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ATTACHMENT B RFP 5165Z1

Nebraska Level 1 Form - PASRR

First Name:_____Middle Initial:_____Last Name:_____

Mailing Address:_____City:_____State:____Zip:_____Phone: _____

Social Security #:_____-_____-_____Date of Birth:____/_____/_____Marital Status: ☐ M ☐S ☐W ☐D

Gender: ☐ Male ☐ Female Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other:_____

Payment Method: ☐ Medicare ☐ Private Pay ☐Medicaid Pending ☐Medicaid #_____

Living Situation Prior to Current Placement: ☐NF ☐Assisted Living ☐Group home ☐Hospital ☐ Other _____

Current Location: _____ Admission Date: _____

☐ Medical Facility ☐ Psychiatric Facility ☐ Nursing Facility ☐Community ☐ Other:_____

Location Address: _____City: _____State: _____Zip: _____

Admitting Nursing Facility:_____ Date Admitting:_____/___/_____

Admitting Nursing Facility Address:_____City:_____State:_____Zip:_____

Review Type: ☐Preadmission ☐Status Change ☐ Conclusion of a Time Limited Approval

Why is this individual seeking admission to or continued stay in a nursing facility?

☐ Physical problems require NF care and mental illness or substance abuse disorder, *if present*, has no impact on the need for NF care.

☐ Mental illness or substance abuse disorder requires NF care, but no significant physical problems are present.

☐ NF care is primarily required because the individual's mental illness or substance abuse disorder prevents proper handling of physical problem(s) outside a NF setting. Without a mental illness or substance abuse disorder, the individual's physical problem(s) would not require NF care.

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

☐ No

☐ Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Major Depression
- ☐ Psychotic/Delusional Disorder
- ☐ Bipolar Disorder (manic depression)
- ☐ Paranoid Disorder

2. Does the individual have any of the following mental disorders?

☐ No

☐ Suspected: One or more of the following diagnoses is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Depression (mild or situational)

3a. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)

☐ No ☐ Yes (if yes, list diagnosis(es) below):

☐ Diagnosis 1: _____

☐ Diagnosis 2: _____

3b. Does the individual have a substance related disorder?

☐No ☐Yes (if yes, complete remaining questions in this section)

3b.1 List substance related diagnosis(es)

Diagnosis _____ Diagnosis_____

Diagnosis _____ Diagnosis_____

3b.2 Is NF need associated with this diagnosis? ☐ No ☐ Yes

3b.3 When did the most recent substance use occur?

☐ Less than 7 days ☐ 7–14 days ☐ 15–30 days

☐ 31 days-3 months ☐ 4-6 months ☐ 7-12 months

☐ Greater than 12 months ☐ Unknown

Section II: SYMPTOMS

4. Interpersonal– Currently or in the past, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?: ☐ No ☐ Yes

- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

If yes, how recent:

☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months

☐ 13-24 months ☐ 25 months-5 years

☐ Greater than 5 years

5. Concentration/Task related symptoms – Currently or in the past, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]? ☐ No ☐ Yes

- ☐ Serious difficulty completing tasks that she/he should be capable of completing
- ☐ Required assistance with tasks for which s/he should be capable
- ☐ Substantial errors with tasks in which she/he completes

If yes, how recent:

☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months

☐ 13-24 months ☐ 25 months-5 years

☐ Greater than 5 years

Adaptation to change–Currently or in the past, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? ☐No (proceed to Section III) ☐ Yes (complete 6-8)

[redacted]

ATTACHMENT B

Nebraska Department of Health and Human Services

Categorical Determinations and Exemptions

"CONFIDENTIAL"

*Complete this form **only** if the individual is considered to have Serious Mental Illness, Intellectual Disability, Related Condition, or a Dual Diagnosis based on Criteria identified on form DPI-OBRA 1.*

SECTION I: PERSON COMPLETING FORM

Name: _____ Facility: _____ Date: _____

Phone # : _____ Fax # : _____

SECTION II: PATIENT INFORMATION

Name: _____ SS# : _____-_____-_____ Date of Birth: _____

First *Last*

SECTION III: ADVANCED DEMENTIA **Supporting documentation to affirm the diagnosis must be submitted by fax.**	No	Yes
Does the individual have a diagnosis of Serious Mental Illness or Intellectual Disability or a Related Condition **and** have a diagnosis of Dementia, Alzheimer's Disease or related disorder?		
Is the diagnosis of Dementia, Alzheimer's Disease or related disorder considered the **primary** diagnosis?		
Is the individual considered to be in the advanced stages of this condition and no longer able to participate in or benefit from Intellectual Disability/Developmental Disability or specialized services?		

SECTION IV: EXEMPTED HOSPITAL DISCHARGE (EHD)

This individual's physician certifies the following:

___ Admission to a NF directly from a hospital after receiving *acute in-patient medical care* at the hospital; and

___ Requires NF services for the medical condition he/she received care in the hospital; and

___ The attending physician has certified prior to NF admission that the individual will require less than 30 days services.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Phone # : _____

SECTION V: TIME-LIMITED* CATEGORICAL DETERMINATIONS *Please attach the appropriate validating documentation.

The following categories indicate the individual requires NF services and does not require specialized services for the time specified.

☐ **Emergency Protective Service**: individual is admitted to a NF pending further assessment, in an emergency for a stay not anticipated to exceed 7 days.

☐ **Respite**: admission to a NF is needed to care for individual to provide respite for in-home caregivers to whom the MI, MR/RC individual will return. Not to exceed 30 days.

SECTION VI: OTHER CATEGORICAL DETERMINATIONS (non-limited)

Records and/or physician's certification to affirm the above medical condition exists must be submitted with the request.

☐ **Serious Medical:**

Individual has a diagnosis/medical condition of: Coma, Ventilator Dependence, functioning at a brain stem level or a End-stage Medical Condition, which results in the inability to benefit from specialized services.

The following documentation has been attached:

☐ Additional supporting documentation is attached/submitted.

☐ Physician's certification stating less than 30 day nursing facility

☐ Physician's certification/Medical records indicating Serious Medical Condition

Notes: _____

6. ☐ Self-injurious or self-mutilation
☐ Suicidal talk
☐ History of suicide attempt or gestures
☐ Physical violence
☐ Physical threats (with potential for harm)

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

7. ☐ Severe appetite disturbance
☐ Hallucinations or delusions
☐ Serious loss of interest in things
☐ Excessive tearfulness
☐ Excessive irritability
☐ Physical threats (no potential for harm)

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

8. ☐ Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms:_____
_____

If yes, how recent:
☐ Current or within past 30 Days
☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or in the past, has the individual received any of the following mental health services? ☐ No
☐ Yes (the individual has received the following service[s]):
☐ Inpatient psychiatric hospitalization(if yes, provide date:_____)
☐ Partial hospitalization/day treatment(if yes, provide date:_____)
☐ Residential treatment (if yes, provide date:_____)
☐ Other:_____(if yes, provide date:_____)

If yes, how recent:
☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

10. Currently or in the past, has the individual experienced significant life disruption because of mental health symptoms? ☐ No ☐ Yes (check all that apply):
☐ Legal intervention due to mental health symptoms (date:_____)
☐ Housing change because of mental illness(date:_____)
☐ Suicide attempt or ideation (date[s]_____)
☐ Current Homelessness
☐ Homelessness within the past 6 months but not current
☐ Other:_____ (date:_____)

If yes, how recent:
☐ Current or within past 30 Days ☐ 2-6 months ☐ 7-12 months
☐ 13-24 months ☐ 25 months-5 years
☐ Greater than 5 years

11. Has the individual had a recent psychiatric/behavioral evaluation? ☐ No ☐ Yes (date:_____)

Section IV: DEMENTIA

12. Does the individual have a primary diagnosis of dementia or Alzheimer's disease?
☐ No (proceed to 14)
☐ Yes
☐ No, the individual has dementia but it is not primary (proceed to 14)

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia? ☐ No ☐ Yes (check all that apply):
☐ Dementia work up ☐ Comprehensive Mental Status Exam
☐ Other (specify):_____
_____

Section V: PSYCHOTROPIC MEDICATIONS

14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months? ☐ No ☐ Yes (list below)
[use separate sheet if necessary]

Medication	Dosage MG/Day	Diagnosis	Discontinued
			☐
			☐
			☐
			☐

VI: INTELLECTUAL DISABILITIES AND RELATED CONDITIONS

15. Does the individual have a diagnosis of intellectual disability (ID)?
☐ No ☐ Yes

16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed? ☐ No ☐ Yes

17. Is there presenting evidence of a cognitive or developmental impairment that occurred prior to age 18? ☐ No ☐ Yes

18. Has the individual ever received services from an agency that serves people with ID? ☐ No
☐ Yes – agency:_____

19. Does the individual have a diagnosis which affects intellectual or adaptive functioning? ☐ No ☐ Yes (Check all that apply)
☐ Autism ☐ Epilepsy
☐ Blindness ☐ Cerebral Palsy
☐ Closed Head Injury ☐ Deaf
☐ Other: _____

20. Are there substantial functional limitations in any of the following? ☐ No ☐ Yes (Check all that apply)
☐ Mobility
☐ Self-Care
☐ Self-Direction
☐ Learning
☐ Understanding/Use of Language
☐ Capacity for living independently

21. If yes to #19, did this condition develop prior to age 22?
☐ No ☐ Yes

[redacted]

VII: EXEMPTION AND CATEGORICAL DECISIONS (SECTION VII APPLIES ONLY TO PERSONS WITH KNOWN OR SUSPECTED MI AND/OR ID/RC)
(Ascend must approve use of categories and exemptions prior to admission)

22. Does the admission meet criteria for Hospital Exemption?

☐ No

☐ Yes (meets all the following **and** has a known or suspected SMI or ID/RC):

- Admission to NF directly from hospital after receiving acute inpatient medical care, and
- Need for NF is required for the condition treated in the hospital (specify condition: _____), and
- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services **and** the individual's symptoms or behaviors are stable. Physician Name: _____
  Physician Phone:_____
  Physician Licenses #:_____

23. Additional Comments: _____

_____

_____

24. Does the admission meet the criteria for Terminal Illness?

☐ No

☐ Yes (Has a known or suspected SMI or ID/RC **and** MD has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted to Ascend via facsimile within 6 business hours of submission of this form)

25. Does the admission meet the criteria for Severity of Illness?

☐ No

☐ Yes (Has a known or suspected SMI or ID/RC **and** is ventilator dependent or comatose/unresponsive)

26. Does the admission meet criteria for 30 day Respite?

☐ No

☐ Yes (Has a known or suspected SMI or ID/RC **and** is in need of respite stay for up to 30 calendar days in caregiver's absence)

27. Does the admission meet criteria for 7 day EPS Admission?

☐ No

☐ Yes (Has a known or suspected SMI or ID/RC and is in imminent need for short-term placement to ensure safety **and** no other placements are available)

28. Does the admission meet criteria for Dementia/MI?

☐ No

☐ Yes (Has a known or suspected MI **and** Dementia is primary)

29. Does the admission meet criteria for Dementia/ID?

☐ No

☐ Yes (Has a known or suspected ID/RC **and** Dementia is primary)

Section VIII: Guardianship & Physician Information (Required only for individuals with known or suspected Level II conditions)

30. ***Does the individual have a legal guardian?*** ☐ ***No legal guardian.*** ☐ ***Yes, information is below:***

Legal Guardian Last Name_____ First Name_____ Phone:_____

Street_____ City_____ State_____ Zip_____

31. ***Primary Physician's Name***:_____ Phone:_____ Fax:_____

Street_____ City_____ State_____ Zip_____

Section IX: REFERRAL SOURCE SIGNATURE:

By signing my name below, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a health care professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, social workers (with a B.S. degree or higher), physicians, or home health agency clinical staff. Social service staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to Ascend. I understand that NE DHHS considers knowingly submitting inaccurate, incomplete, or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge.

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Ascend Use Only: Reviewer Individualized Service Recommendations (applies if categorical approval [#26–27 or 29] was issued).

☐ Evaluate psychopharmacologic medications
☐ Supportive counseling
☐ Medication education
☐ Foreign language services
☐ Training in ADLs
☐ Explore/prepare for lower level of care
☐ Training in self-health care management
☐ Obtain prior behavioral health records to clarify need
☐ Other (specify) _____
_____
☐ No recommendations at this time

The outcome will be reflected on the computerized screen.