



Tennessee Screening for Mental Illness and/or Mental Retardation

PreAdmission Screening and Resident Review: PASRR

Applicant

Last Name: _____ First Name: _____ Middle Initial _____

Mailing

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Medicaid # _____ Medicare Private Pay Pending

Current Location: _____ Date: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ FAX: _____

Contact Name: _____ FAX: _____ Phone: _____

PASRR (LEVEL I) Screen for Mental Illness & Mental Retardation

The certification of the PreAdmission Screening and Resident Review (PASRR) may be completed by one of the following:
Registered or Licensed Nurse, Licensed Social Worker, Physician, Nurse Practitioner, or Physician's Assistant

Mental Illness (Check YES or NO for each question)

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the individual have a diagnosis of major MENTAL ILLNESS (e.g., schizophrenia, paranoid state, bipolar disorder, atypical psychosis, major depression)? If so, indicate diagnosis: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the individual have any presenting evidence of MENTAL ILLNESS, including disturbances in orientation, affect or mood? Exclude individuals who have a primary diagnosis of dementia (including Alzheimer's disease and related disorders) and exclude individuals who have as secondary diagnosis of dementia (including Alzheimer's disease and related disorders) and who DO NOT have a primary diagnosis of a major mental illness. |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the individual had a history of MENTAL ILLNESS in the last 2 years? |

Mental Retardation (Check YES or NO for each question)

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the individual have a diagnosis of MENTAL RETARDATION? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the individual have any presenting evidence (cognitive or behavior functions) that suggest that the individual has a MENTAL RETARDATION or DEVELOPMENTAL DISABILITY? If there is a developmental disability, please describe it.
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the individual have any history of MENTAL RETARDATION or DEVELOPMENTAL DISABILITY that was manifested before the age of 22? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the individual been referred by an agency that serves persons with MENTAL RETARDATION or DEVELOPMENTAL DISABILITIES, and has the individual been deemed eligible for services of such and agency?
If so, indicate by the name of the agency: _____ |

I certify that the above PASRR information provided above is accurate. I understand that this information will be used to determine the patient's eligibility for nursing facility care. I understand any intentional act on my part to provide false information that will potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act. I further understand that under the Tennessee Medicaid False Claims Act any person who presents, or causes to be presented, to the State, a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and State civil and criminal penalties.

Signature/Title: _____ **Date:** _____

It is requested (but not required) that you attach a history and physical when submitting this form to TennCare.
This will expedite the identification of any information which might require that a PASRR evaluation be performed.



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Select Only One (1) Exemption or Categorical Determination if applicable to resident:

EXEMPTION:

- HOSPITAL EXEMPTION CRITERIA:** Admission meets all the following and has a known or suspected SMI or MR/RC:
 - Admission to NF directly from Hospital after receiving acute inpatient medical care, and
 - Need for NF is required for the condition treated in the hospital
(Specify condition: _____), and
 - Physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable.

- DEMENTIA:** The individual has a primary diagnosis of DEMENTIA (including Alzheimer's disease and related disorders) based on neurological examination; or the individual has a secondary diagnosis of DEMENTIA (including Alzheimer's disease and related disorders) based on neurological examination and does not have a primary diagnosis of a major mental illness.
Note: DEMENTIA is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of MENTAL RETARDATION.

CATEGORICAL DETERMINATION:

- SHORT-TERM CONVALESCENCE:** The individual is being admitted from a hospital to receive convalescent care not to exceed 120 days, and the individual is not a danger to self or to others.

- TERMINAL ILLNESS:** The individual is terminally ill and has a medical prognosis that life expectancy will be six (6) months or less, and the individual is not a danger to self or others.

- SEVERITY OF ILLNESS:** The individual has a medical condition of such severity that it would prohibit the individual from participating in specialized services for MENTAL ILLNESS or MENTAL RETARDATION
(e.g., coma, ventilator-dependent, severe chronic obstructive pulmonary disease, severe congestive heart failure, severe Parkinson's Disease, Huntington's Disease, or Amyotrophic Lateral Sclerosis), and the individual is not a danger to self or to others.
Note: Documentation of the severity of the illness must be submitted.

By my signature below, I CERTIFY that the individual is exempt from the PASRR (LEVEL II) EVALUATION of need for "SPECIALIZED SERVICES" for the reason indicated with a check mark. I understand that this information will be used to determine the patient's eligibility for nursing facility care. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act. I further understand that under the Tennessee Medicaid False Claims Act any person who presents, or causes to be presented, to the State, a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and State civil and criminal penalties.

Physician Signature: _____ Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

FAX: _____ Phone: _____

For instructions to complete this form go to: <http://www.tn.gov/tenncare/long-elderly.html#1>

Mail to: Medicaid Medical Review Unit or Fax to: PAE Unit at 615-741-9260
P. O. Box 450
Nashville, TN 37202-0450