | <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Choking/Aspiration precautions | <input type="checkbox"/> Hospice Services | <input type="checkbox"/> Prosthesis care |
| <input type="checkbox"/> Colostomy/Ileostomy/Ureterostomy | <input type="checkbox"/> Inhalation therapy/Respiratory care | <input type="checkbox"/> Seizure precautions |
| <input type="checkbox"/> CPAP/BIPAP | <input type="checkbox"/> Injections | <input type="checkbox"/> Special skin care/monitoring |
| <input type="checkbox"/> Diabetic monitoring | <input type="checkbox"/> Intake and output | <input type="checkbox"/> Tracheostomy care |
| <input type="checkbox"/> Dietary supplements | <input type="checkbox"/> IV fluids | <input type="checkbox"/> Tube feedings/TPN |
| <input type="checkbox"/> Decubitus care | <input type="checkbox"/> IV meds/antibiotics | <input type="checkbox"/> Weight monitoring |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medication monitoring | <input type="checkbox"/> Wound/incision care |
| <input type="checkbox"/> Fall precautions | <input type="checkbox"/> Therapeutic diet (specify): _____ | |
| <input type="checkbox"/> Ordered labs (specify): _____ | | |
| <input type="checkbox"/> Other (specify): _____ | | |

21. Rehabilitation services. Does the individual receive any type of rehabilitative services?

- None Physical therapy Occupational therapy Speech therapy Restorative nursing services

SECTION VII: Mental Status Examination

1. **Cognitive Capacities.** Please write the individual's responses on the lines provided.

- Unable or unwilling to participate.

Document current mood/anxiety symptoms/content of thought per record review/staff interview in #6 Observations.

- A. What city or town are you in? _____ Correct Incorrect
- B. What month is it? _____ Correct Incorrect
- C. What season is it? _____ Correct Incorrect
- D. What year is it? _____ Correct Incorrect
- E. Repeat the following numbers: "8, 7, 2" _____
- F. Beginning with Sunday say the days of the week backwards. _____

SECTION VII: Mental Status Examination (continued)

- G. Repeat these words after me & remember them, because I'll ask for them later: "hat, car, tree, 26": _____
- H. The opposite of fast is slow. What is the opposite of up? _____
- I. What is the opposite of large? _____
- J. What is the opposite of hard? _____
- K. An orange and banana are both fruits. Red and blue are both? _____
- L. Which is more money -- three dollars or ten quarters? _____ How much more? _____
- M. What were the words I asked you to remember? _____

2. Mood and Content of Thought. Ask the following questions and **comment on any positive responses in #6 (Observations).**

- Yes No A. Do you have episodes of little or no sleep, and still feel energized? _____
- Yes No B. Do you have trouble falling or staying asleep? _____
- Yes No C. Do you feel you sleep too much? _____
- Yes No D. Do you often feel tired or have little energy? _____
- Yes No E. Do you ever feel overly active, restless, fidgety, or have difficulty sitting still? _____
- Yes No F. Are you easily distracted, have trouble concentrating on things, or have racing thoughts? _____
- Yes No G. Do you feel easily annoyed or irritable? _____
- Yes No H. Do you have little interest or pleasure in doing things? _____
- Yes No I. Do you feel down, depressed, or hopeless? _____
- Yes No J. Do you have a poor appetite or feel you eat too much? _____
- Yes No K. Do you feel bad about yourself, like you are a failure and have let your family down? _____
- Yes No L. Do you have thoughts that you would be better off dead or of hurting yourself in some way? _____
- Yes No M. Do you feel nervous, anxious, or on edge? _____
- Yes No N. Do you feel like you worry too much about different things? _____
- Yes No O. Do you feel afraid as if something awful might happen? _____
- Yes No P. Do you have trouble relaxing? _____
- Yes No Q. Have you had any strange or odd experiences lately that you can't explain? _____
- Yes No R. Do you ever hear things that other people can't hear, such as noises or voices of people whispering or talking?

- Yes No S. Do you ever have visions or see things that other people can't see? _____
- Yes No T. Do you ever feel that people are bothering you or trying to harm you? _____
- Yes No U. Does it seem like people are talking about you or taking special notice of you? _____
- Yes No V. Do you have thoughts of harming or killing anyone? _____

3. Nursing Facility Interest. What are your thoughts or feelings about going to or remaining in a Nursing Facility? What are your preferences regarding your current and future living situation?

SECTION VII: Mental Status Examination (continued)

4. **Community Interest.** Are you interested in the possibility of returning to live and receiving services in the community instead of a Nursing Facility? No Yes

5. **Community Services.** Were you previously receiving any services/supports or participating in any activities in the community that you considered helpful, valuable, or important? If Yes specify: No

6. **Observations.** Summarize interview and individual's responses to the above Mental Status exam questions, including detail of positive responses. May include personal appearance and dress, attention, motivation, mood attitude, etc. during evaluation process.

NOTE: If the individual was unwilling/unable to participate in the interview document current mood, anxiety symptoms, and content of thought per record review and/or staff interview.

SECTION VIII: Affective Behavioral Observations

1. Orientation Person Place Circumstance Time Unable to assess

2. Memory
Immediate _____
Short term _____
Long term _____

3. Affect. **Mark all that apply.**

- Appropriate in quality and intensity to stated themes
- Flat or blunted
- Labile
- Angry
- Constricted
- Other (specify): _____
- Mood congruent
- Mood incongruent

1. Does the individual have a primary diagnosis of Dementia (Major Neurocognitive Disorder), including Alzheimer's disease or a related disorder OR a non-primary diagnosis of Dementia in the absence of a primary diagnosis of a major mental disorder?

Yes No If Yes, indicate specific symptoms:

The individual carries a diagnosis of dementia (major neurocognitive disorder) due to Alzheimer's, Lewy body, vascular dementia, Parkinson's, etc.

The individual exhibits memory impairment

The individual exhibits at least one of the following:

Aphasia

Apraxia

Agnosia

Disturbance in Executive Functioning

Do cognitive impairments interfere with the individual's ability to participate in, and benefit from, traditional mental health services? Yes No

Are Dementia related symptoms the primary focus of concern and/or are more prominent than symptoms of a major mental disorder? Yes No Describe:

If you answered "YES" to ALL of the above questions the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Section: Conclusions.

2. Does the individual have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders including schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability?

No (check all that apply)

Individual's current condition is such that assessment results may not be reflective of their typical behavior (due to acute medical illness, delirium, etc). SMI determination cannot be made at this time. Recommend re-evaluation at a later time.

Describe: _____

Individual has a major mental disorder diagnosis, but unable to verify with available information. Further evaluation needed.

Describe: _____

Yes (check all that apply)

Anorexia Nervosa or other eating disorder

Bi-polar Disorder

Major Depressive Disorder

Somatic Symptom Disorder/Conversion Disorder

Delusional Disorder

Schizophrenia

Obsessive-Compulsive Disorder

Panic Disorder

Schizoaffective Disorder

Dissociative identity Disorder

Stressor-Related Disorder (PTSD)

Mood Disorder

Psychotic Disorder

Dysthymic Disorder

Personality Disorder (paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, etc)

Specify: _____

Severe Anxiety Disorder (panic disorder, agoraphobia, generalized anxiety disorder, etc)

Specify: _____

Other mental disorder in the DSM (specify): _____

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Section: Conclusions.

SECTION IX: PASRR Level II Evaluation Report (continued)

3. Indicate specific symptoms to support the DSM-V criteria for the disorder indicated above. Summarize symptoms, precipitating factors, onset, duration and intensity that support the diagnosis.

4. **As a result of the previously indicated major mental disorder**, has the individual experienced functional impairment which has substantially affected one or more major life activities (including ADLs; instrumental ADLs; or functioning in social, family, and academic or vocational contexts), or would have caused functional impairment without the benefit of treatment or other support services?

No Yes (check all that apply)

- Interpersonal Functioning:** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships, impairment of social/family relationships, or social isolation
- Adaptation to Change:** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions; agitation; exacerbated signs and symptoms associated with the illness or withdrawal from situations; self-injurious, self mutilation, suicidal (ideation, gestures, threats or attempts); physical violence or threats; appetite disturbance; delusions; hallucinations; serious loss of interest; tearfulness; irritability; or requires intervention by mental health or judicial system.
- Concentration, Persistence and Pace:** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings; difficulties in concentration; inability to complete simple tasks within an established time period; makes frequent errors or requires assistance in the completion of these tasks, or has impairment of ADLs/IADLs.

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Section: Conclusions.

5. As a result of the previously indicated major mental disorder, has the individual required intensive mental health services (more intensive than routine follow up care) provided by mental health professionals to stabilize or maintain a person experiencing a significant disruption of their major mental disorder in the last 2 years.

Yes No If Yes, specify the type of services (check all that apply):

- Inpatient psychiatric hospitalization, partial hospitalization program, psychiatric residential treatment center
(Specify date/provider): _____
- Referral to mental health crisis/screening center or program, or hospital emergency department
(Specify date/provider): _____
- Intervention by housing or law enforcement officials (Specify): _____
- Psychiatric consultation or other services by MH professionals, DMH/CPS community mental health services, MH primary reason for NF/RCF/ALF admission or continued stay
(Specify date/provider): _____
- Treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the person positive for serious mental illness

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Section: Conclusions.

SECTION IX: PASRR Level II Evaluation Report (continued)

6. Provide a **summary** of the client's medical and social history

7. Individual's **limitations** (developmental needs, physical, communication, memory, needs, etc.)

8. Individual's **strengths** (positive traits and developmental strengths, abilities, accomplishments, personal traits, etc.)

9. Has a prospective Nursing Facility been identified? No N/A (Currently in NF)

If Yes, please indicate facility name: _____

10. Is the level of support for ADLs and other identified needs such that the individual's total care needs could be met in a nursing facility?

Yes, the individual's needs could be met in a nursing facility at this time.

No, the individual's needs cannot be met in a nursing facility at this time (**check all that apply**):

Requires 1:1 supervision to maintain safety due to behavioral/mental health symptoms

Recent/current aggressive/violent behavior requiring seclusion, restraints, PRN medications etc.

Current/active homicidal ideation

Current/active suicidal ideation/self harm

Medication refusal leading to acute exacerbation/continuation/instability of psychiatric symptoms

Other (specify): _____

If the individual requires services beyond the capabilities of a nursing facility contact Bock before proceeding and skip to Section: Conclusions.

11. Could alternatives to NF services be considered at this time? Yes No

SECTION IX: PASRR Level II Evaluation Report (continued)

12. Provide discussion/supporting documentation for Nursing Facility recommendation including community alternatives to NF and services and supports provided to the individual prior to considering NF placement.

13. The individual needs or continues to need the following supports and services.

- A. Provision of specific services to address the individual's **mental health and behavioral needs**.
 - Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP) from DMH Community Mental Health Center and/or Developmental Disability Regional Office.
 - Monitoring of behavioral symptoms
 - Trauma informed services
 - Tools of choice or other Positive Behavioral Support services

Identify and describe behaviors to be addressed in the NF plan of care:

- B. **Medication** therapy and monitoring services
 - Psychiatric follow up to prescribe and manage medications
 - Medication set up/administration by staff and monitoring for compliance with prescribed medication
 - Monitoring of interaction or adverse effects (AIMS, etc)
 - Monitoring of therapeutic effect in managing mental health symptoms including labs as indicated
 - Address, report, and implement plan to manage patient refusals/noncompliance (including cheeking, hoarding, etc.)
 - Provide education/training in drug therapy management
 - Pharmaceutical services/medication review
 - Other: _____

SECTION IX: PASRR Level II Evaluation Report (continued)

C. Provision of a **structured environment**.

- | | |
|--|---|
| <input type="checkbox"/> Maintain environment with low stimulation | <input type="checkbox"/> Provide for individual personal space |
| <input type="checkbox"/> Maintain environment with a minimum of visual/auditory distractions | <input type="checkbox"/> Provide for sensory supports |
| <input type="checkbox"/> Provide instructions at the individual's level of understanding | <input type="checkbox"/> Establish consistent routines |
| <input type="checkbox"/> Environmental supports to prevent elopement | <input type="checkbox"/> Provide schedule of daily tasks/activities |
| <input type="checkbox"/> Assess and plan for the level of supervision required to prevent harm to self or others | |

List needs and rationale as well as level of supervision needed:

D. Implementation of **ADL program** to increase independence and self determination.

Assess and plan a program for the development and maintenance of necessary living skills including **(mark all that apply)**:

- | | | |
|--|---|--|
| <input type="checkbox"/> Grooming/dressing | <input type="checkbox"/> Nutrition needs | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Money Management | <input type="checkbox"/> Maintenance of own living environment |
| <input type="checkbox"/> Toileting/bowel/bladder | <input type="checkbox"/> Other: _____ | |

By providing the following services **(mark all that apply)**

- Physical therapy evaluation and/or treatment
- Occupational therapy evaluation and/or treatment
- Speech-language pathology evaluation and/or treatment
- Restorative services (for turning/positioning, transferring, ambulation, ADLs, range of motion, bowel/bladder program)
- Provision of, training or assistance in use of adaptive equipment or assistive devices
- Dietary or nutritional services
- Provide cueing, reminders, education and/or modeling of daily living skills

E. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. A crisis plan should developed to create clear steps that are to be taken to support client during a behavioral health crisis including who to contact for assistance, how to work together with client during the crisis, and how to determine when the crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: <https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline>

- Suicidal precautions Assault precautions Elopement precautions

SECTION IX: PASRR Level II Evaluation Report (continued)

F. Development of **Personal Supports**

- Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.
- Assess, plan, and develop appropriate personal support network through community and social connections.

G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Identify what supports/services may be needed for the individual to live successfully in a **less restrictive/community setting**.

- | | |
|---|---|
| <input type="checkbox"/> Community based substance abuse treatment | <input type="checkbox"/> Individual counseling/psychotherapy |
| <input type="checkbox"/> Community based psychiatric treatment and supports | <input type="checkbox"/> Medication education/counseling/set-up/admin |
| <input type="checkbox"/> 12 step/substance abuse program | <input type="checkbox"/> Occupational therapy evaluation |
| <input type="checkbox"/> Behavioral supports/supervision | <input type="checkbox"/> Physical therapy evaluation |
| <input type="checkbox"/> Day programming/Adult day care | <input type="checkbox"/> Referral to DMH/DD Regional Office for intake/eligibility evaluation, community services |
| <input type="checkbox"/> Family support/education | <input type="checkbox"/> Residential services/supported housing |
| <input type="checkbox"/> Financial assistance/eligibility evaluation | <input type="checkbox"/> Skills training/vocation rehabilitation/supported employment |
| <input type="checkbox"/> Group counseling/psychotherapy/support group | <input type="checkbox"/> Social Work services/Case management |
| <input type="checkbox"/> Hospice services | <input type="checkbox"/> Speech/language therapy evaluation |
| <input type="checkbox"/> Housekeeping/homemaker services | |
| <input type="checkbox"/> Adaptive equipment evaluation (specify): _____ | |
| <input type="checkbox"/> Home health nursing services (specify): _____ | |
| <input type="checkbox"/> Medical follow up/Physician services (specify): _____ | |
| <input type="checkbox"/> Nutritional/dietary evaluation/meal or shopping assistance (describe needs): _____ | |
| <input type="checkbox"/> Personal care/ADL assistance (specify): _____ | |
| <input type="checkbox"/> Other (describe): _____ | |

SECTION IX: PASRR Level II Evaluation Report (continued)

14. Describe any additional information to be utilized by the nursing facility for care planning purposes.

SECTION: Conclusions

Source of information used in completing evaluation:

- Client interview
- Previous PASRR (date): _____
- Record review - previous facility (specify): _____
- Record review - Regional Office (specify): _____
- Staff interview (specify): _____
- Family/guardian (specify): _____
- Case Manager (specify): _____
- Other (specify): _____
- Record review - current facility
- CIMOR

Assessor Name: _____	Date: _____
Signature: *** Signature on File ***	Title _____
For BOCK USE ONLY:	
Reviewed/Edited by: _____	Date: _____