PENNSYLVANIA PREADMISSION SCREENING RESIDENT REVIEW EVALUATION (LEVEL II) FORM

PA-PASRR-EV (Revised 3/1/2014)

When a Pennsylvania Preadmission Screening Resident Review Evaluation (PA-PASRR-EV) form is completed, the following documentation must be sent to the appropriate program office (Office of Mental Health and Substance Abuse Services, Office of Developmental Programs, Office of Long-Term Living): completed PA-PASRR-EV form, all supporting documentation, the assessor's name and telephone number.

DATE OF ASSESSMENT: ___________________________________

APPLICANT/RESIDENT'S NAME:	SOCIAL SECURITY NUMBER:	AGE:	BIRTH DATE:	COUNTY OF RESIDENCE:
Is the applicant/resident enrolled in or applying for Medical Assistance (MA)? ☐ Yes ☐ No			STATE OF RESIDENCE:	MA NUMBER:

From the list below, check the applicant/resident's diagnosis(es) that meet the criteria for MI, ID, ORC (check all that apply).

CHECK	DIAGNOSIS	CHECK	DIAGNOSIS
	Intellectual disability		Alzheimer's disease or other dementia
	Cerebral palsy		Major mental disorder: schizophrenia or schizoaffective disorder
	Epilepsy/seizure disorder		Major mental disorder: delusional disorder
	Autism spectrum disorder		Major mental disorder: bipolar or depressive disorder
	Blindness and deafness		Major mental disorder: psychotic disorder
	Spina bifida		Major mental disorder: panic or severe anxiety disorder
	Spinal cord injury		Major mental disorder: somatic symptom disorder
	Head injury/brain surgery		Major mental disorder: personality disorder
	Cystic fibrosis		Other developmental disabilities - specify:
	Multiple sclerosis		
	Muscular dystrophy		Other related conditions - specify:

SCREENING EXCEPTIONS

1. Does the applicant/resident have any of the following conditions? Check "Yes" or "No" for each.

CONDITION	YES	NO	CONDITION	YES	NO
Ventilator-dependent			Huntington's disease		
Chronic obstructive pulmonary disease (COPD)			Amotrophic lateral sclerosis (ALS)		
Severe Parkinson's disease			Congestive heart failure (CHF)		
Muscular dystrophy			Alzheimer's disease		
Other severe medical condition: List diagnosis:					
If ANY of these items are checked "Yes" - Go to 2			**If ALL of these items are checked "No" - Go to SECTION I (Mental Illness)**		

2. Is the medical condition or combination of conditions so extreme that the person cannot focus upon, participate in or benefit from specialized services for which a physician prescribes 24-hour medical supervision?

   ☐ Yes ☐ No

3. If #2 above is marked "Yes" this applicant/resident qualifies for a screening exception that specialized services are not needed. Stop screening and go to SECTION IV and complete as directed; if the applicant/resident is not a screening exception, all sections (I, II and III) must be filled out.

I. MENTAL ILLNESS (MI)

A. Documentation of the diagnosis of a MI

1. Is the applicant/resident currently assaultive and/or self-abusive to the degree that he/she might endanger other residents of a nursing facility or might injure himself/herself without constant supervision by mental health personnel?

   ☐ Yes ☐ No

2. For PASRR purposes, the major mental disorders include the following. Please check "Yes" or "No" to indicate if a **CURRENT diagnosis** exists, enter year of onset, and attach documentation. Examples of acceptable documentation include a current psychiatric assessment with diagnosis or other professionally accepted diagnostic practices by a qualified physician or psychiatrist, (see CFR §483.134).

DIAGNOSIS	CURRENT?	ONSET YEAR	DIAGNOSIS	CURRENT?	ONSET YEAR
Schizophrenia	☐ Yes ☐ No		Panic or other severe anxiety disorder	☐ Yes ☐ No	
Schizoaffective disorder	☐ Yes ☐ No		Somatic symptom disorder	☐ Yes ☐ No	
Delusional disorder	☐ Yes ☐ No		Personality disorder	☐ Yes ☐ No	
Bipolar disorder	☐ Yes ☐ No		Depressive disorder	☐ Yes ☐ No	
Psychotic disorder	☐ Yes ☐ No		Other	☐ Yes ☐ No	
If ALL of the above items are checked "No" - Skip to C.1					

3. Does a review of the applicant/resident's case history and/or medical record substantiate that the mental disorder is responsible for the functional limitations in the following areas? (See PASRR-ID for definitions).

Interpersonal functioning	☐ Yes ☐ No
Concentration, persistence and pace	☐ Yes ☐ No
Adaptation to change	☐ Yes ☐ No
Describe:	
If ALL of the above items are checked "No" - Skip to C.1	

4. Does a review of the applicant/resident's treatment history substantiate that the individual experienced **at least one** of the following in the **past two years**?

a. Psychiatric treatment more intensive than outpatient care: ☐ Yes ☐ No

If yes, describe: ____________________

b. In the past two years, 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. (Supportive services include crisis intervention, intensive case management, and/or other social service agency intervention.): ☐ Yes ☐ No

If yes, describe: ____________________

c. Suicide ideation with a plan or attempt: ☐ Yes ☐ No

If yes, describe: ____________________

d. Electroconvulsive Therapy - ECT (related to MI): ☐ Yes ☐ No

If yes, describe: ____________________

e. Mental Health Intensive Case Manager (ICM): ☐ Yes ☐ No

If yes, describe: ____________________

B. Data or information gathered to assess the individual

1. List all current medications that the individual is taking from the following drug groups and his/her response to each medication: Hypnotics, anxiolytics, sedatives, antipsychotics (neuroleptics), mood stabilizers, antidepressants, and all anti-Parkinson's agents.

MEDICATION	RESPONSE

2. The following information in the list below should be gathered to allow MI to evaluate functional level needs of the individual. Indicate the areas for which information could not be found or further assessment is needed. Attach all supporting documentation.

DATA/INFORMATION	ADDITIONAL INFORMATION NEEDED
Complete medical history.	☐
Review of all body systems.	☐
Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; additional evaluations conducted by appropriate specialists.	☐
A comprehensive drug history including current or immediate past use of medications that could mask symptoms or mimic MI.	☐
A psychological evaluation of the individual, including current living arrangements, medical, and support systems.	☐
A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.	☐
Functional assessment of the individual's ability to engage in activities of daily living. Include the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must also determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that nursing facility placement is required. The functional assessment must address the following areas: Self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, or both, self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.	☐

3. Was a mini mental status exam performed? ☐ Yes - Score: __________ ☐ No

4. Estimated level of intelligence of the individual: ☐ High ☐ Average ☐ Low ☐ Unknown

5. List the medical and social supports the individual currently receives, (include activities of interest that show socialization with others):

C. Evaluation of gathered information (recommendation to the program office)

1. Does the applicant/resident have a diagnosis of a major mental disorder which meets the criteria of a "serious MI"?

☐ Yes ☐ No - Skip to **Section II (Intellectual Disability)**

2. Does the applicant/resident need more specialized services (intensive specialized services - inpatient psychiatric setting)? ☐ Yes ☐ No

3. Does the applicant/resident need health rehabilitative services provided by the nursing facility for his/her MI? ☐ Yes ☐ No

If yes, services like: ______________________________

4. Does the applicant need specialized services in the community as described under Specialized Services for MI below? ☐ Yes ☐ No

If yes, services like: ______________________________

5. Determination of need for further evaluation or assessment. ☐ Need further evaluation ☐ No further evaluation needed - Skip to **D.1**

Explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal law says that people with serious MI may not need nursing facility services, and if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have a serious MI. We have to get a professional evaluation to know whether you have a diagnosis of a major mental disorder and whether specialised services are needed.

Note: Under federal law and regulations, an evaluation and diagnosis must be obtained from someone who is a qualified physician or psychiatrist.

D. Desire for specialized services

1. Explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal regulations state that in order for a person with a serious MI, intellectual disability, or an other related condition to have his/her specialized needs met, the individual must receive all services necessary to assist him/her in maintaining or achieving as much independence and self-determination as possible. Explain a kind of care called "specialized services", which is designed to help people learn to cope with their conditions.

An individual may choose to participate in or forego specialized services. Individuals who want "specialized services" want a program in which they will learn, grow and develop through practice and teaching to prevent the loss of skills and abilities. Some individuals may not be able to tolerate these specialized services. Some individuals may want nursing service in a place that only provides food, safety, comfort, and medical attention.

2. Explain "specialized services" as appropriate using the definitions below.

Specialized services for an individual that meet the clinical criteria for a serious MI target group residing in the community are defined as those appropriate community-based mental health services needed by the individual. This includes those types of services currently provided by the county community mental health system such as case management (e.g., intensive case management, resource coordination, administrative case management); supervised living arrangements (e.g., community residential rehabilitation, long-term structured residence, supported housing, personal care homes); psychiatric outpatient clinic services, partial hospitalization services, crisis and emergency services, psychosocial rehabilitation and any other county mental health services.

If the individual meets the clinical criteria for a serious MI and is admitted to a nursing facility, some specialized services may need to continue to be provided to the individual. The provision of specialized services should be assured by the nursing facility and Office of Mental Health. If the Office of Mental Health determines that inpatient specialized services are needed, these services will be provide in an inpatient psychiatric setting.

Specialized services for individuals with serious MI are authorized by the Office of Mental Health. The services shall be based on the individual's needs.

3. Explain further and answer questions as needed.

a. Do you understand what I have told you about specialized services? ☐ Yes ☐ No - Try again

b. If eligible, do you want that kind of service for yourself? ☐ Yes ☐ No

c. Obtain signature of either the applicant/resident or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services, and then go to **Section II**.

APPLICANT'S/RESIDENT'S SIGNATURE:	DATE:
WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

II. INTELLECTUAL DISABILITY (ID)

A. Documentation of the diagnosis of an ID*

1. Does the documentation indicate a diagnosis of an ID? ☐ Yes ☐ No

* (Attach documentation which can include, but is not limited to, IQ and adaptive testing (preferably before age 22), psychological reports, psychiatric reports, school records, summaries from the county ID program or agency, and other relevant professional reports.

2. Does the documentation provide evidence of the following characteristics?

CHARACTERISTIC	
Significantly sub-average intellectual functioning with an IQ of approximately 70 or below on standardized intelligence testing identified by a qualified psychologist?	☐ Yes ☐ No
Deficits in adaptive behavior or functioning on formal assessment?	☐ Yes ☐ No
Onset prior to the age of 22 (consider all relevant and informed sources)?	☐ Yes ☐ No
Are ALL THREE items checked "Yes"?	☐ Yes ☐ No - Skip to **C.1**

3. Indicate level of ID.

☐ Mild (50-69) ☐ Moderate (35-49) ☐ Severe (25-34) ☐ Profound (<25) ☐ Unspecified ☐ Not known (scores not available) ☐ None

B. Data or information (in the absence of data) gathered to assess the individual related to particular health characteristics and functional areas

1. List all current medications that the individual is taking from the following drug groups and his/her response to each medication: Hypnotics, anxiolytics, sedatives, antipsychotics (neuroleptics), mood stabilizers, antidepressants, and anti-Parkinson agents.

MEDICATION	RESPONSE

2. Does the individual have an Intensive Case Manager (ICM)? ☐ Yes - List agency: ______________________ ☐ No

3. List the medical and social supports the individual current receives, (include activities of interest that show socialization with others):

4. The following information in the list below should be gathered to allow ID to evaluate functional level and needs of the individual. Indicate the areas for which information could not be found or further assessment is needed. Attach all supporting documentation.

FUNCTIONAL AREA	ADDITIONAL INFORMATION NEEDED
Self-monitoring of health status	☐
Self-administering and scheduling of medical treatments	☐
Self-monitoring of nutritional status	☐
Self-help development such as toileting, dressing, grooming and eating	☐
Sensorimotor skills such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination and the extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity	☐
Communication skills including expressive and receptive language and the extent to which a communication system, amplification device and/or program of amplification could improve the individual's functional capacity	☐
Social skills including relationships, interpersonal, and recreation-leisure skills	☐
Academic and educational skills including functional learning skills	☐
Independent living skills involving meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to neighborhood, town, city, etc.), orientation skills for individuals with visual impairments, laundry, housekeeping, shopping, bed making, and care of clothing	☐
Vocational skills	☐
Affective skills including interests, ability to express emotion, making judgements, and independent decision-making	☐
Presence of maladaptive or inappropriate behaviors including their description, frequency, and intensity	☐

5. List documents reviewed:

DOCUMENT REVIEWED	DATE OF DOCUMENT	NAME OF PROFESSIONAL OR ORIGIN OF DOCUMENT	QUALIFICATIONS OF PROFESSIONAL (e.g. licensed psychologist)

C. Evaluation of gathered information

1. Results of Part A; documentation of a diagnosis of an ID:
   a. Does the individual have a diagnosis of an ID? ☐ Yes ☐ No - Skip to **Section III (Other Related Conditions)**
   b. What level of ID? ☐ Mild (50-69) ☐ Severe (25-34) ☐ Moderate (35-49) ☐ Profound (< 25) ☐ Unspecified
   c. Does the individual need additional assessment to determine need for specialized services? ☐ Yes ☐ No
   d. Does the individual need specialized services? ☐ Yes ☐ No

2. Determination of need for further evaluation or assessment: ☐ Need further evaluation - continue ☐ No further evaluation needed - go to **D.1**

   You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal law says that individuals with an ID may not need nursing facility services, and if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have an ID. The assessment information submitted thus far does not provide sufficient information to validate a diagnosis of an ID and/or make a determination for the need for specialized services. The evaluation team will be consulting with the appropriate county program for the developmental services and other agencies and individuals to help us assess an ID and your relative's/friend's/ward's need for nursing facility and specialized services.

D. Desire for specialized services

1. Explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal regulations state that in order for an individual with a serious MI, ID, or a related condition to have his/her specialized needs met, the individual must receive all services necessary to assist him/her in maintaining or achieving as much independence and self-determination as possible. I am going to explain a kind of care called "specialized services", which is designed to help people learn to cope with their conditions.

   An individual may chose to participate in or forego specialized services. Individuals who want specialized services want a program in which they will learn, grow and develop through practice and teaching to acquire or prevent the loss of skills and abilities. Some individuals may not be able to tolerate these specialized services. Some individuals may want nursing service in a place that only provides food, safety, comfort, and medical attention.

2. Explain "specialized services" as appropriate using the definitions below:

   For individuals with an ID residing in nursing facilities, specialized services consist of services which are provided on a continuous basis by qualified ID personnel.

   These specialized services are combined with services provided by the nursing facility or other service providers, and result in treatment which includes aggressive, consistent implementation of a program of specialized and generic training, treatment and related services.

   Specialized services are directed toward the acquisition of the behavior and skills necessary for an individual to function with as much self-determination and independence as possible, or the prevention, or deceleration of regression, or loss of current optimal functional status.

3. Explain further and answer questions as needed:

   a. Do you understand what I have told you about specialized services? ☐ Yes ☐ No - Try again

   b. If eligible, do you want that kind of service for yourself? ☐ Yes ☐ No

   c. Obtain signature of either the applicant/resident or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services, and then go to **Section III**.

APPLICANT'S/RESIDENT'S SIGNATURE:	DATE:
WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

III. OTHER RELATED CONDITIONS (ORC)

ORC include physical, sensory or neurological disabilities which manifested before age 22 are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living. It is important to note that a person can have an ORC regardless of whether the ORC impairs their intellectual abilities.

A. Documentation of the diagnosis of an ORC

1. Is there documentation to substantiate that the applicant/resident meets the following criteria for an ORC? ☐ Yes ☐ No

   Attach documentation to include, but not limited to, a psychological evaluation, physician's note which indicates that the diagnosis and three functional limitations **occurred prior to age 22**, or a statement to this effect from the applicant/resident or family.

2. Does the documentation provide evidence of the following characteristics?

Has a physical, sensory or other neurological disability which is considered an ORC? ☐ Yes - Specify: ______	☐ No
The condition manifested before age 22.	☐ Yes ☐ No
The condition is expected to continue indefinitely.	☐ Yes ☐ No
If ANY of the above items are checked "No" - Skip to C.1	

B. Data or information (in the absence of data) gathered to assess the individual

1. Indicate areas where the applicant/resident has a substantial functional limitation which was manifested **prior to age 22**.

   a. ☐ **Self-care:** A long-term condition which requires the individual to need significant assistance with personal needs such as eating, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care.

   b. ☐ **Receptive and expressive language:** A long-term condition which prevents effective communication with another person without the aid of a third person, a person with special skill or with a mechanical device, or a long-term condition which prevents articulation of thoughts.

   c. ☐ **Learning:** A long-term condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

   d. ☐ **Mobility:** A long-term condition which impairs the ability to use fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.

   e. ☐ **Self-direction:** A long-term condition which requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protection of own self-interest.

   f. ☐ **Capacity for independent living:** A long-term condition that limits performing normal societal roles or which makes it unsafe for an individual to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).

2. List the medical and social supports the individual current receives, (include activities of interest that show socialization with others):

3. The following information in the list below should be gathered to allow ORC to evaluate the individual. Indicate the areas for which information could not be found or further assessment is needed. Attach all supporting documentation.

ASSESSMENT AREA	ADDITIONAL INFORMATION NEEDED
Sensorimotor development (ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination	☐
Speech and language development (includes expressive and receptive language, disorders, i.e. communication disorders)	☐
Social development (includes interpersonal skills, recreation-leisure skills, and relationships with others)	☐
Academic/educational development (grade level of school completed and/or functional learning skills)	☐
Independent living development (includes meal preparation, budgeting and personal finances, survival skills, mobility skills [orientation to the neighborhood, town, etc.] laundry, housekeeping, shopping, bed making, care of clothing and orientation skills for individuals with visual impairments)	☐
Vocational development (include present vocational skills)	☐
Affective development (such as interests and skills involved with expressing emotions, making judgments, and making independent decisions)	☐
IQ and adaptive function testing	☐
Psychological evaluation	☐
Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systemic observation (include frequency and intensity of behavior)	☐
Extent to which prosthetic, orthotic-corrective or mechanical-supportive devices can improve the individual's functional capacity	☐
Extent to which non-oral communication systems can improve the individual's functional capacity	☐

4. List documents reviewed:

DOCUMENT REVIEWED	DATE OF DOCUMENT	NAME OF PROFESSIONAL OR ORIGIN OF DOCUMENT	QUALIFICATIONS OF PROFESSIONAL (e.g. licensed psychologist)

C. Evaluation of gathered information

1. Results of Parts A and B - documentation of an ORC diagnosis

   a. Does the applicant/resident have a diagnosis of an ORC? ☐ Yes ☐ No - Go to **Section IV**

   b. Does the applicant need specialized services? ☐ Yes ☐ No

   If yes, what type of services: ______________________________

   c. Who signed the assessments which provided information about the client's need for specialized services?

NAME	PROFESSIONAL QUALIFICATIONS	DATE

2. Determination of need for further evaluation or assessment. ☐ Need further evaluation - Continue ☐ No further evaluation needed - go to **D.1**

   Explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal law says that people with an ORC may not need nursing facility services and, if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have an ORC. The assessment information submitted this far does not provide sufficient information to validate a diagnosis of an ORC and/or determine the need for specialized services. You may be referred to a developmental disabilities expert (e.g. occupational or physical therapist or adaptive equipment specialist) if functional level assessments are needed.

D. Desire for specialized services

1. You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

   Federal regulations state that in order for a person with a serious MI, ID, or an ORC to have his/her specialized needs met, the individual must receive all services necessary to assist him/her in maintaining or achieving as much independence and self-determination as possible. I am going to explain a kind of care called "specialized services", which is designed to help people learn to cope with their conditions.

An individual may choose to participate in or forego specialized services. People who want specialized services want a program in which they will learn, grow and develop through practice and teaching to prevent the loss of skills and abilities. Some people may not be able to tolerate these specialised services. Some people may want nursing service in a place that only provides food, safety, comfort and medical attention.

2. Explain specialized services as appropriate using the definitions below.

   Specialized services for individuals with an ORC are defined as service specified by the Commonwealth of Pennsylvania which, combined with nursing facility and special rehabilitative services provided by the nursing facility, result in:

   - The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
   - The prevention or deceleration of regression or loss of current optimal functional status.

   Specialized services are authorized for applicants/residents with an ORC by the Office of Long Term Living or its agent. For individuals with an ORC, specialized services primarily include:

   - **Service coordination/advocacy services:** Development and maintenance of a specialized service plan, facilitating and monitoring the integration of specialized services with the provision of nursing facility and specialized rehabilitative services, and assisting or advocating for residents on issues pertaining to residing in nursing facilities.
   - **Peer counseling/support groups:** Linking residents to "role models" or "mentors" who are persons with physical disabilities and who reside in community settings.
   - **Training:** In areas such as self-empowerment/self-advocacy, household management in community settings, community mobility, decision making, laws relating to disability, leadership, human sexuality, time management, self-defense/victim assistance, interpersonal relationships, certain academic/development activities, and certain vocational/development activities.
   - **Community integration activities:** Exposing residents to a wide variety of unstructured community experiences which they would encounter in the event that they must or choose to leave the nursing facilities or engage in activities away from the nursing facilities.
   - **Equipment/assessments:** Purchase of equipment and related assessment of residents who plan, within the next two years, to relocate to community settings.
   - **Transportation:** Facilitation of travel necessary to participate in the above specialized services.

3. Explain further and answer questions as needed:

   a. Do you understand what I have told you about specialized services? ☐ Yes ☐ No - Try again

   b. If eligible, do you want that kind of service for yourself? ☐ Yes ☐ No

   c. Obtain signature of either the applicant/resident or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services, and then go to **Section IV**.

APPLICANT'S/RESIDENT'S SIGNATURE:	DATE:
WITNESS SIGNATURE, IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

IV. NOTICE OF REFERRAL FOR FINAL DETERMINATION

A. You must now explain to the applicant/resident, legal representative and family member or significant other (if the individual agrees to family participation) that:

For persons with a MI:
Federal law states that people with a serious MI may not need nursing facility services and, if so, should generally be in places more suited to their needs. You (or your relative/friend/ward) have been given a diagnosis of a major mental disorder. We must forward this form and the related information to the Department of Public Welfare (DPW) Office of Mental Health to obtain a final determination decision regarding your need for nursing facility care and specialized services.

For persons with an ID:
Federal law states that all applicants for nursing facility services for people with an ID must have a separate determination regarding their need for nursing facility care and specialized services. In Pennsylvania, this determination is made by the DPW Office of Developmental Programs (ODP). Since our primary evaluation indicates that you (or your relative/friend/ward) may have an ID, we are forwarding this form and related information to ODP. You will receive notification from ODP regarding your ID diagnosis and whether you have been determined to need nursing facility care and/or specialized services.

For persons with an ORC:
Federal law states that people with an ORC may not need nursing facility services and, if so, should generally be in places more suited to their needs. It is also possible that some people may be eligible for nursing facility services and, with their consent, could be supported in the community with the necessary supports and specialized services. Therefore, we must forward this form and the related information to the DPW Office of Long Term Living, Bureau of Participant Operations for review by the ORC program office. This office/contractor will provide you with a final determination decision regarding your need for nursing facility care and specialized services.

B. Questions about the preparation of this form should be referred to the person completing this form.

PRINT NAME:	TITLE:		DATE:
SIGNATURE:	DATE:	TELEPHONE:	

C. **ASSESSOR SHOULD COMPLETE THE NOTIFICATION INFORMATION BELOW, MAKE A COPY OF THE ASSESSMENT PACKET FOR THEIR RECORDS AND THEN FORWARD THE ASSESSMENT PACKET TO THE APPROPRIATE PROGRAM OFFICE OR ITS DESIGNEE FOR A FINAL DETERMINATION.**

V. NOTIFICATION

THIS MUST BE COMPLETED FOR ALL ASSESSMENTS.

COPIES OF THE EVALUATION REPORT SHOULD BE SENT TO THE FOLLOWING:		
1. THE APPLICANT/RESIDENT		
Name:	Social Security number:	Telephone number:
2. THE LEGAL REPRESENTATIVE - AN INDIVIDUAL DESIGNATED BY STATE LAW TO REPRESENT THE APPLICANT/RESIDENT. THIS INCLUDES A COURT-APPOINTED GUARDIAN OR AN INDIVIDUAL HAVING POWER OF ATTORNEY.		
Name:		Telephone number:
Address:		
City:	State:	Zip code:
3. ADMITTING/RETAINING NURSING FACILITY (if known)		
Name:		Telephone number:
Address:		
City:	State:	Zip code:
Attention:		
4. APPLICANT'S/RESIDENT'S ATTENDING PHYSICIAN		
Name:		Telephone number:
Address:		
City:	State:	Zip code:
5. LIST FULL NAME OF DISCHARGING HOSPITAL (if individual is seeking nursing facility admission directly from a hospital)		
Name:		Telephone number:
Address:		Fax number:
City:	State:	Zip code:
Contact person and telephone number:		