NEW MEXICO DEPARTMENT OF HEALTH

NEW MEXICO PASRR LEVEL I IDENTIFICATION SCREEN

A New Mexico PASRR Level I Identification screen is required for every Medicaid certified nursing facility applicant regardless of payment source.

Please print legibly. Incomplete referrals will not be processed.

The information in this document constitutes a Level I referral. This document must be part of each individual's nursing facility record. The document must be updated only if the individual's Mental illness (MI, Intellectual Disability (ID), and/or Related Condition (RC) status changes (Resident Review Significant Change Review).

A. TYPE OF REVIEW: (CHECK ONE) Pre-Admission Screening ☐ or Resident Review (Significant Change Review) ☐

B. INDIVIDUAL'S INFORMATION

Name: ______________________ DOB: ____________ SSN: ______________
Last, First, Middle Initial — Complete Number

Current Location: ____________________ City: ____________ State: ______________

Next of Kin, Medical Surrogate or POA: ________________________________

Telephone: ________________________________

Pertinent Medical Diagnoses: ________________________________

C. IDENTIFICATION OF MENTAL ILLNESS (MI) EVALUATION CRITERIA

☐ YES ☐ NO Is there a diagnosis or suspected mental illness? If yes, Diagnosis: ______________

a mental illness (from the DSM -5) includes diagnoses such as;

Schizophrenia	Disorders of Mood	Panic Disorder
Anxiety Disorder	Personality Disorder	Psychotic Disorder
Somatoform	Depression	Substance Related

This list is not all-inclusive; contact PASRR for questions on a diagnosis

☐ YES ☐ NO Due to the Mental Illness, within the past two years, has the individual had;

- ☐ More than one in-patient psychiatric hospitalization or in -patient drug intervention; **OR**
- ☐ Any intervention by the housing authority, adult protective services, or law enforcement; **OR**
- ☐ An episode of significant disruption to their living situation that necessitates supportive services to maintain functioning in a residential setting

If both questions were answered "yes," a referral to PASRR is required prior to a nursing facility admission. Continue with screening form for Intellectual Disability (ID) and Related Condition (RC) Evaluation Criteria

D. IDENTIFICATION OF INTELLECTUAL DISABILITY (ID) EVALUATION CRITERIA

☐ YES ☐ NO Is there a diagnosis or evidence of intellectual disability or developmental disability prior to the age of 18?

☐ YES ☐ NO Is the individual receiving services for their intellectual disability?
Name of Agency: ______________________

If either question is answered "yes", a referral to PASRR is required prior to a nursing facility admission.

E. IDENTIFICATION OF RELATED CONDITION (RC) EVALUATION CRITERIA

☐ YES ☐ NO Is there a history, diagnosis, or evidence of a Related Condition (RC), affecting intellectual or adaptive functioning **with age of onset prior to age 22.** Any severe, chronic disability, other than mental illness, that may indicate a developmental disability will qualify.

Examples:

Seizure Disorder	Epilepsy	Cerebral Palsy	Spina Bifida
Deafness	Quadriplegia	Multiple Sclerosis	TBI
Blindness	Paraplegia	Muscular Dystrophy	Autism

Comments: (Specify Related Condition and age of onset) ____

This list is not all-inclusive; contact PASRR for questions on a specific diagnosis
If question is answered "YES," a referral to PASRR is required prior to a nursing facility admission.

F. Dementia

☐ YES ☐ NO Is there a diagnosis of Dementia?

PASRR will issue a Dementia waiver if the individual has a diagnosis of Mental Illness (MI), Intellectual Disability (ID) and/or Related Condition (RC), when a physician/provider completes the certification below.

My patient; ____, has advanced or primary diagnosis of Dementia.
Name of patient

____
Physician/Provider Signature/Date ☐ Electronic Signature

G. Severity of Illness

PASRR will issue a Severity of Illness waiver if the individual has a diagnosis of Mental Illness (MI), Intellectual Disability (ID) and/or Related Condition (RC), and needs to be transferred to a nursing facility for Hospice or Palliative Care. A physician/provider must complete the certification below.

My patient; ____, meets PASRR guidelines and has ____________________
Name of patient

____, a Medical condition which meets end of life criteria.

____
Physician/Provider Signature/Date ☐ Electronic Signature

H. Respite

PASRR will issue a Respite waiver if the individual has a diagnosis of Mental Illness (MI), Intellectual Disability (ID) and/or Related Condition (RC), and requires respite for a period of 14 days. A physician/provider must complete the following order.

My patient; ____, meets PASRR criteria and will require respite care at;
Name of patient

____, for a period not to exceed 14 days.
Name of nursing facility

____
Physician/Provider Signature/Date ☐ Electronic Signature

I. REQUIRED DOCUMENTATION TO BE SUBMITTED WITH THE LEVEL I IDENTIFICATION SCREEN

Mandatory

- ☐ A completed Level I identification screen
- ☐ Current physician/provider history and physical
- ☐ List of current medications

If available

- ☐ Psychiatric evaluation/consult
- ☐ ID/RC history/documentation
- ☐ Neuropsychological evaluation/consult
- ☐ Documentation of Dementia/CT/Brain Scan
- ☐ Mental Status Exam

Please remember to provide mandatory information, as incomplete referrals will not be processed. Fax all documentation to PASRR 505-841-5537.

J. ADMITTING NURSING FACILITY INFORMATION

Name of Facility: ___________________________ NF E-mail Address: ____________________@__________

Telephone: ______________________________ Expected date of Admission: ____________________

Type of nursing facility care this individual needs: ☐ SNF (less than 30 days) or ☐ Long-term care

For a convalescent care waiver to be issued, the individual must currently be in the hospital and must be going directly to a nursing facility for convalescence for the medical condition the individual received treatment for while in the hospital.

PASRR will issue a convalescent care waiver for Individual's needing Skilled Nursing Facility care when a Physician certifies the expected length of stay at a nursing facility will be 30 days or less. If the individual is admitting to a nursing facility for skilled care, complete the physician/provider order below.

Admit to ______________________________ for convalescence for ______________________

Name of nursing facility — Medical condition the individual received treatment while in the hospital

______________________________ for a period, not to exceed 30 days.

____

Physician/Provider Signature/Date

☐ Electronic Signature

If the individual met criteria for Mental illness (MI), Intellectual Disability (ID), and/or Related Condition (RC) and long-term care is needed for this individual, a PASRR Level II Evaluation will be required prior to nursing facility admission. Submit this Level I identification screen to PASRR and a Level II Evaluation will be scheduled.

K. NAME AND TITLE OF INDIVIDUAL COMPLETING PASRR LEVEL I SCREEN

NAME/TITLE: ______________________________ Signature: ______________________________

Hospital, Nursing Facility, Agency: ____

Telephone/extension: ____________________ Email address: ________________________@________

Date form completed: ____________________ Date Form faxed to PASRR: ________________________

☐ Electronic Signature

For PASRR Staff use only					
☐ **Revised/Corrected Level I Screen.**		**Reason Revised/Corrected:**			
☐ **Met Criteria**	☐ **Issued Waiver**	**Waiver Type/Date:**		**PASRR Staff Member:**	