West Virginia Department of Health and Human Resources

PRE-ADMISSION SCREENING

PAS Level 0

Facility/Agency/Person making referral **FROM** | Contact Person First Name | Contact Person Last Name

Address: | City: | State: | Zip

Fax Number: | Fax Extension: | Phone Number: | Extension:

Facility/Agency/Person making referral **TO** | Contact Person First Name | Contact Person Last Name

Address: | City: | State: | Zip

Fax Number: | Fax Extension: | Phone Number: | Extension:

Reason for Screening (check only ONE)

☐ Nursing Home Only Initial
☐ Nursing Home Only Transfer
☐ Nursing Home Waiting Waiver - Yes
☐ Other Explain

1. Demographic Information

1a. First Name | 1b. Middle Name | 1c. Last Name | 1d. Suffix | 2. Gender ☐ Male ☐ Female

3. Medicaid Number: | Medicare Number:

5a. Address: | 5b. City: | 5c. State: | 5d: Zip:

6. Private Insurance/Private Pay
☐ Yes If yes, specify
☐ No

7. County (WV Only) | 8. Social Security Number: | 9. Date of Birth | 10. Age | 11. Phone Number

12a. Spouse First Name: | 12b. Spouse Midde Name: | 12c. Spouse Last Name: | 12d. Spouse Suffix:

13a. Spouse Address (if different from above): | 13b. City: | 13c. State: | 13d: Zip: | 13e. County:

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services):

15. Name and Address of Provider, if applicable:

15a. Provider First Name: | 15b. Provider Last Name:

15c. Provider Address: | 15d. Provider City: | 15e. Provider State: | 15f. Provider Zip: | 15g. County

16. Medicaid Waiver Recipient:

☐ Yes, If Yes - ☐MR/DD Waiver ☐Aged and Disable Waiver

☐ No

17. Has the option of Medicaid Waiver been explained to the applicant?

☐ Yes

☐ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.

SIGNATURE - Applicant or Person acting for Applicant	Relationship	Date:

☐ Checking this box certifies that the person indicated above has signed the completed PAS and a copy of this document containing the above-named applicant's signature (or person signing for the applicant) is on file in the applicant's record.

☐ If a verbal consent was received from the applicant, then checking this box certifies that this PAS has been signed by two witnesses and is on file in the applicant's record

19. Check if applicant has any of the following:

☐ a. Guardian ☐ c. Medical Power of Attorney ☐ e. Durable Power of Attorney ☐ g. Other

☐ b. Committee ☐ d. Power of Attorney ☐ f. Living Will

Name of Representative	Address			Phone Number
	City	State	Zip	

II. Medical Assessment

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available.)

☐ Checking this box certifies that the attached document(s) contains the most recent health assessment data available for this member and that the most recent hospital discharge summary and physical has been attached, if applicable.

21. Normal Vital Signs for the Individual:

a. Height (inches or cm)	b. Weight (pounds or kg)	c. Blood Pressure (mmHg)	d. Temperature (°F or °C)	e. Pulse	f. Resp. Rate
		/			

22. Check if abnormal:

☐a. Eyes	☐g. Breasts	☐m. Extremities	☐s. Musculo Skeletal
☐b. Ears	☐h. Lungs	☐n. Abdomen	☐t. Skin
☐c. Nose	☐i. Heart	☐o. Hernias	☐u. Nervous System
☐d. Throat	☐j. Arteries	☐p. Genitalia Male	☐v. Allergies
☐e. Mouth	☐k. Veins	☐q. Gynecological	Specify:
☐f. Neck	☐l. Lymph System	☐r. Ano-Rectal	

Describe abnormalities and treatment:

23. Medical conditions/symptoms (Grade as following: 0 - None, 1 - Mild, 2 - Moderate, 3 - Severe)

	Grade		Grade		Grade
a. Angina - Rest		e. Paralysis		i. Diabetes	
b. Angina - Exertion		f. Dysphagia		j. Contracture(s)	
c. Dyspnea		g. Aphasis		k. Mental Disorder(s)	
d. Significant Arthritis		h. Pain		l. Other (Specify):	

24. Does applicant have a decubitus?

☐ Yes - If yes please fill out the following ➔ Location _____ e.g. (left - arm, leg, hip, buttock; right - arm, leg, hip, buttock; other)

☐ No Stage _____ 1, 2, 3, or 4

Size _____

Treatment _____

Developed at _____ home, hospital, or facility

25. In the event of an emergency, the individual can vacate the building (select one):

☐ Independently
☐ With Supervision
☐ Mentally Unable
☐ Physically Unable

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

	Item	Level 1	Level 2	Level 3	Level 4
a.	Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.	Bathing	Self/Prompting	Physical Assistance	Total Care	
c.	Dressing	Self/Prompting	Physical Assistance	Total Care	
d.	Grooming	Self/Prompting	Physical Assistance	Total Care	
e.	Continent/Bladder	Continent	Occasional Incontinent	Incontinent	Catheter
f.	Continent/Bowel	Continent	Occasional Incontinent	Incontinent	Colostomy
g.	Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h.	Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
i.	Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
j.	Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (doors, etc.)	Total Assistance
k.	Vision	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Blind
l.	Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m.	Communication	Not Impaired	Impaired/Understandable	Understandable with aids	Inappropriate/None

27. Professional and technical care needs (check all that apply):

☐a. Physical Therapy
☐b. Speech Therapy
☐c. Occupational Therapy
☐d. Inhalation Therapy
☐e. Continuous Oxygen
☐f. Ostomy
☐g. Suctioning
☐h. Tracheostomy
☐i. Ventilator
☐j. Dialysis
☐k. Parenteral Fluids
☐l. Sterile Dressings
☐m. Irrigations
☐n. Special Skin Care
☐o. Other

28. Individual is capable of administering his/her own medications:

☐ Yes
☐ With Prompting Supervision
☐ No

Comments

29. Current Medications

Is this Applicant on any Medications: ☐ Yes ☐ No If yes add medication in form below or attached medication list

Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

☐ **Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted**

III. MI/MR Assessment

30. Current Diagnosis (Check all that apply):

☐ a. None
☐ b. Mental Retardation
☐ c. Autism
☐ d. Seizure Disorder (Age at Onset): _____
☐ e. Cerebral Palsy
☐ f. Other developmental disabilities (Specify):
☐ g. Schizophrenic Disorder
☐ h. Paranoid Disorder
☐ i. Major Affective Disorder
☐ j. Schizoaffective Disorder
☐ k. Affective Bipolar Disorder
☐ l. Tardive Dyskinesia
☐ m. Major Depression
☐ n. Other related conditions (specify):

Date of last PASRR Level II Evaluation __/__/____

31. Has an individual ever received services from an agency serving person with mental retardation/developmental disability and/or mental illness?

☐ Yes, specify Facility Address

☐ No Admission Date Discharge Date

32. Has the individual received any of the following medications on a regular basis within the last two years?

☐ Yes
☐ No

☐ Chlorpromazine	☐ Perphenazine	☐ Haloperidol	☐ Promazine	☐ Fluphenazine
☐ Trifupromazine	☐ Fluphenazine HCl	☐ Loxapine	☐ Thioidazine	☐ Trifluphenazine
☐ Mesoridazine	☐ Chlorprothixene	☐ Procholorperazine	☐ Actiphenazine	☐ Thiothixene
☐ Thorazine	☐ Trilafon	☐ Haldol	☐ Sparine	☐ Prolixin
☐ Vesprin	☐ Permitil	☐ Loxitane	☐ Mellaril	☐ Stelazine
☐ Serentil	☐ Taractan	☐ Molindone	☐ Tindal	☐ Navane
☐ Clozapine	☐ Compazine	☐ Moban	☐ Clozaril	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

☐ **Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted**

33. Was this medication used to treat a neurological disorder? ☐ Yes ☐ No

34. Clinical and Psychological Data - Please check any of the following behaviors which the individual has exhibited in the past two years:

- ☐ a. Substance Abuse (Identify)
- ☐ b. Combative
- ☐ c. Withdrawn Depressed
- ☐ d. Hallucinations
- ☐ e. Delusional
- ☐ f. Disoriented
- ☐ g. Bizarre Behavior
- ☐ h. Bangs Head
- ☐ i. Sets Fire
- ☐ j. Displays inappropriate social behavior
- ☐ k. Seriously Impaired Judgment
- ☐ l. Suicidal Thoughts, Ideations/Gestures
- ☐ m. Cannot Communicate Basic Needs
- ☐ n. Talks About His/Her Worthlessness
- ☐ o. Unable to Understand Simple Commands
- ☐ p. Physically Dangerous to Self and Others, If Unsupervised
- ☐ q. Verbally Abusive
- ☐ r. Demonstrates Severe Challenging Behaviors
- ☐ s. Specialized Training Needs
- ☐ t. Sexually Aggressive

Does the individual have Alzheimer's, mulit-infarct, senile dementia, or related condition? ☐Yes ☐ No

Other (Specify):

IV. Physician Recommendation

35. Prognosis (check only one)

- ☐ Stable
- ☐ Improving
- ☐ Deteriorating
- ☐ Terminal
- ☐ Other:

36. Rehabilitative Potential (check only one)

- ☐ Good
- ☐ Limited
- ☐ Poor

37. Diagnosis Include ICD code and descriptor

a. Primary:

b. Secondary:

c. Tertiary:

d. Other medical conditions requiring services

Explain:

West Virginia Department of Health and Human Resources

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38. Physician Recommendations:

A. FOR NURSING FACILITY PLACEMENT ONLY

On the basis of present medical findings, the individual may eventually be able to return home or be discharged

☐ Yes ☐ No

If yes, check one of the following:

☐a. Less than 3 months

Please specify estimated length of stay (in calendar days): _____

☐ b. 3-6 months

☐c. More than 6 months

☐d. Terminal illness

B. I recommend that the services and care to meet these needs can provided at the level of care indicated.

☐A. Nursing Home

☐B. Nursing Home Waiting AD Waiver

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (MUST be signed by M.D. or D.O.)

Physician Signature	☐ MD ☐ DO Physician Credentials	Date Assessment Completed

☐ Checking this box certifies that the MD/DO Name typed into the 'Physician's Signature' field above is the Physician who completed this PAS form. Also checking this box certifies that #39 of this PAS form will be completed with the MD/DO signature for this applicant and is on file in the applicant's record.

Physician's Name and Address:

DISCLAIMER: Approval of this form does not guarantee eligibilty for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.