PASRR/ID Modified
For Special Admit and Out of State Evaluations

For BOCK use only

RedCap _____ ☐ Pre-Admission Screening ☐ Resident Review

PASRR Outcome: ☐ IDD/RC ☐ Unable to verify IDD/RC

Needs exceed NF Level of Services? ☐ No ☐ Yes/ID Additional 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 ☐ Female ☐ 4. DCN _____ 5. Evaluation Date _____

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

7. Facility Name _____ Admit Date _____

City _____

Contact person _____ Phone _____

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

Name _____ Phone _____

Address _____

City _____ State MO Zip Code _____

Relationship: [Select or type response] _____

SECTION II: Modified Evaluation Type

1. Select reason for the modified evaluation.

☐ Special Admit (serious/terminal illness)

☐ Out of State

☐ Other (specify): _____

SECTION III: Education and Functional Assessment

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

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

SECTION IV: Psychiatric Assessment/History

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

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

SECTION V: Behavioral Assessment

1. 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): _____

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

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:

SECTION VI: MI/IDD/RC Determination

1. 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: [Select or Type Response] _____

2. 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
   - ☐ 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
   - ☐ Other (specify): _____

   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 the following areas of major life activity prior to age 22. **Mark all that apply.**

   - ☐ Self Care
   - ☐ Mobility
   - ☐ Understand and use of language
   - ☐ No functional limitations
   - ☐ Learning
   - ☐ Self Direction
   - ☐ Capacity for independent living

3. 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.

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

   - ☐ Has IDD OR has 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.

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

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 ID disability proceed to Section: Conclusions.

SECTION VII: Psychosocial Assessment

1. Is English the individual's primary language? Yes ☐ No ☐ If No, primary language is: _____

2. Marital Status: [Select or Type Response]

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

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

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: _____

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

SECTION VIII: Level of Functioning

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

1. Personal care and independent living skills:

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

Comments: _____

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

☐ Normal/Fully independent ☐ Aids (cane/walker) ☐ Unsteady ☐ Staff assist

☐ Wheelchair unassisted ☐ Wheelchair assisted ☐ Bedfast ☐ Other: _____

Comments: _____

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

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

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

SECTION IX: Medical History

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

If Yes, specify: _____

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

SECTION IX: Medical History (continued)

3. 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: _____

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

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

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

☐ No If Yes, describe:

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

☐ Current Diagnosis List/History & Physical Attached Date: _____

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

☐ None ☐ Mild ☐ Moderate ☐ Severe

SECTION X: Physical Assessment

1. Appetite: _____

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

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

3. 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
- ☐ Bowel and bladder/Incontinence care
- ☐ Catheterization care
- ☐ Choking/Aspiration precautions
- ☐ Colostomy/Illeostomy/Ureterostomy
- ☐ CPAP/BIPAP
- ☐ Diabetic monitoring
- ☐ Dietary supplements
- ☐ Decubitus care
- ☐ Dialysis
- ☐ Fall precautions
- ☐ Foot care
- ☐ Fracture care
- ☐ Hemodialysis
- ☐ Hospice Services
- ☐ Inhalation therapy/Respiratory care
- ☐ Injections
- ☐ Intake and output
- ☐ IV fluids
- ☐ IV meds/antibiotics
- ☐ Medication monitoring
- ☐ Therapeutic diet (specify): _____
- ☐ Monitoring of Vital Signs
- ☐ Oral suction
- ☐ Oxygen
- ☐ Prosthesis care
- ☐ Seizure precautions
- ☐ Special skin care/monitoring
- ☐ Tracheostomy care
- ☐ Tube feedings/TPN
- ☐ Weight monitoring
- ☐ Wound/incision care
- ☐ Ordered labs (specify): _____
- ☐ Other (specify): _____

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

☐ None ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Restorative nursing services

SECTION XI: 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
- ☐ Unable to determine
- ☐ Angry
- ☐ Constricted
- ☐ Other (specify): _____
- ☐ Mood congruent
- ☐ Mood incongruent

SECTION XII: PASRR Level II Evaluation Report

Client Name: _____

1. (Reserved):

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

☐ Has IDD or a related condition (other than mental illness) as defined by PASRR

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

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

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

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

If Yes, please indicate facility name: _____

SECTION XII: PASRR Level II Evaluation Report

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

- ☐ The individual's needs could be met in a nursing facility at this time.
- ☐ 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.

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?

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

SECTION XII: 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 XII: 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.

SECTION XII: 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:

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 XII: PASRR Level II Evaluation Report (continued)

Community based psychiatric treatment and supports:

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

Home and Community Based Services:

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

Comments regarding Supports/Services

SECTION XII: PASRR Level II Evaluation Report (continued)

10. 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): _____
- ☐ Record review - Community Mental Health Provider (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: _____