# PREADMISSION SCREENING RESIDENT REVIEW
# PASRR LEVEL II

**UTAH DIVISION OF SUBSTANCE ABUSE**
**AND MENTAL HEALTH**
**195 N 1950 W**
**SALT LAKE CITY, UT 84116**

## SECTION 1: DEMOGRAPHIC AND ASSESSMENT INFORMATION

| NAME (LAST, FIRST, MIDDLE) | | | | LEVEL I DOCUMENT # |
|---|---|---|---|---|
| | | | | |
| SOCIAL SECURITY (LAST FOUR DIGITS) | BIRTH DATE (MM/DD/YYYY) | AGE | UT MEDICAID # | GENDER ☐ F ☐ M ☐ Other |
| | | | | PRONOUNS/ |

| RACE | ETHNICITY |
|---|---|
| ☐ African-American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islander | ☐ Hispanic |

| TYPE OF EVALUATION | TYPE OF RE-EVALUATION |
|---|---|
| ☐ Pre-Admission ☐ Initial ☐ End of Provisional Stay | ☐ End of Convalescent Care Stay ☐ End of Short Stay |
| ☐ Over 30 Day MD Certified Stay ☐ End of Respite | ☐ Significant Change ☐ Assessment Update |

## SECTION 1.1: REFERRAL INFORMATION/SCREENING LOCATION

| REFERRAL DATE | ASSESSMENT START DATE | DATE MEDICAL/PHYSICAL INFO AVAILABLE (LEVEL I, H&P AND MD ORDER) |
|---|---|---|
| | | MDS attached: ☐ YES ☐ NO |

| HOSPITAL ADMISSION? | NAME OF HOSPITAL | ADMIT DATE | DISCHARGE DATE | ER ONLY |
|---|---|---|---|---|
| ☐ YES ☐ NO | | | | ☐ YES ☐ NO |

| REFERRING AGENCY IF NOT HOSPITAL | ADMIT DATE IF IN NF | NAME OF REFERRAL SOURCE | PHONE NUMBER |
|---|---|---|---|
| | | | |

## SECTION 1.2: LEGAL STATUS

| ☐ Self ☐ Legal Guardian/Conservator | POWER OF ATTORNEY | PHONE # |
|---|---|---|
| ☐ Commitment ☐ Legal Representative/POA | | |

| LEGAL GUARDIAN NAME | PHONE # | CELL PHONE |
|---|---|---|
| | | |

| LEGAL GUARDIAN ADDRESS |
|---|
| |

| APPLICANT/RESIDENT AGREES TO LEGAL GUARDIAN/REP. AND/OR FAMILY PARTICIPATION | TRANSLATOR REQUIRED (IF YES, PLEASE PROVIDE TRANSLATOR NAME AND LANGUAGE) | |
|---|---|---|
| ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **NO** | Name:<br>Language: |

**Applicant/Resident:**

## SECTION 2: MEDICAL JUSTIFICATION & INTENSITY OF SERVICES NEEDED IN NURSING FACILITY

| Diagnosis | Onset Date | Diagnosis | Onset Date |
|---|---|---|---|
| | | | |
| | | | |

**Include height and weight if obesity/eating disorder is a factor:** Height: Weight: BMI:

## SECTION 3: MENTAL ILLNESS SYMPTOMS/SUBSTANCE USE SUMMARY

**Onset of Psychiatric Symptoms with a Medical Condition:** Describe medical conditions that may be contributing to the onset of psychiatric symptoms, including date of onset of the medical condition. See p. 48 of manual.

**History/Onset Of Psychiatric Symptoms:** Describe when symptoms started and if there was a precipitating event or circumstance. Also, describe how these specific Psychiatric diagnoses and related symptoms have resulted in serious difficulty in functional limitations in major life activities.

**Substance Use History:**

**Current Psychiatric Functioning:** General summary of current functioning. Document supportive services required due to SMI in reference to Sec 4 - 483.102(iii)(A)(B). For eg: "Supportive Services" include home health, case management, assistance with self-care and/or other supports.

## Section 3.1: DIAGNOSTIC SPECIFIC CHECKLISTS

For all psychiatric diagnoses, there must be a history of functional impairment. Sufficient symptoms to meet the criteria must have been present in the past or currently. Symptoms must have been present in the ABSENCE of substance misuse, and must PRE-DATE medical diagnoses that have psychiatric symptoms as a physiological consequence. ☐/☐ = **Current/Past**

### AFFECTIVE DISORDERS

**Major Depressive Episode/Disorder** (must meet 1. or 2. AND 4 additional for the past 2 weeks)

1. ☐/☐Depressed Mood
2. ☐/☐Anhedonia
3. ☐/☐Weight change: ☐Loss or ☐Gain
4. ☐/☐Sleep: ☐ Insomnia or ☐ Hypersomnia
5. ☐/☐Psychomotor: ☐ Retardation or ☐ Agitation
6. ☐/☐Fatigue/Loss of Energy
7. ☐/☐Worthlessness or Inappropriate Guilt
8. ☐/☐Concentration Impairment
9. ☐/☐Thoughts of Death or ☐/☐ Suicidal ideation or ☐/☐ Suicide attempt

**Manic Episode/Hypomanic Episode**

☐/☐ A period of elevated, expansive, or irritable mood AND persistently increased goal-directed activity or energy lasting at least one week for a manic episode and at least 4 days for a hypomanic episode and present most of the day nearly every day.
AND –
Three or more of the following (4 if mood is only irritable):

1. ☐/☐ Grandiosity/inflated self-esteem
2. ☐/☐ Decreased need for sleep
3. ☐/☐ Pressured speech
4. ☐/☐ Racing thoughts/Flight of ideas
5. ☐/☐ Distractibility
6. ☐/☐ Increased goal-related activity or psychomotor agitation
7. ☐/☐ Increased risk-taking

**Bipolar I Disorder**

☐ Criteria have been met for at least one manic episode
☐ The symptoms are not better explained by another psychotic disorder (schizoaffective disorder, schizophrenia, etc.)

**Bipolar II Disorder**

☐ Criteria have been met for at least one hypomanic episode
☐ Criteria have been met for a Major Depressive episode

### PSYCHOTIC DISORDERS

**Schizophrenia** (1., 2. or 3. below plus one additional)

1. ☐/☐ Delusions 2. ☐/☐ Hallucinations 3. ☐/☐ Disorganized speech
4. ☐/☐ Negative symptoms (i.e. diminished emotional expression)
5. ☐/☐ Grossly disorganized or catatonic behavior.

AND
☐ Significant decrease in level of functioning since onset AND
☐ Continuous signs of the disorder for at least 6 months

**Schizoaffective Disorder**

☐/☐ Schizophrenia and a major mood episode occur concurrently AND
☐/☐ Delusions or hallucinations in the absence of mood symptoms at some point during the illness AND
☐/☐ Major mood symptoms are present the majority of the time

**Delusional Disorder**

☐/☐ The presence of one or more delusions for at least one month
☐/☐ Schizophrenia criteria have never been met
☐/☐ Apart from the delusion(s), functioning is not very impaired
☐/☐ If Mania or MDD have occurred, they have been brief relative to the duration of the delusion(s)

**Psychotic Disorder NOS**

☐/☐ Symptoms characteristic of schizophrenia or another psychotic disorder are present that cause clinically significant distress or impairment in major life functioning but do not meet the full criteria for any disorder.

### ANXIETY DISORDERS

**Generalized Anxiety Disorder** (must meet first 2 criteria AND 3 of the remaining 6 for at least 6 months)

☐ Excessive worry about many things for at least 6 months AND
☐ Difficulty controlling the worry

1. ☐/☐ Restlessness
2. ☐/☐ Easily Fatigued
3. ☐/☐ Concentration difficulty/mind going blank
4. ☐/☐ Irritability
5. ☐/☐ Muscle Tension
6. ☐/☐ Sleep impairment (initiation, staying asleep)

**Panic Disorder** (must meet first criteria AND 4 of the remaining)

☐/☐ Abrupt surge of intense fear, peaking within minutes AND

- ☐/☐ Increased heart rate
- ☐/☐ Trembling/Shaking
- ☐/☐ Choking sensation
- ☐/☐ Abdominal distress
- ☐/☐ Sweating
- ☐/☐ Fear of dying
- ☐/☐ Chills or hot flushes
- ☐/☐ Derealization/Depersonalization
- ☐/☐ Shortness of breath/Smothering
- ☐/☐ Chest discomfort
- ☐/☐ Light-headed/dizzy/unsteady
- ☐/☐ Fear of losing control/going crazy
- ☐/☐ Numbness/Tingling

At least one attack has been followed by one month of either:
☐ Excessive worry about having another panic attack OR-
☐ A maladaptive change in behavior (i.e. to avoid further attacks)

**Agoraphobia**

Marked fear or anxiety about 2 or more of the following:

- ☐/☐ Using public transportation
- ☐/☐ Being in enclosed spaces
- ☐/☐ Being in open spaces
- ☐/☐ Being outside of the home alone
- ☐/☐ Standing in line or being in a crowd

AND -
☐/☐ Avoidance of such situations because escape might be difficult,
☐/☐ The situations almost always provoke fear/anxiety, AND
☐/☐ The situations are actively avoided, require the presence of a companion, or are endured with intense fear/anxiety.

**Posttraumatic Stress Disorder**

☐ Exposure to a life-threatening event to self or significant other AND -
Intrusion – presence of one or more of the following symptoms:

- ☐ Recurrent, involuntary, and intrusive distressing memories
- ☐ Recurrent distressing dreams related to the event
- ☐ Dissociative reactions (e.g. flashbacks)
- ☐ Intense or prolonged distress at exposure OR
- ☐ Marked physiological reactions to cues that symbolize or resemble the event AND -

Avoidance of Trauma Associations (must meet 1 or more)

- ☐ Internal: Thoughts, feelings, memories
- ☐ External: Activities, places, people, situations AND -

Negative mood/cognitions as evidenced by 2 or more of the following:

- ☐ Inability to recall aspects of the event (not due to TBI)
- ☐ Negative beliefs/expectations about self/others
- ☐ Inappropriate blaming of self or others for the event
- ☐ Persistent negative emotional state (fear, anger, guilt, shame)
- ☐ Diminished interest in significant activities
- ☐ Feelings of detachment or estrangement from others
- ☐ Persistent inability to experience positive emotions AND –

Increased arousal/reactivity as evidenced by 2 or more:

- ☐ Irritability/anger with little or no provocation
- ☐ Reckless or self-destructive behavior
- ☐ Hypervigilance
- ☐ Exaggerated startle response
- ☐ Problems with concentration
- ☐ Sleep disturbance

AND –
☐ Duration of disturbance is greater than one month

**Applicant/Resident:**

**PERSONALITY DISORDERS** - Below is a summary of all personality disorders. If an individual's presentation is consistent with the description, the evaluator should review the specific DSM V diagnostic criteria for the disorder to determine whether diagnostic criteria are met. In all instances, the described symptoms are severe, pervasive, have been present since early adulthood, and are seen in a variety of contexts/situations

**Cluster A:**

Paranoid Personality – Distrust and suspiciousness of other such that their motives are interpreted as malevolent.

Schizoid Personality – Detachment from social relationships and a restricted range of expression of emotions in interpersonal settings.

Schizotypal Personality – Social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships and by cognitive or perceptual distortions and behavioral oddities.

**Cluster B:**

Antisocial Personality – Disregard for and violation of the rights of others, beginning by age 15.

Borderline Personality – Instability of interpersonal relationships, self-image, and affect as well as marked impulsivity.

Histrionic Personality – Excessive emotionality & attention seeking.

Narcissistic Personality – Grandiosity (in fantasy or behavior), an excessive need for admiration, and a marked lack of empathy.

**Cluster C:**

Avoidant Personality – Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality – Excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation.

Obsessive-Compulsive Personality – Preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency.

**ANXIETY DISORDERS (cont.)**

**Obsessive Compulsive Disorder** (must meet 1. or 2. AND 3 or 4.

1. ☐/☐ Obsessions – intrusive thoughts, urges, images that cause marked distress, with an attempt to ignore or suppress with another thought or a compulsion OR
2. ☐/☐ Compulsions –repetitive behavior driven to perform due to an obsession or a set of rigid rules, to reduce anxiety, are not realistically connected to the obsession or are clearly excessive.
3. ☐/☐ Time consuming –more than one hour a day OR
4. ☐/☐ Cause clinically significant distress/impairment

**Somatization Disorder** (must meet first criteria AND 2 additional)

☐/☐ Presence of one or more very distressing somatic symptoms that cannot be fully explained by a general medical condition AND

1. ☐/☐ Disproportionate and persistent thoughts about the symptom
2. ☐/☐ Persistently high level of anxiety about health or symptom(s)
3. ☐/☐ Excessive time and energy devoted to the symptom(s)

AND

☐ Duration of symptoms is 6 months or more.

**ALL DIAGNOSES GIVEN MUST MEET DSM V CRITERIA, NOT TO INCLUDE "V" CODES, SUBSTANCE OR SUBSTANCE-/MEDICATION-INDUCED DISORDERS, NEURODEVELOPMENTAL DISORDERS, AND NEUROCOGNITIVE DISORDERS.**

## SECTION 4: LEVEL OF IMPAIRMENT (ADAPTED FROM CFR 483.102(II)(A)(B)(C))

Functional limitations in major life activities within the past 3 to 6 months. Must have at **least one** of the following characteristics on a **continuing or intermittent** basis in each area - Adaptation to Change, Concentration and Interpersonal Functioning.

**Adaptation to change (serious difficulty)**

- ☐ Adapting to typical changes in circumstances associated with: ☐ Family ☐ School ☐ Social Interaction ☐ Work
- ☐ Exacerbated signs and symptoms associated with the illness
- ☐ Manifests agitation
- ☐ Requires intervention of the mental health or judicial system
- ☐ Withdrawal from the situation

**Concentration, Persistence and Pace (serious difficulty)**

- ☐ Difficulties in concentration
- ☐ Inability to complete simple tasks within an established time period
- ☐ Makes frequent errors
- ☐ Requires assistance in completion of these tasks
- ☐ Sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work setting or work-like structured activities occurring in school or home settings

**Interpersonal Functioning (serious difficulty)**

| | |
|---|---|
| ☐ Maintaining interpersonal relationships | ☐ Employment |
| ☐ Communicating effectively with others | ☐ Criminal Justice Involvement |
| ☐ Housing | ☐ Social Isolation |
| ☐ Fear of strangers | ☐ Violence |

**483.102(iii)(A)(B) Recent Treatment**

- ☐ Psychiatric treatment more intensive than outpatient care **more than once** in the past 2 years: (e.g., partial hospitalization/day treatment or in-patient hospitalization; crisis intervention) **OR**

**Within the last 2 years:**

- ☐ Experienced an episode of significant disruption to the normal living situation which:
  - ☐ Required supportive services **due to serious mental illness**, to maintain function at home or in a residential treatment environment **OR**
  - ☐ Resulted in intervention by housing or law enforcement officials

**Applicant/Resident:**

## SECTION 5.0 MENTAL STATUS EXAMINATION/SUMMARY

### SECTION 5.1 DESCRIPTION

| |
|---|
| Appearance: |
| Attitude: |
| Overt Behavior: |
| Affect: |
| Thought Form & Content: (i.e. linear, logical, tangential): |
| Speech Clarity & Modes of Expression: |

### SECTION 5.2: EVALUATION OF COGNITIVE FUNCTIONING

| | | | | |
|---|---|---|---|---|
| **ORIENTATION: (Y)es, (P)artial, (N)o, (U)nable to assess** | _ - Person | _ - Place | _ - Situation | _ - Time |
| **CONSCIOUSNESS:** | ☐ - Alert | ☐ - Drowsy | ☐ - Delirious | ☐ - Comatose |
| **JUDGMENT:** | Independent ☐ | Modified Independence ☐ | Moderately Impaired ☐ | Severely Impaired ☐ |

| | | | | | |
|---|---|---|---|---|---|
| **MEMORY:** | RECENT: | ☐ Poor | ☐ Fair | ☐ Intact | ☐ Unable to assess |
| | REMOTE: | ☐ Poor | ☐ Fair | ☐ Intact | ☐ Unable to assess |
| **INSIGHT** (Knowledge of Illness) | | ☐ Poor | ☐ Fair | ☐ Intact | ☐ Unable to assess |

**Additional Testing Results (if available):** (i.e. mental status exam, depression inventory. Attach copy.)

**Would the Applicant/Resident benefit from referral for guardianship/conservatorship services?** ☐ YES ☐ NO

### SECTION 5.3: ASSESSMENT FOR DANGER TO SELF OR OTHERS

Do your findings indicate the Applicant/Resident may be a substantial danger to himself/herself or others? ☐ Yes ☐ No
If Yes, does the nursing facility's supervision and structure mitigate the danger? ☐ Yes ☐ No If yes, please explain:

### SECTION 5.4: INTELLECTUAL DISABILITY-RELATED CONDITION

Does the Applicant/Resident have a documented history of intellectual disability? ☐ Yes ☐ No
Does the Applicant/Resident have a documented history of a related condition? ☐ Yes ☐ No
If Yes to either question, what is the diagnosis?

## SECTION 6: CURRENT MEDICATIONS - Psychiatric medications taken within the last 30 days that could mask or mimic symptoms of mental illness:

| MEDICATION | DOSE/FREQUENCY | MEDICATION | DOSE/FREQUENCY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Allergies/Adverse Reactions/Side Effects:

**Applicant/Resident:**

## SECTION 7: MENTAL ILLNESS/SUBSTANCE USE DISORDER DIAGNOSTIC SUMMARY IMPRESSION

| ICD 10 | Diagnosis Description | ICD 10 | Diagnosis Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Diagnostic Formulation:

Recommendations for services to be provided by the Nursing Facility:

Recommendation for Specialized Services for mental illness treatment:

Gradual dose reduction concerns:

## SECTION 8: REVIEW OF RECOMMENDATIONS– ONLY CHECK ONE RECOMMENDATION

### SECTION 8.1: RECOMMENDATIONS FOR CATEGORICAL DETERMINATIONS

☐ **Convalescent Care Stay** ☐ **Short Stay -** Complete Section 14 and sign the evaluation
☐ **Severe Physical Illness** ☐ **Terminal Illness -** Complete Sections 9 through 14 and sign the evaluation

### SECTION 8.2: RECOMMENDATIONS FOR NSMI/DENIAL DETERMINATIONS

☐ **Not Seriously Mentally Ill (NSMI) for purposes of PASRR –** Stop here and sign the evaluation

☐ **Denial A due to the need for acute psychiatric treatment with a medical need that requires NF services**
☐ **Denial B due to the need for acute psychiatric treatment with no medical need**
**Denials A and B –** Complete Section 14 and sign the evaluation

☐ **Denial C due to a lack of medical need and no need for acute psychiatric treatment** – Complete Sections 9 through 14 and sign the evaluation

**For all Denial recommendations:** Inform the Nursing Facility and the State PASRR office (pasrradmin@utah.gov) no later than the day the evaluation is submitted to the online PASRR system.

### SECTION 8.3: RECOMMENDATIONS FOR LONG TERM CARE

☐ **Long Term Care -** Complete Sections 9 through 14 and sign the evaluation.

**Applicant/Resident:**

## SECTION 9: PSYCHOSOCIAL EVALUATION/SUMMARY

**SECTION 9.1: Applicant/Resident's place of residence prior to hospital or nursing facility placement. Include social history (developmental, educational, special education, occupational, marital and social supports)**

**SECTION 9.2: PSYCHOSOCIAL STRENGTHS**

**SECTION 9.3: PSYCHOSOCIAL NEEDS (identify recommendations)**

## SECTION 10: APPLICANT/RESIDENT'S ACTIVITIES OF DAILY LIVING FUNCTIONAL ASSESSMENT

| ACTIVITIES | N/A | SELF INITIATES ADL TASKS INDEPENDENTLY | SUPERVISION, OVERSIGHT, ENCOURAGEMENT OR CUEING | LIMITED ASSISTANCE RECEIVES PHYSICAL HELP (RESIDENT INVOLVED) | EXTENSIVE ASSISTANCE RESIDENT PERFORMED PART OF ACTIVITY | TOTAL DEPENDENCE COMPLETE NON-PARTICIPATION |
|---|---|---|---|---|---|---|
| 1. Toilet Use | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Bladder Continence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Catheter | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Bowel Continence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Locomotion - On unit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| - Off Unit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. ☐ Wheelchair/ ☐ Walker/ ☐ Cane | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Bed Mobility | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Transfers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Verbal/Gestural or Written Communication | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Self-Monitoring of Health Status | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Self-Administration of Medication | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Medication Compliance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Self-Directive Accessing Medical Treatment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Eating & Monitoring of Nutritional Status | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Bathing-Personal Hygiene | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Dressing Skills | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Handling Money | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Source of Information: | | | | | | |

**Applicant/Resident:**

## SECTION 11: NURSING FACILITY SERVICES

Identify the specific nursing facility services that the Applicant/Resident requires for nursing facility placement. Check all that apply.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Assistance with ADL's | ☐ | IV Antibiotics | ☐ | Oxygen | ☐ | Colostomy Care |
| ☐ | Occupational Therapy | ☐ | Feeding Tube | ☐ | Wound Care | ☐ | Monitor Safety (i.e. falls, wandering risk) |
| ☐ | Physical Therapy | ☐ | Monitor Diet | ☐ | Skin Care | ☐ | Total Care for ADL's |
| ☐ | Speech Therapy | ☐ | Monitor Medications | ☐ | Catheter Care | ☐ | Other |

## SECTION 12: DISCHARGE POTENTIAL AND PROGNOSIS FOR NON-INSTITUTIONAL LIVING ARRANGEMENTS

☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

| | | |
|---|---|---|
| **Could Applicant/Resident currently reside in a less restrictive community-based setting?** | ☐ **YES** | ☐ **NO** |
| **Is the Applicant/Resident in agreement with nursing facility placement?** | ☐ **YES** | ☐ **NO** |
| **If no, is the Applicant/Resident medically capable of residing in a non-institutional setting?** | ☐ **YES** | ☐ **NO** |

## SECTION 13: TYPE OF SUPPORTS THAT MAY BE NEEDED TO PERFORM ACTIVITIES IN THE COMMUNITY

If the applicant/resident's medical condition stabilizes, identify the supports that will be needed to perform activities of daily living in the community. Include recommendations & alternative placement options:

## SECTION 14: PASRR LEVEL II NURSING FACILITY LEVELS OF CARE

The request for nursing facility services must document that the applicant/resident has **TWO or MORE** of the following elements according to Administrative Rule R414-502:

| | |
|---|---|
| ☐ | Due to diagnosed medical conditions, the Applicant/Resident requires at least substantial physical assistance with activities of daily living about the level of verbal promptings, supervising, or setting up; |
| ☐ | The attending physician has determined that the Applicant/Resident's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program **(Documentation must be provided to substantiate significant cognitive deficits)**; |
| ☐ | The medical condition and intensity of services indicate that the care needs of the Applicant/Resident cannot be safely met in a less structured setting or without the services and support of an alternative Medicaid health care delivery program **(Justification is provided that less structured alternatives have been explored and why alternatives are not feasible).** |

## SECTION 15: SIGNATURE

| | | |
|---|---|---|
| Completed by: | License: | PASRR Contractor: |
| Evaluator Signature: | | Date: |

Revised 09/21/2021