

**MODULE V: LEVEL I SCREEN  
FOR MENTAL ILLNESS/MENTAL RETARDATION**

Agency Name and Address: \_\_\_\_\_

**IDENTIFICATION AND BACKGROUND INFORMATION**

1.	APPLICANT NAME	First: _____ (MI) _____ Last: _____	7.	EMERGENCY CONTACT: Name: _____ Address: _____ Relationship: _____ Telephone: _____ Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	ADDRESS	Street: _____ City/Town: _____ County: _____ State: _____ ZIP: _____ Phone: (____) _____	8.	CONTINUING PHYSICIAN Address: _____ Telephone: _____
3.	SOCIAL SECURITY NO.	_____	9.	Name & Address of Nursing Facility: Name: _____ Address: _____
4.	MAINECARE NO. (if applicable)	_____	10.	Estimated length of stay _____ days Has physician documented that this applicant's stay in a NF will be 30 days or less? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	MEDICARE NO. (if applicable)	_____		
6.	BIRTH DATE	Month _____ Day _____ Year _____		

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NURSING FACILITY LEVEL I SCREEN**

1. Does the individual have a major mental illness Yes - **Proceed with Level II** No - **Go to Question 3**  
diagnosis?

2. Diagnosis (Dx) \_\_\_\_\_ DSM Code: -

3. Does the individual have a suspected mental illness as evidenced by any of the following:

a. Inability to communicate effectively with others Yes No

b. Inability to complete simple tasks unassisted Yes No

c. Serious difficulty interacting with others appropriately Yes No

d. Danger to self or others, aggressive, assaultive, suicidal Yes No

e. **Frequently isolates or avoids others or exhibits signs that suggest severe anxiety or fear of strangers** Yes No

f. **Other major mental health symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms** Yes 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 Yes No

b. Supportive services at home Yes No

c. Housing/law enforcement intervention Yes No

d. Residential treatment Yes No

e. **Intensive community supports** Yes No

**\*Add the total number of Yes answers: \_\_\_\_\_**

**\* Add the total number of yes answers: \_\_\_\_\_**

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**Questions 1 or 3 & 4 must have one "Yes" answer to meet PASRR criteria for diagnosis of mental illness.  
If yes Mental Illness, FAX TO: Attention: OAMHS Statewide Coordinator fax # 287-2156, phone: 287-2175**

**IF NO MENTAL ILLNESS: SEND COPY OF THIS FORM TO NURSING FACILITY**

5. Does the individual present evidence of diagnosis and/or documented mental retardation? (Check one)  Yes  No  
**IDENTIFICATION OF MENTAL RETARDATION:** Mental retardation refers to significantly sub-average general functioning existing concurrently with the deficits in adaptive behavior, and manifested during the developmental period.

**IF YES MENTAL RETARDATION, FAX TO:** \*REGION I 822-0295(fax) 822-0270(phone)

\*REGION II: Augusta 287-7186(fax) 287-2205(phone)

Lewiston 782-1753(fax) 753-9100(phone) Rockland 596-2304(fax) 596-4302 (phone)

\*REGION III: Bangor 941-4389(fax) 941-4360(phone) Aroostook: 493-4173(fax) 493-4000 (phone)

**IF NO MENTAL RETARDATION: SEND COPY OF THIS FORM TO NURSING FACILITY**

\***Note:** Regional office areas are by counties: REGION I – Cumberland & York REGION II – Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo REGION III – Aroostook, Hancock, Penobscot, Piscataquis and Washington

**IF ANSWERS TO THE ABOVE QUESTIONS 1-5 ARE ALL "NO"  
A COPY OF THIS FORM MUST BE SENT TO THE NURSING FACILITY.**

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Fax #