NEW MEXICO
Department of Health
Developmental Disabilities Supports Division

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 (SELECT ONE)

- ■ Pre-Admission Screening (hospital, agency, doctor office)
- ☐ Resident Review/Significant Change Review (nursing facility only)
- ☐ Adult Protective Services **ONLY**

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: _____
(do not document using codes)

C. IDENTIFICATION OF MENTAL ILLNESS (MI) EVALUATION CRITERIA

1. ☐ 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 specific diagnosis.

2. ☐ YES ☐ NO Due to the Mental Illness listed above, within the past two years, has the individual had
   - ☐ More than one in-patient psychiatric hospitalization or in-patient drug intervention; **OR**

     _____ (Date of in-patient psychiatric hospitalization or drug treatment intervention)
     _____ (Date of in-patient psychiatric hospitalization or drug treatment intervention)
   - ☐ 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

When both questions are 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.

Is this individual receiving mental health services? If so, name of agency/therapist:
_____

Developmental Disabilities Supports Division – PASRR Program
5301 Central NE., Suite 1100, Albuquerque, NM 87108 | TELEPHONE: 505-372-8025 or 505-272-6786 | FAX: 505-841-5537

D. IDENTIFICATION OF INTELLECTUAL DISABILITY (ID) EVALUATION CRITERIA

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

2. ☐ 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

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

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

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

F. ADMITTING NURSING FACILITY INFORMATION

Name of Facility: Meadows Home NF E-mail Address: samuel.garcia2 @doh.nm.gov
Required

Telephone: 505-454-2388 Expected date of Admission: _____

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

Note: Long Term Care
If the individual meets criteria for Mental Illness (MI) Section C, Intellectual Disability (ID) Section D, and/or Related Condition (RC) Section E and long-term care is needed for this individual, a PASRR Level II Evaluation is required prior to nursing facility admission. Submit this Level I identification screen to PASRR and a Level II Evaluation will be scheduled.

Waiver Types

G. CONVALESCENT CARE WAIVER (Individual must meet all three requirements)

PASRR will issue a Convalescent Care Waiver:

- ☐ if the individual has a diagnosis of Mental Illness (MI) Section C, Intellectual Disability (ID) Section D, and/or Related Condition (RC) Section E.
- ☐ if the individual needs skilled nursing facility (SNF) care and a physician certifies the expected length of stay at a nursing facility will be 30 days or less.
- ☐ **and** if the individual is currently in the hospital and going directly to a nursing facility for convalescence for the medical condition the individual received treatment for while in the hospital.

If the individual is admitting to a nursing facility for skilled care having met the above requirements, complete the physician/provider order on the following page.

Admit to_____ for convalescence for
Name of nursing facility

_____for a period not to exceed 30 days.
Medical condition the individual received treatment while in the hospital

_____
Physician/Provider Signature/Date

H. DEMENTIA WAIVER (Individual must meet all three requirements)

PASRR will issue a Dementia Waiver;

- ☐ if the individual has a diagnosis of Mental Illness (MI) Section C, Intellectual Disability (ID) Section D and/or Related Condition (RC) Section E,
- ☐ if the individual has an advanced or primary diagnosis of Dementia/Major Neurocognitive Disorder
- ☐ **and** a physician/provider completes the certification below

☐ YES ☐ NO Is there a diagnosis of Dementia/Major Neurocognitive Disorder?

My patient;_____, has advanced or primary diagnosis of
Name of patient

Dementia/Major Neurocognitive Disorder.

_____
Physician/Provider Signature/Date

☐ This person has a Dementia Waiver issued on: (date of issue) _____ Verified with PASRR

I. SEVERITY OF ILLNESS WAIVER (Individual must meet all three requirements)

PASRR will issue a Severity of Illness Waiver:

- ☐ if the individual has a diagnosis of Mental Illness (MI) Section C, Intellectual Disability (ID) Section D and/or Related Condition (RC) Section E,
- ☐ if the individual requires Hospice or Palliative Care due to an end of life diagnosis,
- ☐ **and** a physician/provider completes 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

J. RESPITE WAIVER (Individual must meet all three requirements)

PASRR will issue a Respite Waiver:

- ☐ if the individual has a diagnosis of Mental Illness (MI) Section C, Intellectual Disability (ID) Section D and/or Related Condition (RC) Section E,
- ☐ requires respite for a period not to exceed 14 days,
- ☐ **and** a physician/provider must complete the following order

My patient;_____, meets PASRR guidelines and will require respite
Name of patient

care at; _____, for a period not to exceed 14 days.
Name of nursing facility

_____
Physician/Provider Signature/Date

The following information should only be sent to PASRR if the individual has met criteria in section C, D or E

K. REQUIRED DOCUMENATION TO BE SUBMITTED WITH THE LEVEL I IDENTIFICATION SCREEN

Please select documents sent with the Level I 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 at 505-841-5537.

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

NAME/TITLE: _____ Signature: _____

Hospital, Nursing Facility, Agency: _____

Telephone/extension: _____ Email address: _____@_____
Required Required

Date form completed: _____ Date Form sent to PASRR:_____

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