PASRR/DU Level II Evaluation

Several fields have been expanded to allow for more information to be entered. All dates must be entered in mm/dd/yyyy format (05/25/2025)

For BOCK use only

RedCap _____ ☐ Pre-Admission Screening ☐ Resident Review

PASRR Outcome: ☐ SMI ☐ IDD/RC ☐ Unable to verify SMI ☐ Unable to verify IDD/RC ☐ Primary Dementia

Needs exceed NF Level of Services? ☐ No ☐ Yes/MI ☐ Yes/ID Additional Services? ☐ No ☐ Yes

Re-evaluation required? ☐ No ☐ 180 Days ☐ Other: _____

SECTION I: Identification

1. Name (Last, First, MI) Jane Example 2. Date of Birth 05/25/1964 3. Gender Male ☐ Female ☒

4. DCN 00000001 5. Evaluation Date 05/30/2025 6. Type: ☒ On-Site ☐ Telehealth ☐ N/A (Halted/Partial LV2)

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

8. Facility Name Medical Hospital Of Missouri Admit Date 05/01/2025

City Anywhere, MO

Contact John Provider, hospital SW Phone 5730001111

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

Name Joyce Administrator

Address 115 Anystreet Road

City Anywhere State MO Zip Code 61000

Relationship: [Select or type response] Phone 5731111111

10. Describe current and historical education/academic development/functioning learning skills.

Jane reports attending The ABC School, a specialized institution for children with disabilities. She recalls limited academic progress, stating she "didn't get far," though she is unable to specify the extent of her formal education. She reports her parents frequently kept her out of school. Academically, Jane describes herself as "not very good at reading or math."
According to CIMOR records, she carries a diagnosis of Mild Mental Retardation, dated 07/01/98. Her cognitive limitations, in conjunction with disrupted educational access and early trauma, likely impacted the development of foundational learning skills and continue to influence her academic functioning.

11. Describe current and historical work experience/vocational development skills, including present vocational skills.

Jane reports a limited work history, primarily in supported settings, including workshop-based employment and a position at Goodwill Industries. These roles suggest structured environments with tasks adapted to her capabilities. Given her diagnosis of Mild Intellectual Disability and reported learning challenges, Jane likely requires consistent supervision and simplified routines in vocational settings. Last known employment was over 10 years ago.

SECTION II: Psychiatric Assessment/History

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

**Any DSM diagnosis can be listed in this section including:
dementia
autism spectrum
substance use disorders

Dates may be found in CIMOR (only have to list the oldest date), medical records, or client report.

Ex:
Schizophrenia (CIMOR 1995)
"Mild Mental Retardation" (CIMOR 07/01/98)
Unspecified ID (L1/LOC application)
Schizoaffective Disorder, Bipolar Type (current hospital admission diagnosis)
Dementia without behavioral disturbance (psych eval 5/2025)
Alcohol use DO (previous NF records)
Hospital records note Past diagnoses: depression NOS, Anxiety NOS
"Jane states that she was diagnosed with schizophrenia in her early 20's"

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

EX: CP
CVA 5/2020
brain injury secondary to MVA age 12
COPD
hypothyroidism
seizure DO (childhood onset)
malnutrition, failure to thrive

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

**You can include both historical and recent symptoms here. Can include information from any sources including interview with the client.
**The more descriptive you can be, the better. "Paint a picture" rather than list symptoms.

NO: Hx Depression, anxiety, psychosis, panic attacks, SI/SA (We know that from the dx section above).

YES: Jane reports periods of depression "all her life" but reportedly never went to the doctor. Records document frequent ED visits with minor requests, Other symptoms include report of severely depressed mood with suicidal ideation, history of minor cuts to forearms, drug seeking behaviors, alcohol use, sleep disturbance, high anxiety level, "panic attacks", fearfulness, crying spells, significantly impaired judgment/insight/concentration. Reports having some auditory hallucinations of voices telling her to harm herself and others. She also reported he has experienced auditory hallucinations that negative comments on her actions, but are sometimes "nice voices". Also reported having visual hallucinations in form of seeing flashes and shadows. History of reported prior medication overdoses . She has been non-compliant with medication regimen leading to exacerbation of symptoms and multiple hospitalizations

Her current symptoms include pervasively low mood, which she describes as “sadness,” along with anhedonia, avolition, irritability, and anger. She reports difficulty falling and staying asleep, daytime drowsiness, and poor appetite. Jane also expresses emotional ambivalence, stating, “I do care but I don’t really care.” Throughout the interview, she frequently voiced interpersonal grievances, often labeling others as “rude” and citing lifelong experiences of perceived mistreatment, consistent with longstanding affective instability and maladaptive coping, influenced by psychiatric illness and cognitive impairment.

SECTION II: Psychiatric Assessment/History (continued)

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

**Include DMH CPS treatment services listed in CIMOR EOC summary. If the individual has current DMH/CPS services, records have been requested and uploaded to the database when received.

Ex: Jane' psychiatric treatment history includes a DMH CPS care episode at Swope Health Services from 05/08/2002 to 02/29/2004 (Adult Community Services) .
DMH CPS at ReDiscover from 04/19/18 to 11/11/24 (CPS CCBHC Clinic Services, CPS Adult Targeted Case Management, and CPS Adult Community Services
Jane states she was first treated for major depression around age 20. She stated he has been admitted to inpatient psychiatric units several times, but was unable to clearly state where or when.

She is currently hospitalized at Research Psychiatric Center, where she has been inpatient since 03/31/2025, with records indicating prior admissions as recently as December 2024.

5. Describe any **current/historic DMH/DD regional office services** (include dates and types of services as available).

**Include DMH DD regional office services listed in CIMOR EOC summary. If the individual has current or historical DMH/DD services, records have been requested and uploaded to the database when received.

Ex: Jane has several care episodes with St Louis regional office since the late 1980s, including current services care episode for DD service coordination. History of Comprehensive waiver slot #111 1999-2005 with DD residential services.

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

- ☐ None
- ☐ Psychiatric follow-up/consultation
- ☐ Day program/partial hospital program
- ☒ Inpatient psychiatric treatment
- ☒ Individual therapy/counseling
- ☒ Medication administration/management/monitoring
- ☐ Sheltered workshop
- ☐ Supported community living/Independent supported living
- ☒ Group therapy/counseling
- ☒ Secured/behavioral unit — can include both locked hosp or NF units
- ☐ ECT
- ☒ DMH Services (specify): ☒ CPS ☒ DD ☐ ADA
- ☒ Safety precautions (specify): 15 minute checks, suicide precautions
- ☐ Other (specify): _____

SECTION II: Psychiatric Assessment/History (continued)

7. 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.

**Include DMH/ADA services listed in CIMOR EOC summary
If found, may include results of UDS or BAL levels

EX: CIMOR documents 6 care episodes for ADA treatment between 1997 and 2009. Jane reports drinking beer in high school and using marijuana occasionally. Hx meth use in the past with jail time for drug related charges. She reports no use since released from jail. Admission UDS negative, no alcohol detected in admission labs

Describe current/recent use: Prior to previous NF admission

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

Jane reported she has experienced several episodes of suicidal ideation. She showed superficial scars on bilateral forearms. She also reported she has overdosed on medications in the past. Reported suicidal ideation on the medical unit prior to current admission. Denies SI during this evaluation.

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

Jane denied being aggressive or violent in the past and no instances are documented, however is known to become agitated when overstimulated, or in a loud, chaotic environment. She can be verbally aggressive/abusive to staff when redirected or denied perceived needs. Jane denies ever thinking about killing or harming anyone.

SECTION II: Psychiatric Assessment/History (continued)

10. 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.

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

11. Describe frequency and intensity of behaviors and staff response to behaviors noted above. ☐ N/A

Jane remains under suicide precautions with 15 minute checks in the inpatient hospital setting. She is encouraged to attend groups and activities. She is verbally redirected during period of demanding behavior and reminded of unit expectations and appropriate behaviors. When Jane is noncompliant with lab draws, she is educated about importance and approached again later. PRNs offered during periods of agitation.

Throughout her hospitalization, Jane has demonstrated a pattern of seclusiveness, often isolating in bed with minimal interaction and avoiding eye contact, as noted in nursing observations on 04/28/25. She has exhibited persistent suspiciousness and paranoid ideation, including beliefs that someone had harmed her during the night. Additionally, she has intermittently refused to engage in hygiene tasks, requiring frequent reminders and redirection to complete basic self-care activities.

12. 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:

On 5/6/25, Jane was escorted by security to the quite room after becoming agitated with a peer and verbally threatening to harm him. Physical restraint was not required. PRN accepted and Jane quickly calmed down and was able to return to unit activities.

SECTION III: MI/IDD/RC Determination

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?

☒ No

- ☐ No dementia diagnosis found in available documentation.
- ☒ Dementia diagnosis, but not primary or in the absence of a primary diagnosis of a major mental disorder.

☐ Yes (check all that apply)

- ☐ The individual has a diagnosis of dementia (major neurocognitive disorder) due to Alzheimer's, Lewy body, vascular dementia, Parkinson's, etc.
- ☐ Cognitive impairments interfere with the individual's ability to participate in, and benefit from traditional mental health services.
- ☐ Dementia related symptoms are the primary focus of concern and/or are more prominent than symptoms of a major mental disorder.

Comments:

EX NO: Jane has a dementia diagnosis and shows some mild memory impairment, however this does not appear to be primary focus of concern at this time. She was alert and oriented during interview process and able to recall information regarding family and recent events. She admits to forgetting names of some care providers during current admission.

EX NO: There is no documented diagnosis of dementia in the available medical records. However, Jane has demonstrated significant cognitive impairments, including orientation limited to person and notable short-term memory deficits. No formal cognitive or neuropsychological testing has been completed to further assess for a neurocognitive disorder.

If you answered "Yes" to the above questions the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.

SECTION III: MI/IDD/RC Determination (continued)

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: (Note: delirium diagnosis at hospital admission, symtpoms appear to have resolved)

- ☐ Current/historical symptoms are inconsistent with documented diagnosis.

  Describe:

☒ Yes (check all that apply) NOTE: #2 is a yes or no question, please do no mark both yes and no.

- ☐ 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 (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 Question #6.

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.

***ONLY mark the diagnosis you feel you are best able to verify documenting the individual's symptoms consistent with the DSM criteria for that diagnosis. DO NOT mark every diagnosis that the person has been given.

YES: Jane has carried a diagnosis of schizoaffective DO for many years and has been treated long term with antidepressant, antipsychotic and antianxiety medications. She has a history of auditory hallucinations, episodes of severely depressed mood with suicidal ideation, history of minor cuts to forearms, drug seeking behaviors, sleep disturbance, high anxiety level, "panic attacks", fearfulness, crying spells, significantly impaired judgment/insight/concentration. She denies any manic episodes however has had periods of irritability and rapid, pressured speech.

NO: Jane has an uninterrupted period of illness where there are both symptoms of schizophrenia (delusions, hallucinations, disorganized speech or behavior, negative symptoms) and a major mood episode (mania or depression) Her mood episode symptoms were present for the majority of the total illness duration.

SECTION III: MI/IDD/RC Determination (continued)

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 Question #6.

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): current inpatient psych admission-Research MH Center

☐ 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, or MH primary reason for NF/RCF/ALF admission or continued sta

NOTE: This choice includes current DMH/CPS service episodes, or closed within the last 2 years. Please check and provide info per CIMOR in this answer.

(Specify date/provider): consult during medical admission prior to current psych adm, Open care episode with DMH/CPS Burrell

☐ 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 Question #6.

6. Has the individual been diagnosed with Intellectual Disability (ID) that results in significantly sub-average general intellectual functioning, **originating before age eighteen (18)**, that is associated with significant impairment in adaptive behavior (Note: Do not include Borderline Intellectual Functioning)? ☒ Yes ☐ No

If Yes indicated level of impairment: Mild (IQ 50/55-70)

SECTION III: MI/IDD/RC Determination (continued)

7. Does the individual have a related condition other than mental illness resulting in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons? ☒ Yes ☐ No If Yes, **mark all that apply:**

- ☐ Cerebral Palsy
- ☐ Down's Syndrome
- ☒ Epilepsy/Seizure Disorder
- ☐ Traumatic Brain Injury
- ☐ Spinal Cord Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☒ Other (specify): DO NOT INCLUDE ID DIAGNOSIS HERE
- ☐ Autism Spectrum Disorder (Asperger's Syndrome, Pervasive Developmental Disorder)
- ☐ Severe Hearing and Visual Impairment
- ☐ Spina Bifida or other neural tube defect
- ☐ Fetal Alcohol Syndrome
- ☐ Fragile X Syndrome or other genetic disorder
- ☐ Prader-Willi Syndrome
- ☐ Para/Quadraplegia or other orthopedic impairment

Was the impairment **manifested before the person reached the age of 22**? ☐ No ☐ Yes

Is the impairment likely to continue indefinitely? ☐ No ☐ Yes

As a result of the above diagnosis, the individual has substantial functional limitations in t to age 22. **Mark all that apply.**

- ☐ Self Care
- ☐ Mobility
- ☐ Understand and use of language
- ☐ Learning
- ☐ Self Direction
- ☐ Capacity for independent living

Note: These questions only have to be answered if marking YES to #7 (not for YES r to #6) DO not mark anything under related condition if they only have ID diagnosis. You should leave SFL questions blank unless you are marking a RC condition in #7. DO not include BIF or metal illness diagnoses in this section.

8. Indicate specific results of intellectual functioning measurements, or other methodology used to make determination of intellectual disability. If formal testing results are unavailable, clearly document collateral information that supports the determination of intellectual/developmental disability or related condition.

Jane has a documented diagnosis of mild intellectual disability per CIMOR records and has had DMH/DD services for many years. Although IQ is not found in available documentation, it is reasonable to believe based on education, workshop history etc that Jane functions within range of mild ID. She has qualified for DMH/DD waiver services in the past. Family report that she functions at about the level of a 10 year old child, and has never been able to live independently or hold competitive employment.

9. Based on the previous questions, the individual: **Select One.**

- ☒ Has IDD or a related condition (other than mental illness) as defined by PASRR.
- ☐ Does not have, or absence of clear evidence to substantiate/validate, IDD or related condition as defined by PASRR.

10. Does the individual need further evaluation for possible mental illness, dementia, and/or intellectual/developmental disability? ☐ No If yes, describe:

While there is no formal diagnosis of dementia in Janie's medical records, her clinical presentation warrants consideration of a neurocognitive disorder. Although these symptoms may be attributable to her primary psychiatric diagnoses, the extent and persistence of cognitive deficits raise concern for a possible underlying dementia. A comprehensive cognitive or neuropsychological evaluation is recommended to further assess for a neurocognitive condition.

If unable to confirm ID/DD/RC diagnosis, the individual DOES NOT meet criteria for a PASRR related ID disability.

If the individual DOES NOT meet criteria for a PASRR related mental health disability and DOES NOT meet criteria for a PASRR related ID disability proceed to Section: Conclusions. If the individual DOES meet criteria for a PASRR related disability continue with evaluation.

NOTE: You may wish to contact BOCK if you are submitting a halted/partial L2 evaluation as this may result in payment issues. You DO NOT need to delete any information that you may have already entered into the subsequent evaluation sections.

SECTION IV: 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: Never married

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

Jane identifies her two daughters and her brother as her primary sources of support. However, it is reported by inpatient staff that family involvement has been minimal, and they have largely stepped back from active participation in her care. Per Psych Note (04/21/25): "The family are refusing to care for the patient." Guardianship is currently being pursued by hospital staff.

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

Jane is originally from Memphis, TN. Prior to her current hospitalization 5/1/25, she resided with her brother in Kansas City, MO. She was previously scheduled to discharge home with her daughter; however, her daughter reportedly did not arrive to pick her up. Janie is now pending guardianship and a safe disposition plan. Hx of DMH/CPS supported community living 2020-2021. She also has history of living in a DD ISL1999-2005. Hx of admission to Great Care ALF July 2021-March 2023. Previous NF admission to Nice Nursing Home March 2023-April 2024.

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)**

☒ A. Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)

☐ B. Assistance needed for transfers, ambulation, fall prevention

☐ C. Rehabilitation services needed (physical, occupational, speech therapy)

☐ D. Medical treatment and/or monitoring for acute condition. Treatment needed due to new/recent diagnosis or condition, short term medical care needs.

☐ E. Medical treatment and/or monitoring for chronic conditions with treatment services needed on regular basis in NF setting.

☒ F. 24 hour protective oversight needed due to severity of behaviors or mental illness symptoms. Individual cannot be without supervision at any time.

☒ G. Physical care needs exceed what can be managed in previous/current living situation

☐ H. Alternative care options are unavailable due to lack of funding or availability/wait list for RCF/ALF, low income housing, no DD waiver, or no available slots or providers, etc.

☐ I. Housing instability/homeless

☐ J. Mental health care needs exceed what can be managed in previous/current living situation due to aggression, substance use or medication noncompliance leading to exacerbation of symptoms.

☐ K. Other: _____

SECTION IV: Psychosocial Assessment (continued)

7. 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

Jane was removed from the home at age 4 due to abuse and neglect by biological parents. She was placed in the foster care system until age 18. Records note sexual assault at age 14 by neighbor. She reports being bullied in high school.

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

Jane reports that she enjoys coloring, painting, and completing puzzles. Her preferred group activity at the nursing facility is Bingo. She reports that she used to enjoy bowling and participated in Special Olympics in the past.

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:

p	Toileting	p	Bathing	p	Scheduling of medical treatments
v	Personal hygiene	v	Eating	v	Monitoring of health status
v	Brushing teeth/oral care	p	Meal preparation	v	Maintaining personal safety
p	Laundry/Care of clothing	p	Housekeeping	p	Budgeting and personal finance
v	Selects appropriate clothes	p	Shopping	v	Handling money
v	Dressing/undressing				

NOTE: Must reflect functioning at time of evaluation. DO not just copy from L1/LOC application information.

Comments: Jane requires assistance during episodes of incontinence, she is resistent to changing soiled clothing.

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

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

Comments: Jane has mild shuffling gait, uses walker and can transfer independently

NOTE: Must reflect functioning at time of evaluation. DO not just copy from L1/LOC application information.

3. Sensorimotor development. Does the individual have impairment in the following areas? ☐ No **If Yes, check all that apply**

☒ Ambulation ☒ Gross motor dexterity ☐ Eye-hand coordination ☐ Transfers
☐ Positioning ☐ Visual motor perception ☐ Fine motor dexterity

4. Could prosthetic, orthotic, corrective or **mechanical supportive devices** improve the individual's functional capacity? ☐ No If yes, describe:

Jane currently utilizes a rollator walker to assist with mobility and transfers, indicating a need for continued mechanical support to promote safety, balance, and independence.

5. Describe the individual's speech and language **(communication)** development, such as expressive and receptive language (verbal and nonverbal).

Jane communicates using verbal English. During Level II Evaluation, Jane presented as cooperative and pleasant throughout the interaction. Her speech was clear and intelligible, with a linear and goal-directed thought process. She demonstrated intact associations and no evidence of thought disorder. Jane's expressive language was concrete and somewhat limited in complexity. While she made a noticeable effort to engage and respond appropriately, she exhibited difficulty providing detailed historical information.

SECTION V: Level of Functioning (continued)

6. Could **non-oral communication systems,** amplification devices or a program of amplification improve the individual's functional capacity? ☐ No If yes, describe:

Jane could benefit from a communication board as she has difficulty expressing her wants and needs due to significant speech impediment. Jane should be assessed for hearing aids. She states they were lost during her recent hospitalization.

7. Describe the individual's **social development** such as interpersonal skills, recreation-leisure skills, and relationships with others.

Jane presents with a calm and cooperative disposition and is generally pleasant in interpersonal interactions. She reports supportive relationships with her siblings, particularly her sister and two brothers. She is able to engage with others in structured settings, though her social understanding is limited, and she often perceives others as "rude" or dismissive, reflecting challenges with social interpretation and perspective-taking. She presents with a childlike demeanor and requires some assistance in maintaining friendships. She is able to identify recreational activities that she enjoys, but has difficulty in initiating/participating in recreational activities without staff prompting or set up.

8. Describe the individual's **affective development** such as interest and skills involved with expressing emotions, making judgments, and making independent decisions.

Jane demonstrates limited emotional insight and expresses her feelings in broad terms, stating that she feels "sad" and reporting frustration related to perceived mistreatment by others. She appears to have difficulty interpreting social interactions and often attributes interpersonal conflict to external causes. Her judgment is impaired, and she requires support in making routine decisions, with limited awareness of safety concerns and functional limitations. Her affective presentation is consistent with her psychiatric and cognitive limitations. According to OT Evaluation, she has deficits in Safety Judgment: Decreased awareness of need for assistance; Decreased awareness of need for safety. Insight: Decreased awareness of deficits. Problem solving: Assistance required to identify errors made. She requires a legal guardian to make decisions for him in regard to placement, medical/psychiatric care, finances. She is able to state what he wants in regard to daily activities and simple decisions.

SECTION VI: Medical History and Physical Assessment

1. Does the individual have any medication allergies? ☐ No

If Yes, specify: Thorazine, Haldol

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

Records indicate historical treatment with lithium, depakote and various antidepressants .
Allergies are noted to haldol and thorazine suggesting previous use with adverse effect.
Recent meds have included depakote, keppra, cymbalta, as well as PRN narcotic pain medications post surgery. John has PRN hydroxyzine ordered for anxiety/ agitation.

If this information isn't found in available documentation, you may ask the individual, "Have you ever taken medication to help control your depression, anxiety, etc? Do you remember any specific medications? When did you first start taking medications? How long did you take x medication?

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

SECTION VI: Medical History and Physical Assessment (continued)

4. Current Medications. Record current meds (include drug name, dosage, frequency, and start date), excluding convenience meds or attach current MAR/Physician Orders/POS.

☒ Current MAR /Physician Orders/POS attached Date: 05/30/2025

Jane is currently prescribed Depakote, cymbalta, keppra for seizure DO and PRN hydroxyzine for anxiety/agitation, and PRN trazodone for insomnia

**Med list must be CURRENT!! If the med list attached to the application/referral is old/out of date, please obtain a current list. This may be faxed or emailed directly to Bock Associates. We will notify you by email when records are uploaded, however your evaluation isn't complete until this information is received. You may have to ask for this information more than once.

**Please give a short summary of current psych meds here.

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

**If they are on any of the above listed medications, you must complete this question.

Jane describes mildly depressed mood. No seizure activity noted during current admission. Per records, Jane has tolerated these medications well , denies any medication side effects and none are documented in available records

6. Describe the individual's ability to self-administer physician-prescribed medications: Physical Assist/Dependent on staff

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

Duloxetine was restarted and zoloft was d/c'd during last psych admission 4/2025.

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:

Jane has frequently used PRN hydroxyzine during periods of anxiety/ agitation during the last month. She does not ask for this, but generally agrees to take it if offered by staff

SECTION VI: Medical History and Physical Assessment (continued)

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

☒ Current Diagnosis List/History & Physical Attached Date: 05/01/2025

CVA 5/2020
brain injury secondary to MVA age 12
COPD
hypothyroidism
seizure DO (childhood onset)
malnutrition, failure to thrive (resolved)
HTN-controlled with medication

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

☐ None ☐ Mild ☒ Moderate ☐ Severe

11. Height 5'5 12. Weight: 160 13. Weight trend past six months: Increased less than 10%

14. Appetite: Generally eats 75-100% of meals

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

☐ Normal ☒ Problems falling asleep ☐ Problems staying asleep
☒ Receives medication ☐ Severely disturbed pattern ☐ Hypersomnia/daytime sedation
☒ Other: Jane has an insomnia diagnosis and is prescribed Trazodone PRN HS, takes it regularly.

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: David Doctor Date: 05/01/2025

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

Left hemiparesis, left facial droop. Significant receptive aphasia. PERL. Unable to determine whether visual field cut is present. Able to answer "yes/no" but answers not reliable. CN II-XII normal per H&P.

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: David Doctor Date: 05/01/2025

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

Notes reflect no acute abnormalities or complaints other than occasional hip pain. Seizures have been well controlled. ROS and PE otherwise negative/normal.

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)**

☐ Blood transfusions	☐ Foot care	☒ Monitoring of Vital Signs
☒ Bowel and bladder/Incontinence care	☐ Fracture care	☐ Oral suction
☐ Catheterization care	☐ Hemodialysis	☐ Oxygen
☐ Choking/Aspiration precautions	☐ Hospice Services	☐ Prosthesis care
☐ Colostomy/Ileostomy/Ureterostomy	☒ Inhalation therapy/Respiratory care	☒ Seizure precautions
☒ CPAP/BIPAP	☒ Injections	☒ Special skin care/monitoring
☒ Diabetic monitoring	☐ Intake and output	☐ Tracheostomy care
☒ Dietary supplements	☐ IV fluids	☐ Tube feedings/TPN
☐ Decubitus care	☐ IV meds/antibiotics	☒ Weight monitoring
☐ Dialysis	☒ Medication monitoring	☐ Wound/incision care
☒ Fall precautions	☒ Therapeutic diet (specify): regular NCS	
☒ Ordered labs (specify):		
☒ Other (specify): elevate HOB 45 degrees, pressure relieving mattress,		

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?	Missouri	☐ Correct	☒ Incorrect
B. What month is it?	May	☒ Correct	☐ Incorrect
C. What season is it?	Spring	☒ Correct	☐ Incorrect
D. What year is it?	2023	☐ Correct	☒ Incorrect

E. Repeat the following numbers: "8, 7, 2" 8 7 2

F. Beginning with Sunday say the days of the week backwards. S S F T W T M

G. Repeat these words after me & remember them, because I'll ask for them later: "hat, car, tree, 26": hat car tree 26

H. The opposite of fast is slow. What is the opposite of up? down

I. What is the opposite of large? small

J. What is the opposite of hard? easy

K. An orange and banana are both fruits. Red and blue are both? colors

L. Which is more money -- three dollars or ten quarters? $3 How much more? i don't know

M. What were the words I asked you to remember? I don't know

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?	sometimes
☐ 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?	there's nothing to do here
☒ Yes	☐ No	I. Do you feel down, depressed, or hopeless?	a little bit
☒ Yes	☐ No	J. Do you have a poor appetite or feel you eat too much?	the food is terrible, i can't eat it
☐ 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?	not anymore
☒ Yes	☐ No	M. Do you feel nervous, anxious, or on edge?	all the time
☒ Yes	☐ No	N. Do you feel like you worry too much about different things?	i worry about what is going to happen to me
☐ Yes	☒ No	O. Do you feel afraid as if something awful might happen?	
☒ Yes	☐ No	P. Do you have trouble relaxing?	sometimes
☐ 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?	i used to, but not any more

SECTION VII: Mental Status Examination (continued)

☐ 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?	sometimes
☒ Yes	☐ No	U. Does it seem like people are talking about you or taking special notice of you?	the staff do
☐ Yes	☒ No	V. Do you have thoughts of harming or killing anyone?	

3. **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.

Jane was interviewed in her hospital room at Research Psychiatric Center. She appeared disheveled and unkempt, dressed in hospital attire and wearing non-working headphones. While she was receptive to the introduction and maintained a friendly and pleasant demeanor, her overall attitude was passive and indifferent as well as somewhat childlike. Her speech was mumbled and frequently incomprehensible, marked by incomplete sentences and significant word-finding difficulty. Although she occasionally appeared to understand the discussion, her responses were often incoherent or unrelated, indicating fluctuating comprehension. The interview was frequently interrupted by spontaneous and persistent somatic complaints. Janie was oriented to person but was unable to accurately identify her location, stating only that she was in “Missouri”,and incorrectly identified the year as 2023. She appeared disoriented to the broader situation, stating that she had been in the hospital “a while” and was unable to recall where she had been living prior to admission. When asked to remember four words, she demonstrated no recollection of the task or the words later in the interview. She showed moderate difficulty recalling and retelling details of her personal history. Janie admits to some history of psychiatric illness, as well as mild symptoms of anxiety, depression, paranoid ideation. She denies current HI/SI.

SECTION VIII: NF/Community Interest

1. **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?

*** Ask the person these questions during the interview.

Jane had difficulty clearly verbalizing her preferences regarding her current and future living situation, stating vaguely that she would like to go to “another part... I can't think.” When provided with specific examples, she expressed a preference for having her own apartment if possible.
According to Psych Note (04/22/25): "The patient continues to make inappropriate safety planning secondary to cognitive impact of her psychiatric illness representing grave disability and she can not be discharged without a high degree of support."

2. **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 ☐ Unknown/Unable/Unwilling to answer

SECTION VIII: NF/Community Interest (continued)

3. **Community Services.** If the individual is currently receiving DMH community services (CPS, DD, ADA), does the individual wish for these services to continue? ☐ Yes ☒ No ☐ N/A

Note question change: This only refers to open episodes of DMH services (DD, CPS, ADA) as documented in CIMOR. DMH is working on obtaining funding for some of these services to be available to NF residents.

Jane is unaware that she currently receives DMH/DD or CPS services.

SECTION IX: Affective Behavioral Observations

1. Orientation ☒ Person ☐ Place ☐ Circumstance ☐ Time ☐ Unable to assess

2. Memory

Immediate	No obvious deficits
Short term	Moderate impairment
Long term	Unable to assess

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

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

SECTION X: PASRR Level II Evaluation Report

Client Name: Jane Example

1. **Mental Health disability.** Based on this Level II evaluation the individual:

- [x] Has a mental health disability as defined by PASRR
- [ ] Does not have, or absence of clear evidence to substantiate/validate mental health disability as defined by PASRR
- [ ] Has primary Dementia

2. **IDD/Related Condition.** Based on this Level II evaluation the individual:

- [x] Has IDD or a related condition (other than mental illness) as defined by PASRR
- [ ] Does not have, or absence of clear evidence to substantiate/validate IDD or related condition as defined by PASRR

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

Jane is a 72-year-old single female originally from Memphis, TN. She is a high school graduate with an unknown employment history; she currently receives disability income. Prior to her current hospitalization, Jane was residing with her brother in Kansas City, MO. She identifies her two daughters and her brother as her primary sources of support.
Jane's past medical history includes HTN and CAD. Her psychiatric history includes diagnoses of Major Depressive Disorder, Schizophrenia, and Schizoaffective Disorder, Bipolar Type. She previously received care through DMH during a CPS episode at Swope Health Services from 05/08/2002 to 02/29/2004.
Janie is currently hospitalized at Research Psychiatric Center, where she has remained IPBH since 05/1/2025. According to a psychiatric note dated 04/21/25, "The family are refusing to care for the patient." Guardianship proceedings are underway. As noted on 04/22/25, "The patient continues to make inappropriate safety planning secondary to cognitive impact of her psychiatric illness representing grave disability and she can not be discharged without a high degree of support." Janie is now pending legal guardianship and placement in a safe and supportive living environment.

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

Communication deficit
Impaired cognition
Limited family support
Below average intellectual functioning and memory imairment
chronic mental illness symptoms and poor coping strategies
chronic medical issues
inability to independently complete ADLs
unable to return to previous living situation

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

Pleasant and cooperative demeanor
Medically stable
Pending guardianship
compliant with medications in structured setting
good control of psychiatric symptoms with current medications
Generally cooperative with nursing care
able to follow directions and make her wants and needs known

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

If Yes, please indicate facility name: Pretty Nice Nursing Home (**If not listed in referral documentation, ask the current CM or SW)

SECTION X: PASRR Level II Evaluation Report (continued)

7. Nursing Facility Level of Services? (check all that apply)

- [x] The individual's needs could be met in a nursing facility at this time.
- [x] Community alternatives to nursing facility should also be considered, if available, with supports listed in #9.
- [ ] The individual's mental health and/or intellectual disability service needs cannot be met in a nursing facility at this time.
  - [ ] 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): _____

Provide discussion/supporting documentation for the recommendations listed above.

Given Jane's complex psychiatric presentation, notable cognitive impairments, and current functional limitations, Nursing Facility placement is recommended at this time. Janie presents with disorganized thought processes, delusional content, significant short-term memory deficits, disorientation, and impaired insight and judgment. She requires frequent redirection for basic self-care and exhibits ongoing confusion about her situation. Her recent psychiatric decompensation and inability to engage in realistic discharge planning further reflect grave disability, as noted in her treating psychiatrist's documentation. The absence of consistent family involvement and her reliance on staff for daily functioning further support the need for a structured setting. NF placement would ensure 24-hour supervision, consistent medication management, access to medical and psychiatric care, and support with activities of daily living. At this time, her functional deficits necessitate the structure and oversight of an NF environment to ensure her safety and stability.

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

8. The individual needs, or continues to need, the following specialized mental health services?

- [x] Psychiatric diagnostic evaluation
- [x] Individual, family, or group psychotherapy
- [ ] Psychotherapy for crisis
- [x] Health behavior assessment and intervention
- [ ] Tobacco cessation counseling
- [ ] None

For service recommendations in #8 and #9, only mark the services for which you feel the NF needs to incorporate into their plan of care. DO NOT mark everything "just because" these services should be available to all NF residents. DO NOT COPY THE SAME GENERIC INFORMATION INTO ALL COMMENT BOXES. Provide only individualized information that will help the NF in care planning.

Jane would benefit from a psychiatric diagnostic evaluation to further clarify her complex mental health presentation, which includes psychosis and cognitive impairment. Individual psychotherapy is recommended to address her ongoing delusional beliefs, emotional distress, and lack of insight, with an approach tailored to her cognitive limitations. Psychotherapy for crisis may be necessary during periods of acute symptom escalation, given her recent decompensation and hospitalization. Additionally, a health behavior assessment and intervention is indicated due to her difficulty maintaining activities of daily living and persistent somatic complaints, all of which impact her overall functioning and stability. These services would collectively support her psychiatric stabilization, improve coping strategies, and promote better engagement in care.

SECTION X: PASRR Level II Evaluation Report (continued)

9. 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

☒ 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 therapeutic effect in managing mental health symptoms, including therapeutic levels, and/or interaction or adverse effects
- ☐ Provide education/training in drug therapy management
- ☐ Other: _____

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

- ☐ Maintain environment with low stimulation, minimum of visual/auditory distractions, and/or sensory supports
- ☒ Provide instructions at the individual's level of understanding
- ☐ Environmental supports to prevent elopement
- ☐ Assess and plan for the level of supervision required to prevent harm to self or others
- ☒ Provide for individual personal space
- ☒ Establish consistent routines, providing a schedule of daily tasks/activities, etc.

☐ D. **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 X: PASRR Level II Evaluation Report (continued)

☒ E. 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)**:

- ☐ Grooming/dressing
- ☒ Nutrition needs
- ☒ Bathing
- ☒ Personal Hygiene
- ☐ Money Management
- ☒ Maintenance of own living environment
- ☐ Toileting/bowel/bladder
- ☐ 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

☒ 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.

Provide comments regarding any Support and Services previously selected.

YES: Jane would benefit from a comprehensive mental health treatment plan that includes targeted services to address her psychiatric and behavioral needs which include demanding behaviors, noncompliance with hygiene and self care, seclusiveness and isolation. Individual psychotherapy focused on managing psychotic symptoms, enhancing insight, and improving coping strategies should be provided, alongside medication therapy and routine psychiatric monitoring to ensure adherence and evaluate side effects, particularly given her history of parkinsonism and current use of antipsychotic medication. Due to her disorganized thinking, wandering behavior, and functional impairments, Jane requires a highly structured environment with consistent staffing and supervision to ensure safety and stability. As she has experienced a functional decline since her recent medical admission, ADL-focused program, including physical, occupational, and speech therapy as needed, would support improvement in her functional skills and foster greater independence. Nutritional services should also be incorporated to address basic health and dietary needs due to her diabetes diagnosis. Development of personalized support systems, including engagement with consistent caregivers and case management, is recommended to build trust, promote routine, and support Jane's emotional and functional recovery in a stable, therapeutic setting given her ongoing suspiciousness of certain staff members.

NO:
Labs as ordered (Already addressed in B)
Monitor for side effects and compliance (already addressed in B)
Psychiatrist to follow for medication management (already addressed in B)
efficacy of medication, correct, dosage and interactions (already addressed in B)
ADL program to help increase independence (already address in E)

SECTION X: PASRR Level II Evaluation Report (continued)

☒ 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:

YES: A referral for a comprehensive neuropsychological evaluation is recommended to determine the extent of Jane's cognitive deficits and guide future decisions regarding the appropriateness of transitioning to a less restrictive environment. If cognitive and functional status improve and safety can be ensured, future consideration may be given to placement in a RCF/ALF with DMH wraparound services.
As Jane currently has DMH/DD services, an application for Comprehensive waiver services may result in additional community residential service options including ISL services.

NO: Individual and legal guardian to work with facility staff to determine when/if transition to less restrictive living situation is possible.

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

Substance use services:

☐ 1. Community based substance use treatment

☐ 2. 12 step/substance use program

☐ 3. Residential/Intensive substance use treatment/Rehabilitation services

DD Support Services

☐ 1. Referral to DMH/DD Regional Office for intake/eligibility evaluation

☒ 2. Application for DD/Waiver Services

Housing assistance:

☐ 1. Intensive Residential Treatment Services (IRTS)/Psychiatric Individualized Supported Living (PISL)

☐ 2. Cluster apartment services

☒ 3. Residential Services (RCF/ALF)

☐ 4. Permanent supported housing

☒ 5. DD Residential/Independent Supported Living (ISL)

SECTION X: PASRR Level II Evaluation Report (continued)

Community based psychiatric treatment and supports:

- [x] 1. Group counseling/psychotherapy/support group
- [x] 2. Individual counseling/psychotherapy
- [x] 3. Medication education/counseling/set-up/administration
- [ ] 4. Skills training/vocation rehabilitation/supported employment
- [x] 5. Community Psychiatric Rehabilitation/Case Management
- [x] 6. Psychiatric follow-up/Physician services
- [x] 7. Intensive Community Psychiatric Rehabilitation (ICPR)
- [ ] 8. Peer Support Services
- [ ] 9. Crisis Stabilization Services/Mobile Crisis Response
- [x] 10. Behavioral analysis/monitoring/development of behavioral support plan
- [x] 11. Integrated Treatment for Co-Occurring Disorders (ITCD)

Home and Community Based Services:

- [x] 1. Day programming/Adult day care
- [x] 2. Housekeeping/homemaker/chore services
- [x] 3. Nutritional/dietary evaluation/delivered meals or shopping assistance
- [x] 4. Personal care/ADL assistance
- [ ] 5. Respite care
- [ ] 6. Adaptive equipment evaluation/Environmental accessibility adaptations
- [ ] 7. Financial assistance/financial management services
- [x] 8. Family support/education
- [ ] 9. Supported decision making
- [ ] 10. Hospice services
- [x] 11. Medical follow-up/Physician services
- [ ] 12. Home health/nursing care services/nurse visits
- [x] 13. Physical therapy evaluation
- [x] 14. Occupational therapy evaluation
- [x] 15. Speech/Language therapy evaluation
- [ ] 16. Other (describe): _____

Comments regarding Supports/Services

SECTION X: PASRR Level II Evaluation Report (continued)

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

Jane's service coordinator from St Louis RO is Sally Smith. She has been a support to her in the past and is very knowledgeable about her history and behavioral challenges. She has been in contact with the hospital SW regarding placement options.

SECTION: Conclusions

Source of information used in completing evaluation:

- ☒ Client interview
- ☐ Previous PASRR (date): _____
- ☒ Record review - previous facility (specify): Doctor's Hospital-ED records
- ☒ Record review - Regional Office (specify): St Louis RO
- ☒ Record review - Community Mental Health Provider (specify): Burrell Behavioral Health
- ☒ Staff interview (specify): Jane Employee, Hospital SW
- ☒ Family/guardian (specify): PA deputy, George Guardian
- ☒ Case Manager (specify): Sally Smith, SLRO casemanager
- ☐ Other (specify): _____
- ☒ Record review - current facility
- ☒ CIMOR

Assessor Name: Michelle Newbery Date: 05/27/2025

Signature: *** Signature on File *** Title MSSW LCSW

For BOCK USE ONLY:

Reviewed/Edited by: _____ Date: _____