Instruction Manual for SCREEN Form:

DOH-695 (2/2009)

A Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) must be completed before beginning the SCREEN form.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care
Division of Residential Services

www.nyhealth.gov

TABLE OF CONTENTS

OVERVIEW OF
THE SCREEN and THE PRE-ADMISSION SCREEN RESIDENT REVIEW (PASRR) PROCESS

The SCREEN is required by 10 NYCRR Section 400.12 and is based on Federal Regulations found in 42 CFR Part 483, Subpart C. The SCREEN currently serves two purposes. The first purpose of the SCREEN is to determine the person's potential to be appropriately cared for in a setting other than a Residential Health Care Facility (RHCF). The second purpose of the SCREEN is to assess persons being recommended for RHCF placement for possible mental illness (MI) and/or mental retardation or developmental disabilities (MR/DD) with a Level I Review.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) mandated that all individuals applying to certified Medicaid Residential Health Care Facilities (RHCF) be screened for serious mental illness and/or mental retardation/developmental disability. The legislative intent is to assure that seriously mentally ill (MI) and mentally retarded/developmentally disabled (MR/DD) persons are appropriately placed in order to provide for their treatment needs. If the Level I Review identifies a person suspected of having serious MI and/or MR/DD, the next step is a Level II PASRR (Pre-Admission Screen Resident Review). For a person seeking RHCF placement this is known as the Pre-Admission Screen (PAS of the PASRR). A Level II Referral can also be required in certain situations for those currently residing in a RHCF. This is referred to as a Resident Review (RR of PASRR). The Level II Evaluation will determine if specialized services are required and will provide a treatment recommendation.

Each state is responsible for administering its own PASRR program. The New York State Department of Health (NYSDOH) oversees the PASRR process and reviews compliance with the PASRR requirements to ensure that appropriate assessments are being conducted and that necessary services are being delivered. Non-compliance with the PASRR requirements may result in recoupment of Medicaid funds and/or a citation by the NYSDOH.

GENERAL INSTRUCTIONS FOR COMPLETING THE SCREEN

A SCREEN form may only be completed by health care professionals who have completed the New York State Department of Health SCREEN Certification Course and have been issued a ten digit SCREENER identification number. Qualified SCREENERS in RHCFs, hospitals, Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), other community-based agencies and independent health care professionals may complete the SCREEN form. As a qualified SCREENER, you are responsible for periodically checking the New York State Department of Health (NYSDOH) website: **www.nyhealth.gov** and/or the Health Provider Network (HPN) for updates to the SCREEN form and instructions. If your facility does not have a HPN account, please contact the Commerce Accounts Management Unit at 1-866-529-1890.

A SCREEN IS NEEDED:

- Prior to admission to a RHCF for **every person**, for any length of stay.
- Prior to or within 24 hours of a hospitalized patient being designated as Alternate Level of Care (ALC) and every 30 days thereafter until hospital discharge. (See10NYCRR Section 85.8)
- As soon as possible when the ALC patient's status changes as evidenced by a change in the patient's assigned Resource Utilization Group (RUG II). (See10NYCRR Section 85.8)
- If a RHCF resident is **newly diagnosed** with a mental illness and/or mental retardation/developmental disability, a new SCREEN and Level II referral must be completed within 14 calendar days (See 42 CFR 483.20(e) & 483.108(c); 42 USC 1396r(e)(7)).
- If a RHCF resident, who was previously identified as having mental illness and/or mental retardation/developmental disability, is identified as having experienced a significant change in physical and/or mental condition. A new SCREEN and Level II Evaluation must be completed within 14 calendar days. (See 42 U.S.C. Section 1396r(e)(7)(B)(iii)).
- If a resident of a RHCF, who was identified as having mental illness and/or mental retardation/developmental disability on their admission SCREEN Level I Review and met the criteria for Categorical Determination (convalescent care, seriously physically ill, terminally ill, or provisional emergency admission), requires a length of stay longer than the appropriate physician documented number of days. A SCREEN and Level II Evaluation must then be completed. (See 42 CFR, Part 483, Subpart C)
- If a resident of a RHCF, who was identified as having mental illness and/or mental retardation/developmental disability on their admission SCREEN Level I Review, and met the criteria for Categorical Determination for a brief or finite stay (requiring less than a 30 day stay), requires a length of stay longer than 30 days. A SCREEN and Level II Evaluation must be completed by the 40th day. (See 42 CFR, Part 483, Subpart C)

NOTE: The RHCF is responsible for ensuring that a copy of the resident's most recent SCREEN, which may include a Level II evaluation, accompanies the resident upon transfer to a hospital or another RHCF. (See 42 CFR 483.106) For residents who are discharged to the community with skilled services, it is suggested that, for informational purposes, a copy of the most recent SCREEN, and Level II evaluation as appropriate, be made available to the service provider.

WHEN COMPLETING THE SCREEN FORM FOR PERSONS UNDER THE AGE OF 18:

- Complete items 1- 6 and items 22-38 ONLY.
- Item 27, CONVALESCENT CARE is amended to 365 days.
- For residents 18 years of age or older, or for emancipated minors, follow the rules for the adult population.

DOCUMENTATION GUIDELINES FOR COMPLETING THE SCREEN

- This is a legal document.
- Black or blue ink is required to enter your answers.
- If an incorrect entry is made, place one line through the incorrect response and make the appropriate change.
- All changes must be initialed.
- Do not use whiteout.
- This form may not be updated. A new SCREEN form must be completed.

SOURCES OF DATA

In order to complete the SCREEN, the SCREENER must review a current (one that has been completed within the last 90 days and reflects this person's current status) completed Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI). Use as many sources of data as are relevant and available. This may include observation, documentation, or verbal communication. Any pertinent observations or verbal communication relating to the completion of the SCREEN must be documented in the medical record by the SCREENER.
Examples of data sources may include:

- Patient
- Informal supports – family, friends, neighbors
- Formal service agencies
- Patient record
- Professional staff
    - Nursing
    - Social work
    - Physicians
    - Therapists
    - Aides
    - Ancillary staff

SCREEN COMPONENTS

There are four (4) components to the SCREEN. The components must be completed in order following the step by step instructions.

1.) The first component of the SCREEN (items 1-6) is the identification information. These items must be completed every time the SCREEN is completed.

2.) The second component of the SCREEN (items 7-21) is used to determine the person's potential for placement in a community setting.

3.) The third component of the SCREEN (items 22-35) is a Level I Review to identify those suspected of having serious MI and/or MR/DD. Persons suspected of having serious MI and/or MR/DD must be referred for the Level II PASRR to determine if there is a need for specialized services.

4.) The fourth component of the SCREEN (items 36-38) includes the person's disposition based on items 1-35. This also includes acknowledgements by the person/representative and the SCREENER.

The detailed SCREEN instructions that follow explain item by item how the SCREEN form should be filled out. Many of the items are arranged in such a way that either a YES or NO answer is the only possible outcome. Whether the SCREENER answers YES or NO determines which item is answered next. Thus, the items must be answered in the appropriate sequence.

DETAILED INSTRUCTIONS FOR COMPLETING THE SCREEN

IDENTIFICATION

1. **Facility Operating Certificate Number**
   - Seven numbers followed by a letter (H or N)
     - H = Hospital
     - N = Nursing Facility
   - CHHA certificates consist of seven numbers with no letter.
   - Independent SCREENER enter "0" on this line.

2. **Patient/Resident/Person's Social Security Number**
   - If there is no number or it is not known, print "0" on this line.

3. **Name of Person(s) Completing SCREEN**
   - Print or type
   - First name first, then last name

4. **Patient/Resident/Person's Name**
   - Print or type
   - First name first, then last name

5. **Date of H/C PRI or PRI Completion**
   - Enter the date of the current PRI or H/C PRI. Use this to complete the SCREEN.

6a. Date of SCREEN Initiation
   - Enter the date the SCREEN was begun.

6b. Date of SCREEN Completion
   - Enter the date the SCREEN was completed. This date should match item 39.

DIRECT REFERRAL FACTOR FOR RESIDENTIAL HEALTH CARE FACILITY (RHCF)

YES NO

7. ☐ ☐ **This person has a home in the community (owns or rents a home, lives in an Adult Care Facility [ACF] or with family or friends) and that residence is still available OR appropriate community based living can be arranged OR this person is eligible for an Adult Care Facility**.

NOTE: This item addresses physical living space only!

NOTE: FOR ADULT CARE FACILITIES

The characteristics of Adult Care Facility residents vary among facilities. As a guideline, a person can be cared for in an Adult Care Facility if :

- all PRI or H/C PRI ADL responses = 1 or 2 (see PRI or H/C PRI part III, Items 19-22),

AND

- This person can vacate the building independently in the event of an emergency.

YES

This person owns or rents a home.

OR

He/she lives with family or friends.

OR

He/she lives in an Adult Care Facility.

AND

That residence is still available for this person.

OR

NO

All potential alternatives for community based living space have been investigated and none can be arranged.

This person is eligible for an Adult Care Facility.

OR
Appropriate community based living can be arranged.

Guideline: If item 7 is marked **YES**, proceed to DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT (items 8 –12).
If item 7 is marked **NO**, explain on a separate sheet of paper and attach to this form; refer to RHCF. Proceed to REFERRAL RECOMMENDATION (item 21).

DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT

YES NO

8. ☐ ☐ This person understands information given and opposes placement/continued stay in a Residential Health Care Facility.

YES	**NO**
This person has a realistic understanding of their capabilities.	This person considers nursing home placement/continued stay to be a favorable alternative.
AND	**AND**
This person is strongly motivated to return to or remain at home.	This person has considered entering/remaining in a nursing home.
AND	**OR**
This person understands and accepts any risk associated with home placement.	This person opposes entering/remaining in a nursing home but is unrealistic about ability to return to/remain at home.
	OR
	This person does not understand risk(s) associated with home placement.
	OR
	This person is non-responsive (i.e., heavily medicated, or comatose).

NOTE: If the answer(s) cannot be determined, answer **"NO".**

YES NO

9. ☐ ☐ **This person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility. Evaluator specifically described all necessary community services and described private resources (such as insurance coverage, savings, income or financial aid provided by a spouse, relative or friend) that may be available to pay for such services. Medicare and Medicaid should NOT be included as private financial resources.**

YES	**NO**
This person has private financial resources to pay for community living expenses and services.	Private financial resources are not sufficient to purchase the amount of care needed and to cover living expenses.
AND	**OR**
This person agrees to use these financial resources for care at home or in an Adult Care Facility.	This person refuses to use private resources for home care.

YES NO

10. ☐ ☐ This person has an informal support system. Individuals in this system are willing and are physically and mentally capable of caring for this person, and providing for most of his/her specific needs.

NOTE:

An informal support is any person who provides any service to this person on a voluntary (not paid) basis.

Include service providers that charge no fee or a nominal fee (i.e., friendly visiting) as informal supports.

YES	**NO**
This person has someone to provide service on a voluntary (not paid) basis.	Informal supports have limitations which render them incapable of caring for most of this person's needs such as:
AND	• mental illness
Informal supports have a realistic understanding of this person's needs.	• physical illness
	• full time employment • significant distance • care of young children • care of other disabled persons.
AND	**OR**
Informal supports are willing, as well as physically and mentally capable of providing for most of the specific needs, or will be capable with instruction.	Informal supports are not willing to meet most of the specific needs of this person.
AND	**OR**
This person wants to receive care from informal supports.	This person does not want to receive care from informal supports.

YES NO

11. ☐ ☐ All ADL responses = 1 or 2 (see PRI or H/C PRI PART III, 19-22).

NOTE:
Refer to the H/C PRI or the PRI, PART III, ACTIVITIES OF DAILY LIVING (ADL), questions 19-22.

YES	**NO**
All ADL responses are either 1 or 2. Include Eating, Mobility, Transfers and Toileting.	Any of ADL responses are a 3, 4, or 5.

YES NO

12. ☐ ☐ This person was independent in ADLs prior to most recent acute episode and shows good rate of return of physical and mental functioning.

NOTE:

This decision should be based on information from the person, medical records and informal supports.

"Independent" means being able to perform ADLs and Instrumental Activities of Daily Living (IADLs) without supervision or physical assistance.

IADLs mean instrumental activities of daily living (e.g. shopping, laundry, housekeeping).

YES	**NO**
This person performed ADLs and IADLs independently prior to his/her most recent acute episode (or most recent exacerbation of chronic illness).	This person needed supervision or assistance with ADLs or IADLs prior to the most recent acute episode (or most recent exacerbation of chronic illness).
AND	**OR**
This person's good rate of return is exhibited by increasing strength and ability to bear weight and to perform active range of motion.	This person is recovering function at a substantially lesser rate than expected.
OR	
If this person has mental impairment, a good rate of return is exhibited by increasing orientation and ability to perform daily tasks.	

NOTE: Community Based Assessment Guidelines

What is a community based assessment?

A review of a person's environment, informal supports, economic status and physical and mental needs, as they relate to the possibility of care being provided to them in the community. An actual visit does not have to be made to this person's home.

Who can do a community based assessment?

Only individuals from authorized agencies, which include:

1. All certified home health care agencies including VNA and Public Health
2. The Lombardi Long Term Home Health Care Program
3. CASA's (Community Alternative Systems Agency)

What information should the written assessment contain?

1. There is no required form, only what a particular agency chooses to use
2. Name and phone number of agency, date of assessment
3. Name and case number of resident/patient/person
4. Determination:
   a) If this person can be cared for at home, include a recommended plan of care.
   b) If this person cannot be cared for at home, include reasons.

While there is no mandatory time frame for completion of the community based assessment, the SCREEN process cannot continue until the results of the community based assessment are obtained.

Results:

1. Once the community based assessment is returned to the SCREENER, the form is attached to the SCREEN.
2. If the community based assessment indicates that care cannot be given in the community, the SCREENER continues with the Home and Caregiving Arrangements section on the SCREEN.

If the community based assessment indicates that care can be given in the community, the SCREENER goes directly to Referral Recommendation (item 21) and checks c.1.

Guidelines:

If any direct referral factor (items 8-12) is marked **YES**, refer to a Certified Home Health Agency (CHHA) for a community based assessment. Attach the community based assessment to the SCREEN, then proceed to REFERRAL RECOMMENDATIONS (item 21). If all referral factors (items 8-12) are marked **NO,** proceed to HOME AND CAREGIVING ARRANGEMENTS (item 13).

HOME AND CAREGIVING ARRANGEMENTS

NOTE: Items 13 through 20 should be answered according to the information that is available at the time you are completing this form.

13. a. Estimate the total number of hours per day that the informal support(s) system is willing and able to provide supervision or assistance to this person. **a.____**

b. Estimate the total number of hours per day that this person can be alone. **b.____**

c. Add a. and b. (a + b = c) **c.____**

YES NO

☐ ☐ **d. Does c. total 12 or more hours?**

13a. Estimate the total number of hours per day that informal support(s) system is willing and able to provide supervision or assistance to this person. **a._____**

13 a. NOTE:

Do **not** consider the times of day, **only the number of hours**.

An informal support is any person who provides any service to this person on a voluntary (not paid) basis.

Include service providers that charge no fee or a nominal fee (i.e., friendly visiting) as informal supports.

1. Consider all informal support persons who could provide help, and total the hours per day that these people are willing and able to provide supervision or assistance. Include sleeping time, if informal support persons are willing and able to attend to this person's needs during these hours.

OR

Average out the hours of informal support time per day. If informal support persons cannot be present daily or if hours per day vary, total the number of hours per week for all informal supports, and divide by seven to arrive at the average daily hours.

2. Enter the hours per day that informal supports are available in item 13a.

13 b. Estimate the total number of hours per day that this person can be alone. b.____

Note:
Do not consider the times of day, only the number of hours. For the purpose of this estimate, DO NOT include any hours that informal or formal support assistance is present.

Consider this person's ability to perform unscheduled activities (such as toileting or use of toileting equipment) (PRI or H/C PRI PART II, 22).

AND

All tasks that this person can perform without supervision or assistance (PRI or H/C PRI, PART III, 19-22).

AND

The amount of time that this person is NOT physically active.

AND

This person's orientation including:

- Ability to perform daily tasks independently.
- Is there a history of unpredictable behavior?

Average the hours. If the hours per day vary, total the number of hours per week that this person can be alone and divide by seven for the average daily hours.
Enter the hours per day that this person can be alone in item 13b.

13 c. Add a and b (a + b =c) c._____

Add 13a (total number of hours per day of informal support) to 13b (total number of hours per day that the person can be alone).

Enter the hours per day (13a + 13b) in item 13c.

YES NO

13 d. ☐ ☐ **Does c. total 12 or more hours?**

YES	**NO**
The sum of 13a and 13b (as entered in 13c) is twelve (12) hours or more.	The sum of 13a and 13b is less than twelve (12) hours.

Guideline: If item 13 d is marked YES, proceed to item 16.
If item 13 d is marked NO, proceed to item 14.

YES NO

14. ☐ ☐ **Can the number of hours that this person is attended by self or informal supports be expected to increase to 12 or more hours per day within six months?**

YES	**NO**
According to your estimate, the number of hours that this person can be alone (as entered in item 13b) or attended by informal supports (as entered in item 13a) can be increased to twelve (12) or more hours (12) within six (6) months.	The number of hours this person can be alone or attended by informal supports is not expected to increase to twelve hours or more within six (6) months.

Guideline: If item 14 is marked YES, proceed to item 16.
If item 14 is marked NO, proceed to item 15.

15. If the answer to item 14 is NO, enter reason(s) (a, b, and/or c):_____

a. This person's physical and/or mental condition is not expected to improve to a degree that would permit increased self care within six months.

b. This person has no informal supports.

c. Informal supports are unable or unwilling to provide additional assistance, or person does not want care from informal supports.

15 a. This person's physical and/or mental condition is not expected to improve to a degree that would permit increased self care within six months.

Choose a if:

- This person is not expected to have significant physical improvement within six (6) months.

AND/OR

- This person is not expected to have significant mental improvement within six (6) months.

15 b. This person has no informal supports.

Choose b if:

- No one can provide any service to this person on a voluntary basis.

15 c. Informal supports are unable or unwilling to provide additional assistance or this person does not want care from informal supports.

Choose c if:

- There are people who provide assistance on a voluntary basis, but they will be limited in the amount of assistance they can provide because of full-time employment, physical/mental incapacity, caring for young children or another disabled person, distance from person and/or travel is unrealistic.

OR

- Informal supports are unwilling to provide additional assistance.

OR

- Informal supports are available, but this person has stated that he/she does not want care from informal supports.

Guideline: Proceed to item 16.

YES NO

16. ☐ ☐ Is there a need for restorative services documented by a physician or rehabilitation specialist?

NOTE:
" Restorative Services" are provided to persons who are:

- expected to improve or regain functioning,
- are not maintenance or preventative services,
- require a licensed professional therapist for supervision or performance,
- include physical, mental or sensory restoration.

"Rehabilitation Specialist" is a licensed professional with specialized rehabilitative training (physiatrist, physical therapist, occupational therapist, speech pathologist).

YES	**NO**
A rehabilitation specialist or physician has evaluated this person.	This person has not been evaluated for restorative potential.
AND	**OR**
The rehabilitation specialist or physician has documented that he/she needs restorative services in order to regain functioning.	This person has been evaluated and the rehabilitation specialist or physician has not documented the need for restorative services.
	OR
	This person has been evaluated and the rehabilitative specialist or physician has documented the need for services to maintain present level of functioning or to prevent deterioration.

Guideline: If item 16 is marked YES, proceed to item 17.
If item 16 is marked NO, proceed to item 19.

YES NO

17. ☐ ☐ **Can this person receive restorative services at home, at adult day care, or as an outpatient?**

YES	**NO**
Adequate restorative services are available in this person's community.	All available community based restorative services have been investigated.
AND	**AND**
He/she can access these services.	This person cannot receive restorative services at home, at adult day care or as an outpatient.
AND	
He /she can afford the services, or they are covered by his/her insurance.	

Guideline: If item 17 is marked YES, proceed to item 19.
If item 17 is marked NO, proceed to item 18.

18. If the answer to item 17 is NO, enter principal reason(s) (a, b and/or c): ____

a. Restorative services are not available in this person's community.
b. Restorative services are too costly or not covered in this person's community.
c. This person cannot access restorative services in their community.

18 a. Restorative services are not available in person's community.

NOTE: Enter this response only after investigating all sources of restorative services in the community. "Community" means the person's home or outpatient setting.

Choose a if:

- Restorative services are needed at a frequency not available in this person's community.

OR

- Intensity of services needed exceeds that which is available in this person's community. "Intensity" means the number of times per day services are needed, duration of visits, types of service and special equipment requirements.

18 b. Restorative services are too costly or not covered in this person's community.

NOTE: Investigate person's insurance coverage. Compare the cost of community based restorative services with the cost of the nursing home.

Choose b if:

- Services are not covered by this person's insurance.

OR

- Services would be less costly if this person entered or remained in a nursing home.

18 c. This person cannot access restorative services in their community.

NOTE: "Access" means the ability to obtain transportation to and from restorative services. Investigate availability and cost of transportation. Evaluate if this person's medical condition will allow them to access various modes of transportation.

Choose c if:

- Transportation cannot be arranged for outpatient visits.

OR

- Cost of transportation is prohibitive.

OR

- Transportation cannot be tolerated by this person for medical reasons.

Guideline: Proceed to item 19.

YES NO

19. ☐ ☐ Does this person have any risk factors that could cause undue risk to self or others if placed in the community? If YES, enter reason(s) (a, b, c, and/or d): ____

NOTE: Evaluate this person's potential risks based on the reasons below.
If there is a risk factor, answer **YES** and enter the reason(s): a, b, c, and/or d.
If there are NO risk factors, the answer is **NO.**

19 a. This person has history of unpredictable behaviors and may injure self or others. This condition is not temporary.

19 b. Comatose (PRI or H/C PRI Part II, 17A) or all ADL responses = 4 or 5 (PRI or H/C PRI PART III, 19-22).

19 c. Requires constant monitoring due to health threatening medical conditions.

19 d. Skilled services are needed at least one (1) time per day and cannot be delegated to nonprofessionals or informal supports.

19 a. This person has a history of unpredictable behaviors and may injure self or others. This condition is not temporary.

YES	**NO**
This person exhibits frequent violent or unsafe behaviors toward self or others.	This person is somewhat forgetful.
OR	**OR**
He/she exhibits regressive or passive behavior to the point of failing to care for self or to receive care.	The condition is expected to improve within six months due to rehabilitation or therapeutic intervention.
AND	
Without constant supervision his/her behavior will result in injury to self or others.	

19 b. Comatose or all ADL responses = 4 or 5 (PRI or H/C PRI PART III, 19-22).

YES	NO
This person is comatose as documented on the PRI or H/C PRI (PART II, 17 A.).	This person is not comatose.
OR	**OR**
All ADL responses are 4 or 5 on the PRI or H/C PRI (PART III, 19-22).	All ADL responses do not = 4 or 5.
	OR
	There is no undue risk due to these conditions because this person is constantly attended by informal supports.
	OR
	This person is expected to improve or be rehabilitated within six months.

19 c. Requires constant monitoring due to health threatening medical problems.

YES	NO
This person's life will be threatened or there will be a significant decline in health if this person is not closely monitored.	There is no undue risk to this person if not closely monitored.
	OR
	This person is expected to improve or be rehabilitated within six months.

19 d. Skilled services are needed at least one (1) time per day and cannot be delegated to nonprofessionals or informal supports.

NOTE: Only consider skilled services as documented on the PRI or H/C PRI Part II, 18A - M. Skilled Services do **not** include physical and occupational therapies.

YES	**NO**
Skilled services, such as nursing treatments, respiratory therapy, and others (see PRI or H/C PRI PART II 18, A-M) are absolutely necessary at least one (1) time per day.	This person does not need skilled services at least one (1) time per day.
AND	**OR**
These services must be performed by a licensed professional.	Informal supports are available, willing, and could be trained to perform the services.
AND	**OR**
These services cannot be learned by informal supports or nonprofessional/paraprofessional personnel.	This person's condition is expected to improve to the point that skilled services will not be needed every day within the next six (6) months.
AND	
The need for these services is not temporary but continuous; that is, within six (6) months, the condition is not likely to improve to the point that these services will not be necessary on a daily basis.	

Guideline: Proceed to item 20.

YES NO

20. ☐ ☐ **Based on the answer to item 19, can this person be placed safely in the community without causing undue risk to self or others?**

YES	NO
This person has no identifiable risks as determined in item 19.	The answer to item 19 was YES. This person cannot be placed safely in the community due to the risk factor(s) identified in item 19 (a, b, c, and/or d). **AND** <u>The risk will still exist after 6 months.</u>

GUIDELINE: Proceed to item 21.

REFERRAL RECOMMENDATION

21. Based on the information obtained by the screener during the screen assessment, check the principal referral recommendation and reason, and explain as needed:

a. RHCF:

1. ( ) A community based assessment was done by a Certified Home Health Agency (CHHA), and it was determined that this person cannot be cared for in the community. This community assessment represents this person's current status.

2. ( ) This person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility, or cannot live with family or friends).

3. ( ) Appropriate community based living cannot be arranged because this person cannot be adequately cared for in the community and/or is a risk to self or others.

4. ( ) Both community based and RHCF care are being investigated. Recommendation is RHCF.

b. RHCF for Restorative Services:

1. ( ) This person cannot receive restorative services in their community.

c. Community:

1. ( ) A CHHA completed a community based assessment and determined that this person can be cared for in the community.

NOTE: Your referral recommendation is based on the information entered on the SCREEN form for items 7-20, and community based assessment if required. Check the principal reason for your Referral Recommendation.

21a. RHCF:

1. ( ) A community based assessment was done by a Certified Home Health Agency (CHHA), and it was determined that this person cannot be cared for in the community. This community assessment represents this person's current status.

NOTE: This answer (21 a. 1.) is based on the Community Based Assessment completed by the CHHA.

2. ( ) This person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility, or cannot live with family or friends).

NOTE: Choose this answer (21 a. 2.) if item 7 is NO

3. ( ) Appropriate community based living cannot be arranged because this person cannot be adequately cared for in the community, and/or is at risk to self or others.

NOTE: Choose this answer (21 a. 3.) if there is a principal reason listed in item 15 and /or item 20 is answered NO.

4. ( ) Both community based and RHCF care are being investigated. Recommendation is RHCF.

NOTE: If choosing this answer (21 a. 4.) please explain.

b. RHCF for Restorative Services:

1. ( ) This person cannot receive restorative services in their community.

NOTE: Choose this answer if item 17 is NO.

c. Community:

1. ( ) A CHHA completed a community based assessment and determined that this person can be cared for in the community.

NOTE: This answer (21 c. 1.) is based on the Community Based Assessment completed by the CHHA.

Guideline: If RHCF (item 21a) or RHCF for Restorative Services (item 21b) is chosen, proceed to item 22. If Community (item 21c) is chosen, proceed to item 36.

DEMENTIA DIAGNOSIS

YES NO

22. ☐ ☐ Does this person have a dementia diagnosis (including Alzheimer's disease) documented in the medical record?

YES	**NO**
This person has a diagnosis of dementia that is documented in the medical record.	This person does not have a diagnosis of dementia documented in the medical record.

Guideline: Proceed to item 23.

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

YES NO

23. ☐ ☐ **Does this person have a serious mental illness?**

YES

An individual is considered to have a serious mental illness (MI) if the individual meets all of the following requirements on diagnosis, level of impairment and duration of illness /recent treatment:

(i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders

The mental disorder is:

A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability;

AND

NOTE: ***Major life activities** include:

- self care
- understanding and use of language
- learning
- mobility
- self direction
- capacity for independent living

(ii) Level of Impairment. The disorder results in functional limitations within the past 3 to 6 months in ***major life activities** that would be appropriate for the individual's developmental stage. An individual

NO

The person does not meet all criteria listed in the YES column for:

- Diagnosis
- Level of Impairment
- Recent Treatment
- Duration of Illness

typically has at least one (1) 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, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

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; and

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.

AND

(iii) Recent duration of illness/treatment. The treatment history indicates that the individual has experienced at least one (1) of the following:

A) Psychiatric treatment more intensive than outpatient care more than once in the past two (2) years (e.g., partial hospitalization or inpatient

hospitalization);

OR

B) Within the last two (2) years, due to the mental disorder, 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.

Guideline: Proceed to Level I Review for Possible Mental Retardation/Developmental Disability (MR/DD) items 24-26.

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

NOTE: Answer **ALL** items 24-26 in order.

YES NO

24. ☐ ☐ **Does this person have a diagnosis or documented history of mental retardation and/or a developmental disability, and did the mental retardation or developmental disability manifest itself prior to age 22, and is it likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of major life activity?**

DEFINITIONS (Mental Hygiene Law section 1.03 (22)

"Mental Retardation" means subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

"Developmental disability" means a disability of a person which:

(a) (1) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, or autism;

(2) is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such person; or services similar to those required for such person; or

(3) is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

(b) originates before such person attains age twenty-two (22);

(c) has continued or can be expected to continue indefinitely; and

(d) constitutes a substantial handicap to such person's ability to function normally in society.

This person's records must clearly indicate that the disability manifested prior to this person's 22nd birthday. Such evidence may include documentation or notations in a medical or clinical

record by a physician, psychologist or other clinicians. Documentation may also include records provided by other service providers, agencies or institutions as well as educational records. However, such evidence should indicate that the services were provided to address this person's mental retardation or other developmental disability and not another type of disability.

Traumatic Brain Injury (TBI) may qualify as a developmental disability if the brain injury and related substantial adaptive deficits occurred prior to age 22. TBI can result in a neurological impairment but must occur prior to this person's 22nd birthday to qualify as a developmental disability.

NOTE:
The following codes found in this person's medical record may be indicators of a possible diagnosis of mental retardation or other developmental disability.

1. Retardation
   - Mild Mental Retardation (317.0)
   - Moderate Mental Retardation (318.0)
   - Severe Mental Retardation (318.1)
   - Profound Mental Retardation (318.2)
   - Unspecified Mental Retardation (319.0)
2. Epilepsy
   - General Nonconvulsive Epilepsy (345.0)
   - Generalized Convulsive Epilepsy (345.1)
   - Petit Mal Status (345.2)
   - Grand Mal Status (345.3)
   - Partial Epilepsy, With Impairment of Consciousness (345.4)
   - Partial Epilepsy, Without Mention of Impairment or Consciousness (345.6)
   - Infantile Spasms (345.6)
   - Epilepsia Partialis Continua (345.7)
   - Other Forms of Epilepsy (345.8)
   - Epilepsy, Unspecified (345.9)
3. Pervasive Developmental Disorder
   - Autistic Disorder
   - Not Otherwise Specified (299.80)
4. Cerebral Palsy
   - Diplegic (343.0)
   - Hemiplegic (343.1)
   - Quadriplegic (343.2)
   - Monoplegic (343.3)
   - Infantile Hemiplegia (343.4)
   - Other Specified Infantile Cerebral Palsy (343.8)
   - Infantile Cerebral Palsy, Unspecified (343.9)
   - Symptomatic Torsion Dystonia (333.7)

The SCREENER may rely on documentation of the above evidence in existing records or may rely on his/her observations or conversations. If the SCREENER relies on observation or interviews for determining onset of the problem and degree of substantial functional limitations, he/she must document affirmative responses to each item, and the source of each verification.

YES	NO
This person has a diagnosis of mental retardation or a developmental disability as defined above and documented in the medical record.	This person does not have a diagnosis of mental retardation or a developmental disability as defined above and documented in the medical record.
AND	**OR**
It is manifested before this person reached age twenty-two (22).	This person does not meet criteria listed under the YES column.
AND	
It is likely to continue indefinitely.	
AND	
It results in substantial functional limitations in three (3) or more of the areas of major life activity: self care understanding and use of language learning mobility self direction capacity for independent living	

Guideline: Proceed to item 25.

YES NO

25. ☐ ☐ Has this person ever been deemed eligible for and/or received MR/DD services, or has this person been referred by an agency that serves persons with MR/DD?

NOTE:
Many agencies serve individuals with various disabilities, including persons with mental retardation or developmental disabilities. There must be verification that the services provided by an agency were provided to the person being screened to address the person's mental retardation or other developmental disability, and not another type of disability.

Verification of services provided must be documented in the medical or clinical records. If verbal verification of such services is obtained through conversation or interview, the screener should include this information in the person's Level II referral.

If there is a question regarding a particular agency, contact the appropriate OMRDD Developmental Disabilities Services Office (DDSO).

YES	**NO**
This person is currently receiving services from an agency that serves persons with MR/DD.	This person is NOT currently receiving services from an agency that serves persons with MR/DD.
OR	**AND**
This person was receiving services from an agency that serves persons with MR/DD prior to hospitalization.	This person was not receiving services from an agency that serves persons with MR/DD prior to hospitalization.
OR	**AND**
This person was referred to the hospital, CHHA, etc. by an agency that serves persons with MR/DD.	This person was not referred to the hospital, CHHA, etc., by an agency that serves persons with MR/DD.
AND	
This person was deemed eligible for that agency's services because of MR/DD.	

Guideline: Proceed to item 26.

YES NO

26. ☐ ☐ Does this person present with evidence of cognitive deficits and/or adaptive skill deficits that may indicate the presence of mental retardation or developmental disability?

NOTE:
When the person's records do not include documentation of a diagnosis of mental retardation or developmental disability or the involvement of an agency that provides services to persons with such disabilities, the SCREENER may rely on observations or conversations AND information provided by family members, caregivers, or the person himself.

Information obtained through conversation and observation must relate to the definition of mental retardation and developmental disabilities as described on pages 33 through 35 in these instructions, and refer to a history of this person that can be supported by medical records, clinical reports and/or school records that may exist but are not in the record available to the SCREENER. The SCREENER should document conversations and interviews to support a finding that a person may have mental retardation or a developmental disability.

If the person is reported to have received a head injury which has resulted in substantial handicaps to the person's ability to function normally in society, the head injury must have occurred prior to age 22 to possibly qualify as a developmental disability.

YES	**NO**
This person's records document evidence which may indicate the presence of mental retardation or developmental disability.	The person does not present documented evidence, which may indicate the presence of mental retardation or developmental disability.
OR	**AND**
Verbal evidence has been obtained and documented by the SCREENER which may indicate the presence of mental retardation or developmental disability.	No other information has been obtained by the SCREENER that would indicate the presence of mental retardation or developmental disability.
OR	**AND**
This person has had a TBI prior to age 22 with evidence of cognitive deficits and/or adaptive skill deficits.	No TBI prior to age 22 or this person has had a TBI prior to age 22 with NO evidence of cognitive deficits and/or adaptive skill deficits.

Guideline: If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30). If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).

CATEGORICAL DETERMINATIONS

NOTE: Answer all items 27-30.

YES NO

27. ☐ ☐ **Does this person qualify for convalescent care?**

NOTE:
Convalescent care is defined as a medically prescribed period of post acute hospital care recovery in a RHCF not to exceed one hundred and twenty (120) days as documented by the physician in the medical record, e.g. discharge plan.

YES	**NO**
This person qualifies for convalescent care as defined above.	This person does not qualify for convalescent care as defined above.

Guideline: Proceed to item 28.

YES NO

28. ☐ ☐ **Is this person seriously physically ill?**

NOTE:
Examples of a seriously physically ill person can include a person who is comatose, ventilator dependent, or has a diagnosis of one (1) of the following chronic debilitating conditions at a severe level:

Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis or Congestive Heart Failure as documented in the medical record, and whose PRI or H/C PRI responses are 3, 4, or 5 (see PRI or H/C PRI Part III, items 19-22).

YES	**NO**
This person meets the above definition of seriously physically ill.	This person does not meet the above definition of seriously physically ill.
AND	**OR**
All ADL responses are 3, 4, or 5 (See PRI or H/C PRI Part III, items 19-22).	All ADL responses are NOT 3, 4, or 5 (See PRI or H/C PRI Part III, items 19-22).

Guideline: Proceed to item 29.

YES NO

29. ☐ ☐ **Is this person terminally ill?**

NOTE:
The definition of a terminally ill person is a person for whom there is documentation in the medical record by a physician that his/her life expectancy is six (6) months or less.

YES	**NO**
This person meets the above definition of terminally ill.	This person does not meet the above definition of terminally ill.

GUIDELINE: Proceed to item 30.

YES NO

30. ☐ ☐ Is this person to be admitted for a very brief and finite stay or a provisional emergency admission?

NOTE:
A very brief and finite stay is defined as a stay in which the duration is expected to be 30 days or less (e.g., scheduled short term care stay (respite)).
A provisional emergency admission is defined as a stay in which the duration is not to exceed 7 days and the purpose is to provide protective services.
Documentation describing either of the above "stays" is required.

YES	**NO**
This person meets the criteria for a brief and finite stay or a provisional emergency admission.	This person does NOT meet the criteria for a very brief and finite stay or a provisional emergency admission.

Guideline: If any of the items 27-30 are marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 31). If all are marked NO, proceed to LEVEL II REFERRALS (item 33).

DANGER TO SELF OR OTHERS QUALIFIERS

YES NO

31. ☐ ☐ **Based on your interview with this person (and/or available informants), and/or a review of this person's medical record, is there any evidence to suggest that this person is, or may have been, a danger to self or others during the past two (2) years?**

NOTE:
If your interview with this person and/or knowledgeable informants, and/or review of this person's medical records raises any questions about whether this person is a danger to self or others, **answer this question YES and seek a psychiatric evaluation.**

YES	**NO**
There is evidence to suggest that this person is, or may have been, a danger to self or others during the past two (2) years.	There is no evidence to suggest that this person is, or may have been, a danger to self or others during the past two (2) years.

GUIDELINE: If item 31 is marked YES, proceed to item 32. If item 31 is marked NO, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

YES NO

32. ☐ ☐ Has this person been deemed a danger to self or others based on a current psychiatric evaluation by a licensed mental health professional?

NOTE:

- A current psychiatric evaluation is one which has been completed within three (3) months prior to the date of this SCREEN completion.
- An existing psychiatric evaluation must address the issue of a danger to self or others for the evaluation to be valid.
- If there is no existing psychiatric evaluation one must be completed. It does not need to be a full psychiatric evaluation but must address the issue of a danger to self or others.
- There is no mandatory form required for purposes of completing the psychiatric evaluation.
- All psychiatric evaluations for this item must be completed by one of the following:
  - board certified/eligible psychiatrist
  - Ph.D. psychologist
  - psychiatric nurse
  - MSW social worker

STOP! : THE SCREEN PROCESS CANNOT CONTINUE WITHOUT THE RESULTS OF THE CURRENT PSYCHIATRIC EVALUATION.

YES	**NO**
A current consultation as defined above has been done which indicates that this person is a danger to self or others.	A current consultation as defined above has been done which indicates that this person is not a danger to self or others.

Guideline: If item 32 is marked YES, proceed to LEVEL II REFERRALS (item 33).
If item 32 is marked NO, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

LEVEL II REFERRALS

NOTE: The SCREEN Level II is also known as PASRR (Pre Admission Screen and Resident Review). When completed for RHCF applicants, the process is called Pre-Admission Screening (PAS). When completed for residents of RHCFs, the process is called Resident Review (RR). This Level II evaluation should correspond to this person's current functional level.

33. Enter the Level II Referral(s): a, b, or c) _____

a. Level II mental illness evaluation by the designated mental health review entity.

b. Level II evaluation by the Office of Mental Retardation and Developmental Disabilities (OMRDD).

c. Both a and b.

Choose item **a, Level II mental illness evaluation by the designated mental health review entity,** if there is a YES response in item 23 or 32, and there is a NO response in all of items 24-26.

Choose item **b, Level II evaluation by the Office of Mental Retardation and Developmental Disabilities (OMRDD)** if there is a NO response in item 23 and item 32, and there is a YES response in ANY of items 24-26.

Choose item **c, Both a and b** if there is a YES in item 23 or 32, AND there is a YES response in ANY of items 24 –26.

IN ORDER TO OBTAIN A LEVEL II MENTAL ILLNESS EVALUATION BY THE DESIGNATED MENTAL HEALTH REVIEW ENTITY:

The SCREENER is required to complete and submit to the designated mental health review entity, all necessary intake information including:

Information regarding the referral entity:

- Caller name
- Address
- Contact person
- Department/Organization

- Phone number
- Medical record or case number

Information regarding this person:

- Persons name
- Address where this person currently resides
- Contact person or responsible party for this person
- Date of birth
- Pay source
- Medicaid number
- Social Security number
- Phone number
- Placement date (or anticipated date)
- Language spoken

In addition, the following relevant documentation is needed to complete the Level II evaluation:

- Physician request for services which maybe a written order or supporting documentation for RHCF placement/stay.
- H/C PRI including the RUG score.
- A copy of the SCREEN form that triggered this requested Level II referral.
- Complete medical history and physical including last 2 years of inpatient history and treatment.
- Current drug history.
- Neurological evaluation including motor function and sensory function.
- Psychosocial evaluation.
- A detailed psychiatric evaluation. If this person has had a psychiatric hospitalization within the past two (2) years the applicable discharge summary is needed.

IN ORDER TO OBTAIN A LEVEL II EVALUATION BY THE DEVELOPMENTAL DISABILITIES SERVICE OFFICE (DDSO) :

The SCREENER is required to complete and submit to the DDSO all necessary intake information, including:

Information regarding the referral entity:

- Caller name
- Address
- Contact person
- Department/Organization
- Phone number
- Medical record or case number

Information regarding this person:

- Persons name
- Address where this person currently resides
- Contact person or responsible party for this person
- Date of birth
- Pay source
- Medicaid number
- Social Security number
- Phone number
- Placement date (or anticipated date)
- Language spoken

In addition, the following relevant documentation is needed to complete the Level II evaluation:

- Physician request for services which maybe a written order or supporting documentation for RHCF placement/stay.
- H/C PRI including the RUG score.
- A copy of the SCREEN form that triggered this requested Level II referral.
- Complete medical history.
- Current drug history.
- Neurological evaluation including motor function and sensory function.
- Psychosocial evaluation.

IN ORDER TO OBTAIN LEVEL II EVALUATIONS BY BOTH THE DESIGNATED MENTAL HEALTH REVIEW ENTITY AND THE DEVELOPMENTAL DISABILITIES SERVICE OFFICE:

The SCREENER must determine which referral to make first. The initial referral should be based on this person's IQ level if it is known or available in the medical record. The second referral is made by the SCREENER after there has been a determination on the initial referral.

- If the IQ level is greater than 70, the referral should be made first to the designated mental health review entity.

- If the IQ level is less than 50, the referral should be made first to the DDSO.

- If the IQ level is unknown or is between 50 and 70 inclusive, the SCREENER is to use his/her judgment to determine the individual's overriding needs, and make the initial referral accordingly.

Guideline: Proceed to Item 34.

YES NO

34. ☐ ☐ **I, as the QUALIFIED SCREENER, acknowledge that this Patient/Resident/Person and his/her legal representative* have received verbal and written notification that the Patient/Resident/Person is being referred for a Level II Evaluation.**

***Legal representative means an individual whose appointment is made and regularly reviewed by a state court or agency empowered under state law to appoint and review such officers, and having the authority to consent to health/mental health care or treatment of an individual.**

NOTE:
Complete NOTIFICATION OF NEED FOR LEVEL II EVALUATION found on page 7 of the SCREEN form. Make the needed copies of the completed NOTIFICATION OF NEED FOR LEVEL II EVALUATION and provide one copy to this person and one copy to this person's legal representative if applicable. This will serve as the written notification that this person is being referred for a Level II evaluation. In addition verbal notification of this person and his/her legal representative, if applicable, is also required. By checking YES you are acknowledging that verbal and written notification has been provided.

NOTE: Complete item 35 only after obtaining the LEVEL II DETERMINATIONS from the appropriate mental health review entity and/or DDSO.

Guideline: STOP! Do not complete items 35 through 38 until you have obtained the Level II recommendations from the designated evaluator(s).

LEVEL II RECOMMENDATIONS

YES NO

35. ☐ ☐ **Specialized services are recommended based on the Level II Evaluation(s).**

NOTE:
For mental illness, specialized services mean the services specified by the State, which results in an individualized plan of care that demands hospitalization. For mental retardation, specialized services means the services specified by the State, which, combined with services provided by the RHCF or other service providers, results in treatment which meets the requirements of Section 483.440(a)(1).

YES	**NO**
A Level II evaluation has been completed and it has been determined by the OMH and/or OMRDD or their designee that this person DOES require specialized services.	A Level II evaluation has been completed and it has been determined by the OMH and/or OMRDD or their designee that this person does NOT require specialized services.

Guideline: Proceed to item 36.

PATIENT/RESIDENT/PERSON DISPOSITION

36. Enter one response (a,b,c,d,e,f,g,h,i,j):_____

a.	**Home**	**g.**	**RHCF for restorative services**
b.	**Home with home care services**	**h.**	**RHCF for other services**
c.	**Adult Care Facility**	**i.**	**Person died**
d.	**Inpatient Psychiatric Care**	**j.**	**Other (specify)_____**
e.	**OMR/DD Residential Placement**		
f.	**Adult Care Facility with home care services**		

NOTE:
The Level II recommendation has been considered.
Mark where this person will reside.

Guideline: **Proceed to item 37.**

PATIENT/RESIDENT/PERSON AND/OR LEGAL REPRESENTATIVE AND /OR HEALTH CARE AGENT ACKNOWLEDGEMENT

37. I have had the opportunity to participate in decisions regarding the arrangements for my continuing care and I have received verbal and written information regarding the range of services in my community.

_____
Date

_____
Signature of the patient/ resident/person being assessed and/ or legal representative and/or health care agent

NOTE:
Legal representative means an individual whose appointment is made and regularly reviewed by a state court or agency empowered under state law to appoint and review such officers, and having the authority to consent to health/mental health care or treatment of an individual**.** Health care agent means an adult to whom authority to make health care decisions is delegated under a health care proxy.

Signing does not mean that this person agrees with anything. It is an acknowledgement of this person's opportunity to participate in decisions regarding the arrangements for their continued care, AND it is an acknowledgement that this person has received verbal and written information regarding the range of services in this person's community.

The acknowledgement can be left blank if this person is unwilling /unable to sign and this person has no legal representative or health care agent. If item 37 is left blank the SCREENER must enter the reason in the space where the signature is required.

This person and/or legal representative and/or active health care agent dates and signs on the line provided, and CIRCLES the appropriate designation (patient/resident/person being assessed, and/or legal representative or health care agent).

Guideline: Proceed to item 38.

QUALIFED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN and I certify that I am a trained and qualified SCREENER and the information contained herein is a true abstract of this person's current condition and circumstances.

_____

Print date, name and title of qualified SCREENER

_____

Signature of qualified SCREENER

_____

SCREENER Identification Number
(Assigned by NYSDOH)

NOTE:
The qualified SCREENER must enter the date, print and sign their name and professional title and enter his or her SCREENER identification number which was assigned by NYSDOH. As a qualified SCREENER you are responsible for periodically checking the NYSDOH website: **www.nyhealth.gov**
and your facility's NYSDOH Health Commerce Account for updates to the SCREEN form and instructions. If you do not have a Health Commerce Account, please contact your facility's Health Provider Network (HPN) Coordinator. If you do not know who that is, please contact the Commerce Accounts Management Unit: 1-866-529-1890.