



LEVEL I PASRR SCREEN and Determination For Mental Illness/Mental Retardation/ORC

Agency Name and Address _____
Date: _____ / _____ / _____ Fax# _____ Phone # _____

Print Name and Title of Person Completing Form _____ Signature _____

Section I: Identification and Background Information

1.	Applicant Name:	First: _____ (MI): _____ Last: _____
2.	Address:	Street: _____ City/Town: _____ State: _____ Zip: _____ County: _____ Phone: _____
3.	Social Security #:	_____ - _____ - _____
4.	MaineCare #:	_____ OR check <input type="checkbox"/> if not applicable
5.	Medicare #:	_____ OR check <input type="checkbox"/> if not applicable
6.	Date of Birth:	Month: _____ Day: _____ Year: _____
7.	Emergency Contact:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Relationship: _____ Phone: _____ Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Continuing Physician	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Phone: _____
9.	Anticipated or Current Nursing Facility:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Phone: _____
10.	Duration of Stay:	Estimated length of stay _____ days. Has physician documented that this applicant's stay in a nursing facility will be 30 days or less? <input type="checkbox"/> Yes <input type="checkbox"/> No

Any decision for a Level II Assessment or deferral/waiver of a Level II Assessment must be made by the
Department of Health & Human Services (DHHS) or the Agent of DHHS



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Section II: Nursing Facility Level I Screen: Mental Illness

1.	Does the individual have a mental illness diagnosis:		
	<input type="checkbox"/> Yes ●		
	<input type="checkbox"/> No -		
2.	Diagnosis (Dx): _____ DSM Code: 000-00 (Number Required) _____		
2a.	This diagnosis has existed for how long? _____		
3.	Does the individual have a suspected mental illness as evidenced by any of the following:		
a.	Inability to communicate effectively with others	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Inability to complete simple tasks unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Serious difficulty interacting with others appropriately:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Danger to self or others, aggressive, assaultive, suicidal:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e.	Frequently isolates or avoids others or exhibits signs that suggest severe anxiety or fear of strangers:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f.	Other major mental health symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Did the individual have any intervention due to a mental illness in the past two years, such as:		
a.	Hospitalization for psychiatric care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Supportive services at home:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Housing/law enforcement intervention:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Residential treatment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e.	Intensive community supports:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Question 1 OR Questions 3 or 4 must have one "Yes" answer to meet PASRR criteria for diagnosis of mental illness.

If Mental Illness is present or suspected to be present, Fax To: APS Healthcare (1-866-325-4752) Attention: APS Healthcare, PASRR Coordinator or via APS CareConnection

For questions re: PASRR or how to complete this form, CALL: 1-866-521-0027 and ask for PASRR Coordinator.

If Answers to the above Questions 1-4 are all "NO" and there is no Diagnosis OR only a Dementia Diagnosis, A copy of this form must be sent to the nursing facility and not to APS Healthcare.



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Section III: Other Related Conditions (ORC)

“Other Related Conditions” include physical, sensory or neurological disabilities which are manifested prior to 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: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self care.

The key to determining whether an individual has an ORC is the age of onset of the disability. It is the obligation of the person completing the PASRR to determine age of onset. If the clinical record does not clearly eliminate the possibility that the individual’s physical disability occurred prior to age 22, the nursing facility must ask the individual (or the individual’s representative if necessary) and document the response. This information must be available upon request to the representatives of the Department of Health and Human Services.

Instructions: An individual is considered to have an ORC which is a severe developmental disability if he/she meets all of the conditions in Sections III-A through III-D, page 3.

Section III-A: Other related conditions

1. Has the individual been diagnosed with or suspected of having one or more of the following conditions:
 Cerebral palsy: No Yes
 Epilepsy: No Yes

OR

Any other condition, other than a serious mental illness, found to be closely related to mental retardation, resulting in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with mental retardation, and requires treatment or services similar to those required for individuals with mental retardation?

- No
 Yes - please specify:

Section III-B: Other related conditions

1. Were the ORC manifested before the individual reached the age of 22? Yes No

Section III-C: Other related conditions

1. Are the ORC likely to continue indefinitely? Yes No

Section III-D: Other related conditions

1. Does the ORC result in substantial functional limitations in 3 or more of the following areas of major life activity? (Check all areas of substantial functional limitation which were present **prior to age of 22** and were directly the result of the ORC).

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

(if three or more of these functional limitations are checked, check Yes
 otherwise, check No

Questions III-A through III-D must have a “Yes” answer to meet PASRR criteria for diagnosis of an ORC.

If “Yes” to ORC, Fax to APS Healthcare (1-866-325-4752) Attention: APS Healthcare, PASRR Coordinator or via APS CareConnection

If “No” to ORC, send copy of this form to nursing facility.

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Yes - please identify facility:

Questions IV-A and IV-B OR IV-C OR IV-D must have one "Yes" answer to meet PASRR criteria for diagnosis of mental retardation, autism or PDD

If "Yes" to mental retardation, autism or PDD, Fax to:

Androscoggin, Oxford, & Franklin, 782-1753 (fax) 753-9100 (phone)

Aroostook County 493-4173 (fax) 493-4000 (phone)

Cumberland & York Counties 822-0295 (fax) 822-0270 (phone)

Kennebec & Somerset Counties 287-7186 (fax) 287-2205 (phone)

Knox, Waldo, Lincoln, & Sagadahoc Counties 596-2304 (fax) 596-4302 (phone)

Penobscot, Piscataquis, Hancock and Washington Counties 941-4389 (fax) 941-4360 (phone)

If "No" to mental retardation, send copy of this form to nursing facility.