# Request for Level II PASRR Evaluation and Determination or Resident Review

**Section I: Request Information**

Date: ______________________________ Request for: ☐ **Initial Level II Evaluation and Determination or** ☐ **Resident Review**

From: ______________________________ Agency: ______________________________ Phone: ____________________

To: ______________________________ Agency: ______________________________ Phone: ____________________

An indication of, or a diagnosis of, a serious mental illness or mental retardation or related condition was identified on the Level I Pre-Admission Screen and Resident Review (PASRR) Screen or the Minimum Data Set revealed a significant change in the resident's mental or physical condition. The Level II Evaluation and Determination should be completed within 7 to 9 days and returned to Comprehensive Assessment and Review for Long-Term Care Services (CARES) or Children's Multidisciplinary Assessment Team (CMAT). The Resident Review should be completed within 7 to 9 days and returned to the Nursing Facility and CARES**.** The Level II Reviewer should notify the individual or legal guardian of the right to appeal the Level II PASRR Determination.

**Section II: Individual Information**

Name: ____________________________________________ DOB: ________________

Current Location: ____________________________________________

MI/MR Indicator: ☐ MI (Serious Mental Illness) ☐ MR (Mental Retardation) ☐ Both (MI and MR)

**Section III: Required Documents for Level II PASRR Evaluation and Determination or Resident Review (Check box for all documents that are attached)**

| For Initial Level II for CARES/CMAT: | For Resident Review for Nursing Facility: |
|---|---|
| ☐ Level I PASRR Screen (AHCA MedServ Form 004, Part A) | ☐ Level I PASRR Screen (AHCA MedServ Form 004, Part A) |
| ☐ Informed Consent Form ( AHCA MedServ 2040, May 2008) | ☐ Relevant Case Notes/Records of Treatment and/or Evaluations (including psychiatric)/ Medication Administration Record (MAR) |
| ☐ Notice of Privacy Practices **(**DOEA HIPAA Form) | ☐ Minimum Data Set (MDS) |
| ☐ Medical Certification for Nursing Facility/Home and Community Based Services Form (AHCA MedServ-3008 form) | |
| ☐ Other Medical Documentation Including Relevant Case Notes or Records of Treatment/Medication Administration Record (MAR) | |
| ☐ Psychiatric Evaluation Forms (DOEA-MH Form 1911-A, Aug 01, and DOEA-MH Form 1911-B, Aug 01) | |
| ☐ DOEA Assessment Instrument (DOEA Form 701B, September 2008) | |
| ☐ CMAT Assessment | |

**Section IV: Level II Reviewer**

Date of Level II Determination: ____________________

Disposition:

1. Does the individual meet the State definition for mental illness or mental retardation or a related condition? ☐ Yes ☐ No
2. Are Specialized Services needed? ☐ Yes ☐ No
3. If yes, can these Specialized Services be provided in a nursing facility? ☐ Yes ☐ No
4. Can Specialized Services be provided in the community? ☐ Yes ☐ No
5. If not, is nursing facility placement appropriate? ☐ Yes ☐ No
6. If Specialized Services are needed, attach the care plan of services that are required.
7. If Specialized Services are not needed, attach other service recommendations required to meet identified needs.

Date of Distribution of Level II Evaluation and Determination to: ______________________

☐ Individual ☐ Nursing Facility ☐ Other: ____________________

☐ Legal Guardian ☐ CARES ☐ Primary Care Physician ☐ CMAT

Signature: ____________________________________________ Title: ______________________________