MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM
(Replaces Patient Transfer and Continuity of Care Form)

(A) FACILITY INFORMATION

Facility From ______________________

Admission Date **Discharge Date**

Facility To ______________________ ____/____/____ ____/____/____

(B) DEMOGRAPHIC INFORMATION

Individual's DOB ____/____/____ Sex ________ Race ________

Individual's Last Name First Name Initial

Individual's Address Phone Number

Nearest Relative/Health Care Surrogate Phone Number

PHYSICIAN INFORMATION

Name ______________________

Will you care for individual in NF? ☐ Yes ☐ No

If no, referred to ______________________

Principal Diagnosis ______________________

Secondary Diagnosis ______________________

Discharge Diagnosis ______________________

(Problem List may be attached)

Surgery Performed & Date ______________________/____/____

Allergy/Drug Sensitivity______________________

MEDICATION AND TREATMENT ORDERS (copies may be attached)

(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION

(Complete for admission to NF only)

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? ☐ Yes ☐ No
3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that apply)
   - ☐ Schizophrenia
   - ☐ Mood disorder
   - ☐ Somatoform disorder
   - ☐ Paranoia
   - ☐ Panic or severe anxiety disorder
   - ☐ Personality disorder
   - ☐ Other psychotic or mental disorder leading to chronic disability
4. Has the individual received MI services within the past two years? ☐ Yes ☐ No
5. Is the individual a danger to self or others? *(please attach explanation)* ☐ Yes ☐ No
6. Is the individual on any medication for the treatment of a serious mental illness or psychiatric diagnosis? ☐ Yes ☐ No
7. If yes, is the MI or psychiatric diagnosis controlled with medication? ☐ Yes ☐ No
8. Is the individual being admitted from a hospital after receiving acute inpatient care? ☐ Yes ☐ No
9. Does the individual require nursing facility services for the condition for which he/she received care in the hospital? ☐ Yes ☐ No
10. Has the physician certified the individual is likely to require less than 30 days of nursing facility services? ☐ Yes ☐ No

(D) ADDITIONAL ORDERS (Orders may be attached)

(E) HISTORY & PHYSICAL AND LABS

1. PHYSICAL EXAM (History & Physical may be attached)

Head Ears Eyes Nose & Throat (HEENT)______________________

Neck ______________________

Cardiopulmonary ______________________

Abdomen______________________

GU ______________________

Rectal ______________________

Extremities ______________________

Neurological ______________________

Other ______________________

Free from communicable diseases ☐ Yes ☐ No

2. LABORATORY FINDINGS (Reports may be attached)

TB Test ☐ Yes ☐ No Date ____/____/____

Results ______________________

Chest X-Ray ☐ Yes ☐ No Date ____/____/____

Results ______________________

(F) IMMUNIZATIONS GIVEN

- ☐ Pneumococcal Vaccine Date ____/____/____
- ☐ Influenza Vaccine Date ____/____/____
- ☐ Tetanus and Diphtheria Vaccine Date ____/____/____
- ☐ Herpes Zoster Vaccine Date ____/____/____

(G) PHYSICAL THERAPY (Attach Orders)

☐ New Referral ☐ Continuation of Therapy

FREQUENCY OF THERAPY ______________________

INSTRUCTIONS ______________________

- ☐ Stretching
- ☐ Passive Range of Motion (ROM)
- ☐ Active assistive
- ☐ Active
- ☐ Progressive resistive
- ☐ Coordinating Activities
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Full weight bearing
- ☐ Progress bed to wheelchair
- ☐ Recovery to full function
- ☐ Wheelchair independent
- ☐ Complete ambulation

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

PRECAUTIONS

- ☐ Cardiac
- ☐ Other ______________________

ADDITIONAL THERAPIES (Attach Orders)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Respiratory Therapy
- ☐ Other ______________________

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

- ☐ Catheter Care
- ☐ Changing Feeding Tube
- ☐ Dressing Changes
- ☐ Ostomy Care
- ☐ Wound Care
- ☐ Suctioning
- ☐ Trach Care
- ☐ Diabetic Care
- ☐ Monitor Blood Sugar/Frequency ______________________
- ☐ Administer Insulin
- ☐ Tube Feeding
- ☐ Oxygen *(Select from below)*
  - ☐ PRN
  - ☐ Continuous @L/min ______________________

Instructions

(I) SPECIAL DIET ORDERS (Orders may be attached)

(J) TYPE OF CARE RECOMMENDED ***(MUST BE COMPLETED AND SIGNED)***

Check one

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

☐ Skilled Nursing Extended Care Facility (ECF), Duration ____________

☐ Intermediate Care: Duration ____________

Admission Date to Nursing Facility ____/____/____

I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.

☐ I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement.

Print Physician's Name ______________________

Effective Date of Medical Condition____/____/____

Address ______________________

Phone Number ______________________ **Fax** ______________________

Email Contact Address ______________________

______________________/____/____

Physician's Signature and Date Required

FOR ONLINE APPLICANT USE ONLY

IF APPLYING FOR MEDICAID, PLEASE INCLUDE DCF

ACCESS CONFIRMATION NUMBER BELOW:

FLORIDA MEDICAID

NURSING/SOCIAL WORK ASSESSMENT
[Page 2 may be completed by a Nurse or Social Worker]

ADLs ARE AT TIME OF NF ADMISSION

INDIVIDUAL'S NAME ______________________________ **DOB** ____________________

(K) VISION (w/glasses if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Blind	**AMBULATION**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Total help ☐ 6. Bed bound
HEARING (w/aid if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 4. No tolerance ☐ 3. Rarely tolerates short acitivities
SPEECH	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Gestures or signs ☐ 5. Unable to speak	**TRANSFER**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Bed bound
COMMUNI-CATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. No assistance ☐ 2. Assistance with difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety restraints needed ☐ 10. Well motivated	**TOILETING**	☐ 1. No assistance ☐ 2. With assistive devices ☐ 3. With supervision ☐ 4. Requires assistance ☐ 5. Total assistance ☐ A- Bathroom ☐ B - Bedside commode ☐ C- Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fatigue ☐ 3. Irritations (rash) ☐ 4. Open Wound ☐ 5. Decubitus Site:__________ Stage:__________ Size:__________	**BLADDER CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence - once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Catheter - indwelling
DRESSING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence-once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Is bathed ☐ A- Tub ☐ B - Shower ☐ C- Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Tray set up only ☐ 3. Requires assistance ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

***(HANDS ON NEEDED)**

Comments:____

SIGNATURE AND TITLE______________________________ **DATE**______/______/______

(L) **SOCIAL WORK ASSESSMENT**

Prior Living Arrangement______________________________

Long Range Plan/Agency Referrals______________________________

Adjustments to Illness or Disability______________________________

Comments ______________________________

*DCF ACCESS Confirmation #:*______________

Florida Agency for Health Care Administration

Pre-Admission Screen and Resident Review (PASRR)

Instructions for Completion of the Level I Screen for Serious Mental Illness (SMI) and/or Intellectual Disability or Related Condition (ID)

A. Purpose

The PASRR Level I screen identifies individuals who are suspected of having a serious mental illness (SMI); an intellectual disability or related condition (ID); or both. The Level I screen must be completed for all individuals prior to admission to a Medicaid-certified nursing facility (NF), including provisional or hospital discharge exempted admissions. The Level I screen may only be completed by an entity delegated to perform the Level I PASRR screen (listed below). See Rule 59G-1.040, Florida Administrative Code. If the Level I screen indicates an SMI or ID or both, or a finding of a significant change in an NF resident, the PASRR Level II evaluation must be completed.

Please note: The Level I screen is to be used only for individuals either referred to or residing in an NF. The PASRR process must be completed regardless of payor source or age. A Level I PASRR screen does not need to be completed if (1) an individual is returning to the NF after being in a hospital for no more than 90 days; or (2) an NF resident is transferred to another NF. The following screeners are responsible for completion of a PASRR Level I:

- Agency for Health Care Administration (or its delegate-the Florida Department of Health) for children under the age of 21years; and
- Florida Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) for adults age 21years and older. CARES may delegate to hospital or NF staff (Physician, RN, MSW, LCSW).

Information inserted manually must be legible. Any illegible information will result in the screen being deemed unacceptable.

B. Acronyms/abbreviations applicable to PASRR:

a. CARES – Comprehensive Assessment and Review for Long-Term Care Services
b. CMAT – Children's Multidisciplinary Assessment Team
c. CMS – Centers for Medicare & Medicaid Services
d. DOH – Department of Health
e. DOEA – Department of Elder Affairs
f. F.A.C. – Florida Administrative Code
g. HIPAA – Health Insurance Portability and Accountability Act
h. ID – Intellectually Disability or Related Conditions
i LCSW – Licensed Clinical Social Worker
j. MM/DD/YYYY – month, day, year
k. MSW – Masters of Social Work
l. N/A – non-applicable
m. NF – Medicaid-certified Nursing Facility
n. PASRR – Pre-Admission Screening and Resident Review
o. RN – Registered Nurse
p. SMI – Serious Mental Illness

C. Instructions

Page 1:

Fill in the blanks with the individual's demographics, screening site, insurance information, etc. Check the boxes to best answer the individual's current location at time of screening. Please be sure to include the individual's parent, guardian, or legal representative's name and phone number if applicable.

The Medicaid or "Other Health Insurance" identification name or number is not required, but may be helpful for the provision of any recommended services.

Section I: Reason to Request PASRR Level I Screening

Check the appropriate box(s) in this section to identify why a Level I screen is required.

A Resident Review is applicable only to an individual already residing in an NF. More than one box may be checked to identify why a Resident Review is required.

The screen is incomplete if the reason for the screen is not indicated.

Section II: PASRR Level I Screen Decision-Making

Steps to Complete Screen

1. Identify diagnoses: Review any pertinent medical records, if available, for diagnoses or suspicion of SMI or ID or both. Medical record sources can include but are not limited to: verbal interview with the individual or parent/legal guardian; the Medical Certification for Nursing Facility/Home-and-Community-Based Services Form (AHCA MedServ-3008); other legal representative; observation; progress notes; the most recent annual physical exam, most recent history and physical records; hospital discharge summaries; or diagnosis list.
2. Indicate the source of all the information gathered if a diagnosis or suspicion of SMI or ID is found.
3. Include additional information if necessary.

- **Please note:** A Level II evaluation must be completed if any box in Section II.A is checked and there is a YES checked in Section III.1, III.2, or III.3.
- A Level II evaluation must be completed if any box in Section II.B is checked and (1) the intellectual disability manifested prior to 18 years of age or a related condition manifested before age 22, and (2) the condition is likely to continue indefinitely, resulting in functional limitations in three or more of the following: self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living.
- A Level II evaluation must be completed if Section III.4 is checked YES.

Section II: PASRR Screen Decision-Making-Examples

☒ Other (specify) Child under the age of 21, Individual Educational Plan of 7/9/2014 indicates visual impairment

☒ Other (specify) CARES assessment of 7/9/2014 for a 65 year old having diagnosis of Williams Syndrome

Section III: Other Indications for PASRR Screen Decision-Making

Check any box indicating any other indication or suspicion of SMI or ID, and add any additional information for basis of findings. The items listed in this section encourage the screener to "look behind" the diagnosis for any suspicion of SMI or ID.

- **Please note:** A Level II evaluation must be completed if any box in Section II.A is checked and there is a YES checked in Section III.1, III.2, or III.3.
- A Level II evaluation must be completed if any box in Section II.B is checked and (1) the intellectual disability manifested prior to 18 years of age or a related condition manifested before age 22, and (2) the condition is likely to continue indefinitely, resulting in functional limitations in three or more of the following: self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living.

A Level II evaluation must be completed if Section III.4 is checked YES.

Section IV: PASRR Screen Provisional Determination

Section IV pertains to provisional admissions. A provisional admission allows an individual to be admitted with completion of the PASRR process in accordance with strict time frames.

If the admission is **NOT** a provisional admission, check the box that indicates this and proceed to section V.

If the admission **IS** a provisional admission, check the appropriate provisional admission box. Choose only one of the provisional admission criteria. Be sure to add the date the PASRR process should be completed.

If an individual is admitted with delirium, the individual **must** be tracked to determine when the delirium clears, so that the PASRR process may be completed.

Section V: PASRR Screen Completion

To complete the PASRR Level I screen, the determination of whether the individual may be admitted to an NF and a request for a PASRR Level II evaluation, if necessary, must be summarized here. Check all that apply.

Complete the screener information (person responsible for completing PASRR I form). All fields must be completed. Complete the distribution area of the form where the PASRR Level I form must be sent. If a Level II evaluation is needed, send the documents listed at the bottom of the form to the evaluating entity.

If the age of the individual is under the age of 21years, check the box "Local DOH office*."

If the age of the individual is age 21years or older, check the box "Local CARES office**."

Enter the date the screen was distributed to the appropriate entities. Include information on how to obtain the screen.

Please ensure all your distributions of the PASRR Level I screen and required documents maintain HIPAA compliance.

*Department of Health

** Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services

State of Florida Agency for Health Care Administration

Pre-Admission Screen and Resident Review (PASRR)
Level I Screen for Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)
Use for Medicaid Certified Nursing Facility (NF) Only

____ _____-_____-______ _____-_____-_____
Name of Individual Being Evaluated (print) SSN* DOB

☐Male ☐Female Age:________

Present Location of Individual Being Evaluated Street Address, City State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home

☐ Other ______________________________ Individual's or Residency Phone Number: ______/______/__________

Legal Representative's Name (if applicable) Street Address, City State, Zip

Representative's Phone Number: ______/______/__________

____

Medicaid Number if Applicable

Screening Date

Other Health Insurance Name and Number if Applicable

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER? Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so.

Section I: Reason To Request PASRR Level I Screen

☐ **Request for admission to an NF**

☐ **Resident Review of an individual already residing in an NF**

Significant Physical Change
☐ Improvement
☐ Decline

Significant Mental Change
☐ Improvement
☐ Decline

New Suspicion of SMI or ID
☐ SMI
☐ ID
☐ SMI and ID

Name of Individual Being Evaluated__________________________ Date of Birth__________________

Section II: PASRR Screen Decision-Making

A.

☐**SMI or suspected SMI (check all that apply):**

☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Dissociative Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ Psychotic Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Somatic Symptom Disorder
☐ Other (specify)

____
____
____

☐ Substance Abuse

B.

☐**ID or suspected ID (check all that apply):**

☐ Autism
☐ Cerebral Palsy
☐ Down Syndrome
☐ Epilepsy
☐ Intellectual Disability with an IQ lower than 70 (specify):

____

☐ Prader-Willi Syndrome
☐ Spina Bifida
☐ Other (specify)

____
____
____
____

Age of onset for intellectual disability?*	____Years
Age of onset for any related condition?*	____Years

*If known.

C. Checks in A and B are based on:

☐ Documented History
☐ Medications
☐ Behavioral Observation
☐ Individual, Legal Guardian, or Family Report
☐ Other (specify)

____

Additional Information:

____
____
____
____
____
____

Section III: Other Indications for PASRR Screen Decision-Making

1. Is there an indication within the past 3 to 6 months the individual has a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐ Yes ☐ No

2. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

   A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been fired. ☐ Yes ☐ No

   B. 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, manifests 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. ☐ Yes ☐ No

   C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐ Yes ☐ No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

   A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization). ☐ Yes ☐ No

   B. Within the last two years, due to the mental illness, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐ Yes ☐ No

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others?
   ☐ Yes ☐ No

NOTES ON SECTIONS II AND III:

- A Level II evaluation must be completed if any box in Section II.A is checked and there is a YES checked in Section III.1, III.2, or III.3.
- A Level II evaluation must be completed if any box in Section II.B is checked and (1) the intellectual disability manifested prior to 18 years of age or a related condition manifested before age 22, and (2) the condition is likely to continue indefinitely, resulting in functional limitations in three or more of the following: self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living.
- A Level II evaluation must be completed if Section III.4 is checked YES.

Section IV: PASRR Screen Provisional Determination

☐ **Not a provisional admission**

☐ **Provisional admission (choose one of the following):**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _________________.

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14 day time limit, on or before (date): ______________

☐ The individual is being admitted under the 30-day hospital discharge exemption (attach Form 3008 and physician signature required below). If the individual's stay exceeds 30 days, the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _________________.

An attending physician's signature is required for those individuals admitted under this 30-day hospital discharge exemption.

____ __________________

ATTENDING PHYSICIAN'S SIGNATURE DATE

If a provisional admission is indicated, the individual may enter an NF without a Level II evaluation if the Level I screen indicated a suspicion of SMI and/or ID. However, a Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES or DOH within the time frame indicated in Section IV.

Name of Individual Being Evaluated___________________________ Date of Birth__________________

Section V: PASRR Screen Completion

☐ **Individual <u>may</u> be admitted to an NF (check one of the following):**	☐ **Individual <u>may not</u> be admitted to an NF. Refer for Level II evaluation because there is a diagnosis or suspicion of:**	☐ **Significant change in an NF resident:**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II evaluation not required.	☐ SMI	☐ SMI
	☐ ID	☐ ID
☐ Provisional admission	☐ SMI and ID	☐ SMI and ID

____
Screener's Name (print)

____
Signature

____
Credentials

______/______/________ ______/______/________ ______/______/________
Date **Fax** **Phone**

____
Place of Employment

******************************Incomplete forms will not be accepted*******************************

Completed Level I screen **distributed to**:	Notice of referral for Level II, if applicable, **distributed to** (including information on how to obtain the evaluation):
☐ Local DOH** office, under the age of 21years Date: _________________ ☐ Local CARES*** Office, age 21years or older Date: _________________ ☐ Nursing Facility Date: _________________ ☐ Discharging Hospital if applicable Date: _________________	☐ Individual/Representative Date: _________________

If the individual requires a Level II evaluation, submit the completed Level I screen, documented informed consent, completed AHCA 3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation to CARES or DOH.

**Department of Health
*** Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services