

PASRR/ID Level II Evaluation

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. Type: On-Site Telehealth
 N/A (Halted/Partial LV2)

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 _____

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

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

SECTION II: 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 **current/historic DMH/DD regional office services** (include dates and types of services as available).

3. 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): _____ | | | |

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

SECTION II: Psychiatric Assessment/History (continued)

5. 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 III: 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: _____

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:**

- | | |
|--|---|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Autism Spectrum Disorder (Asperger's Syndrome, Pervasive Developmental Disorder) |
| <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Severe Hearing and Visual Impairment |
| <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Spina Bifida or other neural tube defect |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Fetal Alcohol Syndrome |
| <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Fragile X Syndrome or other genetic disorder |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Prader-Willi Syndrome |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Para/Quadraplegia or other orthopedic impairment |
| <input type="checkbox"/> 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.**

- | | | | |
|------------------------------------|---|--|--|
| <input type="checkbox"/> Self Care | <input type="checkbox"/> Mobility | <input type="checkbox"/> Understand and use of language | <input type="checkbox"/> No functional limitations |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Self Direction | <input type="checkbox"/> 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.

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

4. Does the individual have a diagnosis of Major Neurocognitive impairment (Dementia)? No Yes

5. 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.

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

If the individual DOES NOT meet criteria for a PASRR related ID disability proceed to Section: Conclusions.

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: _____

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**.

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): _____

SECTION IV: Psychosocial Assessment (continued)

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).

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 | ___ 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. 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

SECTION V: Level of Functioning (continued)

4. Could prosthetic, orthotic, corrective or **mechanical supportive devices** improve the individual's functional capacity?

No If yes, describe:

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

6. Could **non-oral communication systems**, amplification devices or a program of amplification improve the individual's functional capacity?

No If yes, describe:

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

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

SECTION VI: Medical History and Physical Assessment

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

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

SECTION VI: Medical History and Physical Assessment (continued)

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

No If Yes, describe:

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

Current Diagnosis List/History & Physical Attached Date: _____

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

None Mild Moderate Severe

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

13. Appetite: _____

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

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

Other: _____

SECTION VI: Medical History and Physical Assessment (continued)

15. **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: _____

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

17. 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): _____ | | |

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

- None Physical therapy Occupational therapy Speech therapy Restorative nursing services

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?

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

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

SECTION IX: 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

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 X: PASRR Level II Evaluation Report (continued)

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

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)**:

- | | | |
|--|---|--|
| <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

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.

- 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)

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 X: 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: _____