Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT DBH Guidelines on Nursing Facility Referrals and Required Reviews		
POLICY NUMBER **DBH Policy 511.3**	**DATE** DEC 0 1 2014	**TL#** 269

Purpose. To establish the following: (a) procedures for admission in a nursing facility (NF) through the Preadmission Screening and Resident Review (PASRR), (b) review protocols in level of care determination and appropriateness of a NF for those already in a NF, and the (c) processes in discharge and transition when a NF is no longer appropriate for the consumer's level of care. This new revision includes the (a) addition of the Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability form (Exhibit 1), currently being used in practice but not included in the previous policy, and (b) clarification regarding the follow-up and services provided by core service agencies (CSAs) to address mental health needs when consumer is admitted to a NF.

Applicability. Applies to Saint Elizabeths Hospital (SEH), other hospitals in the District of Columbia and to any provider or entity participating in the Department of Behavioral Health (DBH) Mental Health Rehabilitation Services (MHRS) structure and/or has a contract for services with DBH. Also, applies to DBH consumers and sources of referrals for consumers to transfer from one type of facility in the community (e.g., CRF, private home) directly to a NF.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

Effective Date. This policy is effective immediately.

Superseded Policy. This policy replaces DMH Policy 511.3B with the same title dated May 22, 2013.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

Stephen T. Baron
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA	Policy No. 511.3	Date DEC 0 1 2014	Page 1
DEPARTMENT OF BEHAVIORAL HEALTH	**Supersedes** DMH Policy 511.3B with the same title dated May 22, 2013		

Subject: DBH Guidelines on Nursing Facility Referrals and Required Reviews

1. **Purpose**. To establish the following: (a) procedures for admission in a nursing facility (NF) through the Preadmission Screening and Resident Review (PASRR), (b) review protocols in level of care determination and appropriateness of a NF for those already in a NF, and the (c) processes in discharge and transition when a NF is no longer appropriate for the consumer's level of care. This new revision includes the (a) addition of the Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability form (Exhibit 1), currently being used in practice but not included in the previous policy, and (b) clarification regarding the follow-up and services provided by core service agencies (CSAs) to address mental health needs when consumer is admitted to a NF.

2. **Applicability**. Applies to Saint Elizabeths Hospital (SEH), other hospitals in the District of Columbia and to any provider or entity participating in the Department of Behavioral Health (DBH) Mental Health Rehabilitation Services (MHRS) structure and/or has a contract for services with DBH. Also, applies to DBH consumers and sources of referrals for consumers to transfer from one type of facility in the community (e.g., CRF, private home) directly to a NF.

3. **Background**. PASRR is a federal requirement to help ensure that individuals are not placed inappropriately in nursing homes for long term care. Under PASRR, applicants to Medicaid-certified NF must be screened to identify a diagnosis of serious mental illness (SMI) and/or developmental or intellectual disability (DD/ID)[1].

The DBH Behavioral Health Authority (BHA) serves as State PASRR for the District, and performs the Level II pre-admission screening for District citizens who are seeking nursing home placement and have a mental illness or a history of mental illness. DBH establishes the eligibility for admission to a nursing home, reviews continued stay for those who are already in a NF, and determines discharge and transition processes when the NF level of care no longer applies. DBH assesses if the individual has a need for the level of services provided by a NF and if he/she requires specialized services for SMI. Referrals can come from hospitals and organizations with which DBH has no formal relationship.

4. **Authority**. The Omnibus Reconciliation Act of 1987 (OBRA), P.L. 100-203, Section 4211(c)(7), OBRA 1990 and 1993, as amended by the Balanced Budget Amendment of 1996, P.L. 104-315; Department of Behavioral Health Establishment Act of 2013, D.C. Code § 7 – 1131.01 *et seq.* (2001); and 42 CFR § 483.100 *et seq.* Olmstead Community Integration Initiative, District of Columbia, April 2012.

[1] Referrals to NF for individuals with a primary diagnosis of intellectual and/or developmental disability are handled by the D.C. Department on Disability Services and are not the responsibility of the DBH PASRR system.

5. **Definitions/Abbreviations.**

5a. Change in condition. A change in status, either physical or mental, which results in decline or improvement in the mental health or functional abilities of the resident while in a NF which could prompt an evaluation of level of care, which recommends the type of services for the individual.

5b. Dementia. An overall decline in intellectual function, including difficulties with language, simple calculations, planning and judgment, and motor (muscular movement) skills as well as loss of memory.

5c. Nursing Facility (NF). Primarily provides residents with skilled nursing care and related services for the rehabilitation of injured, disabled or sick person, or, on a regular basis, health related care services above the level of custodial care to individuals with developmental disabilities.

5d. Pre-admission Screening and Resident Review (PASRR) Level I Screening. The initial screening required for all individuals prior to admission to a Medicaid certified nursing facility, regardless of payer source. The screening is conducted by hospitals, nursing facilities or DBH CSA providers for preadmission screenings.

5e. PASRR Level II Screening and Determination. A comprehensive evaluation that verifies the diagnosis of mental illness and determines the level of services by a NF including appropriateness of specialized services. It is required for all individuals identified as having possible mental illness. Evaluations are of two types: those that occur prior to admission to a NF and those that occur when a consumer is already residing in a NF and exhibits a significant change in their physical and/or mental status.

5f. Qualis Health. The current contract agency for the District that determines the type of level of care designation for Medicaid eligible consumers only of the District of Columbia and gives the final authorization for NF placement for those consumers. If Qualis Health authorizes the NF placement (based on the referral package), Qualis Health will provide a NF Services Level of Care designation representing this approval. This approval is valid for thirty (30) calendar days and therefore must be utilized within that period.

5g. Level of Care (LOC). A utilization management tool used by Medicaid to determine an individual's level of disability and the appropriate level of care/services they require. A LOC assessment is required when a person is seeking Medicaid payment for certain services in order for Medicaid to pay for NF services.

5h. Level of Care Utilization System (LOCUS). Clinical evaluation tool utilized for level of care (LOC) determination and medical necessity for adults.

5i. Plan of Care. A written plan for those individuals found to have SMI and to be in need of specialized services. These individualized models of care include the identification of the needed specialized services, potential service CSA providers, and the approximate duration, frequency, and intensity of services needed.

5j. Specialized Services. Added to NF services toward the continuous and aggressive implementation of an individualized NF plan of care.

5k. Core Services Agency (CSA). DBH-certified community-based MHRS provider that has entered into a Human Care Agreement with DBH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor.

6. **Policy**.

6a. DBH will conduct the Preadmission Screening and Resident Review (PASRR) for District citizens who are seeking placement in a NF and have a mental illness or a history of mental illness.

6b. The criteria for a NF placement is the need of an individual for 24-hour nursing care and supervision due to chronic and/or acute somatic illness and/or impaired self-care ability.

6c. CSA providers will conduct follow-up and transition planning in addressing consumer's mental health needs when admitted to a NF.

6d. CSA providers will be part of the community re-integration planning team when discharge to a community setting has been determined to be appropriate.

7. **Referrals and Determinations on Eligibility for Admission to a NF.**

7a. The DBH Chief Clinical Officer/designee will:

(1) Review and evaluate applications and referrals of individuals with mental illness who are deemed as appropriate for placement in a NF.

(2) Determine the appropriateness of the NF as the least restrictive setting for the consumer to receive the necessary medical care, psychiatric care, and assistance with activities of daily living.

(3) Make PASRR Level II determinations based on an independent physical and mental evaluation performed by a person or entity other than the Behavioral Health Authority (BHA).

(4) Coordinate actions to obtain the services of an independent psychiatrist to perform the evaluation of consumers at Saint Elizabeths Hospital.

(5) Establish whether consumers require the level of services provided by a nursing facility and whether specialized services are needed for those with mental illness while in the NF. After review and analysis of all data, provide approval where appropriate.

(6) Identify the required services for the level of care in comparison to what the nursing facility provides:

a. If specialized services are recommended, identify the specific mental health services required to meet the consumer's needs;

b. If no specialized services are indicated, identify any specific mental health services of lesser intensity than specialized services that could meet the consumer's needs;

c. Include the bases for the conclusions; and

d. Facilitate the provision of specialized or specific services needed by the consumer while in the NF.

(7) Convey, within seven (7) work days, from receipt of a complete referral package, the determination in writing to the initiating party of the PASRR (e.g., provider or discharging hospital), unless the individual is exempt from preadmission screening. PASRR approval expires thirty (30) days from the date of the determination.

NOTE: The PASRR has to be done each time a person is admitted to a nursing home; however, if the consumer is not admitted during the thirty (30) days of approval, and no significant changes in the individual's condition occurred during that time, contact the PASRR Coordinator to update the PASRR determination. Further, resubmit the DHCF Level of Care Form (Exhibit 3) to Qualis Health for approval.

(8) Conduct resident reviews of consumers already in a NF when an authorized representative notifies DBH of a significant change in the individual's physical or mental condition (see Section 10 below).

7b. The DBH PASRR Coordinator will:

(1) Work with the DBH Chief Clinical Officer/designee to coordinate review of referral packages for a NF.

(2) Coordinate the review of nursing referral packages sent to DBH. These referrals are sent for PASRR Level II screening and approval for individuals with mental illness who may or may not be DBH consumers who have had a Level I screening positive for mental illness and are recommended for NF.

Note: The PASRR Coordinator does not locate NF placements for consumers. This is accomplished at the provider level – see section 7c (2) below.

7c. The provider will:

(1) Have the referring clinician complete a Level I screening (Exhibit 1).

(2) Locate NF placements to refer consumers.

(3) For the Level I screening, at least in the case of first time identifications, issue a written notice to the consumer and his or her legal representative, if any, that the consumer has been observed to have signs of mental illness and is being referred to the

DBH for PASRR Level II screening for a NF.

(4) Complete a psychiatric evaluation of the consumer for the DBH PASRR Level II Screening (The form in Exhibit 2 may be used. If a different form is used all items must be addressed).

a. Saint Elizabeths Hospital is required to obtain an evaluation of consumers by an independent psychiatrist for the DBH PASRR Level II screening. The psychiatrist will determine the appropriateness of the consumer for placement in a NF and document it using the form shown in Exhibit 2.

b. The psychiatrist will also document physical findings that require NF care based on information in the clinical record current within the past thirty (30) days. Saint Elizabeths Hospital contacts the DBH Chief Clinical Officer/designee regarding the need for these evaluations by an independent psychiatrist.

(5) Complete all the items required in the referral package (see Section 8 below).

(6) Send all NF referral packages to the DBH PASRR Coordinator except for referrals for consumers with a primary diagnosis of dementia; or for consumers with a primary diagnosis of intellectual and/or developmental disability (also, see section 7c, 13).

(7) When a consumer is hospitalized in a private community hospital and a NF placement is being considered, it is the hospital's responsibility to complete the NF referral package and coordinate for the PASRR screenings.

(8) Forward a copy of the referral package for Behavioral Health Authority PASRR Level II screening to:

DBH PASRR Coordinator
Department of Behavioral Health
64 New York Ave., NE (3rd Floor)
Washington, DC 20002
Fax #: 202-671-2972

(9) Retain the original referral package so that copies can be made available later for the NF and/or Qualis Health.

(10) Obtain a Level II screening determination notice signed by the DBH Chief Clinical Officer from the DBH PASRR Coordinator. Ensure that all documentation is complete and the provider's working fax number is included (see section 8 below).

(11) Provide a copy of the PASRR Level II determination to the consumer and his or her legal representative, if any.

(12) For Medicaid eligible consumers, after obtaining DBH PASRR approval, fax the referral package and the Level II screening written approval to Qualis Health.

(13) After obtaining PASRR approval of the referral package for consumers eligible to

use private funds, follow internal agency procedures and NF instructions for those consumers.

(14) If there is a primary diagnosis of dementia (including Alzheimer's disease or a related disorder), or a non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, forward the referral directly to Qualis Health without a Level II screening for consumers with Medicaid eligibility. It does not have to be sent to the DBH PASRR Coordinator.

(15) Maintain a copy of the complete referral package and PASRR Level II determinations in the consumer's record in accordance with all federal and local laws and regulations.

(16) Establish internal policies and procedures and NF instructions, as necessary, on the following:

- determination of NF eligibility,
- incompetency and consent issues,
- financial issues (Medicaid eligibility, spend down of income, use of private funds),
- burial funds, and
- transportation.

8. **Referral Package Requirements.**

8a. Contents of the Referral Package. The CSA providers will complete a referral packet that includes the following:

(1) **Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability** (Exhibit 1). The completed PASRR Level I screening form for referrals to Qualis Health and direct referrals to nursing facilities for private pay consumers; signed by a licensed clinician within thirty (30) days of submission of the referral package to the DBH for Medicaid eligible consumers.

(2) **PASRR Level II: Psychiatric Evaluation** (Exhibit 2); signed by a psychiatrist within thirty (30) days of submission of the referral package to the DBH for Medicaid eligible consumers.

(3) **Request for Medicaid NF Level of Care** (Exhibit 3), DHCF 1728 Form revised 7/16/2009, signed by a psychiatrist within thirty (30) days of submission of the referral package to the DBH for Medicaid eligible consumers.

(4) **Psycho-social Assessment** (Exhibit 4) - current within ninety (90) days of submission of the referral package to DBH (this is not the diagnostic assessment); or a different form that include the same information; and

(5) **History and Physical Exam Form for PASRR Review** (Exhibit 5). This provides the medical history, including neurological and other relevant/pertinent examinations, and

pertinent examination results - current within ninety (90) days of submission of the referral package to DBH.

NOTE: ALL documentation must be legible. Illegible documentation may delay or hinder processing. Any additional documentation requested by the BHA from the provider must be provided promptly.

9. **Procedures upon consumer's acceptance in a NF**.

9a. The CSA provider will:

(1) Follow the instructions of the NF admissions coordinator once the consumer has been accepted.

(2) Comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the D.C. Mental Health Information Act. See DBH Policy 645.1, Privacy Policies and Procedures regarding release of information to outside agencies when making placement arrangements.

(3) Notify family members or significant others about consumer being admitted in a NF if they were not previously involved. Provide them with the name, address, and phone number to the NF.

(4) Request that the receiving NF initiate the change of representative payee if DBH is still the representative payee for the consumer. The change of payee must be initiated by the receiving NF immediately following placement. In all instances, financial planning must take place prior to placement.

(5) For individuals placed from Saint Elizabeths Hospital (SEH), SEH must notify the CSA responsible for the consumer of the nursing home placement.

(6) Conduct ongoing mental health services during and throughout transitions into and out of nursing facilities to include completion of LOCUS, when due, and participation in treatment team meetings.

(7) Request DBH to discharge/disenroll consumers from its services after 90 days of placement in NF, depending on the stability of the consumer during transition, complexity of the case, and/or completion of transition plan goals. The CSA shall consult with the PASRR Coordinator and the NF in this regard prior to discharge or disenrollment. The Director of Care Coordination in consult with the PASRR Coordinator must approve the discharge/disenrollment.

10. **Level of Care Review, Continued Stay and Community Re-Integration Processes**.

10a. Federal law requires that the Department conduct a PASSR Level II screening upon a significant change in a resident's physical or mental health condition. A significant change in condition may include a resident's improved condition and desire or plan to leave the NF

and return to the community. When DBH is notified by a NF or through its outreach efforts that a resident wants to return to the community, the PASRR Coordinator will:

(1) Collect the following information about the individual:

a. Demographic information (e.g., age, race, ethnicity, etc.);

b. NF information: address, telephone number and contact person at NF of who will be facilitating the transition into the community;

c. Information about family or other important stakeholders (e.g., guardians, partners, friends, etc.) who may participate in the process;

d. Brief description of the circumstances that led to the NF placement;

e. Brief description of circumstances that led the NF to admit the consumer as having mental health diagnosis and the significant change in status; and

(2) Inform the NF of the DBH requirement to complete the PASRR referral (see Sec. 8 above) to ensure a full assessment and evaluation of the person's needs and level of care.

(3) Facilitate the enrollment of the person with a DBH provider upon completion of the PASRR Level II when discharge to a community setting has been recommended.

(4) Refer the person to the DBH Chief, Continuity of Care.

(5) Nothing in this policy prohibits a resident from leaving a NF according to his or her wishes. However discharge prior to the completion of a PASRR may result in the lack of information necessary to develop and implement a safe and effective community discharge plan.

10b. The DBH Chief, Continuity of Care will:

(1) Complete a LOCUS to inform the assessment process.

(2) If the NF has not previously done so, ensure the person has been referred to the D.C. Office on Aging/Aging and Disability Resource Center (DCOA/ADRC).

(3) Convene a treatment team meeting with all the identified members, including the CSA representative, as applicable, to develop the initial transition plan.

(4) Monitor progress and with the assigned CSA facilitate the acquisition of resources needed for the consumer's transition.

(5) Turn over the responsibility for monitoring progress to the DBH Director of Integrated Care Division when the consumer is in the community setting.

11. **DBH Record Retention, Tracking System, Reports and Quality Improvement.**

11a. The PASRR Coordinator will:

(1) Maintain records of evaluations and determinations in order to support its determinations and actions and to protect the appeal rights of consumers subjected to PASRR.

(2) Track the number of referrals for new admissions to NFs, the number of residents requiring LOCUS, and referrals for which clinical record reviews and/or Level II evaluations are not completed due to situations such as the death of the consumer, discharges/transfers from nursing facilities, those never admitted to nursing facilities, and those admitted for hospitalizations.

11b. The DBH Quality Improvement Director and Chief Clinical Officer/designee will:

(1) Conduct periodic checks on completed referrals using specific protocols and guidelines to determine the accuracy of determinations and appropriateness of recommendations, if applicable and the quality of work related to the PASRR Level II evaluations.

(2) Develop recommendations toward quality improvement activities.

12. **Exhibits.**

Exhibit 1 – Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability
Exhibit 2 - PASRR Level II: Psychiatric Evaluation
Exhibit 3 – Request for Medicaid NF level of Care, DHCF 1728 Form, revised 7/16/2009
Exhibit 4 - Psycho-social Assessment
Exhibit 5 - History and Physical Exam Form for PASRR Review

Approved By:

Stephen T. Baron
Director, DBH

12/1/14
(Signature) **(Date)**

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Pre-Admission Screen/Resident Review for Mental Illness and/or Mental Retardation

CLIENT IDENTIFYING INFORMATION		
Name: (Last)	(First)	(M.I.)
Home Address:		
Social Security Number:		
Date of Birth:	Sex: Male Female (Circle)	
Current Location: __ Home __Hospital __Nursing Facility __Other _____		

Part A. EXEMPTING CRITERIA

Further completion of this form IS NOT NECESSARY if the client meets all of the exemptions listed below. Place a check mark next to each criterion met by the client. Sign and date where indicated. No further action is required. If exempting criteria is not met, proceed to Part B.

____ The individual is admitted to nursing facility directly from a hospital after receiving acute inpatient care.
____ The individual requires nursing facility services for the condition for which he/she received acute inpatient care.
____ The attending physician certifies that the individual is likely to require less than 30 days nursing facility services.
____ I certify that the client does meet **all** of the exempting criteria and that the information is true and accurate to the best of my knowledge.

_____ _____ _____
Signature Title Date

Part B. EVALUATION CRITERIA FOR MENTAL ILLNESS/ MENTAL RETARDATION

MENTAL ILLNESS

(Please check off the appropriate answers to the following three questions)
The client is considered to have a positive screen for mental illness if **all** of the three questions below are answered yes. If any of the questions below are answered no, the client has a negative screen. With a positive screen for mental illness, the client needs to be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.
*** **Please note: A primary diagnosis of Dementia, including Alzheimer's disease or related disorder is NOT considered a major mental illness.**

1. Does the client have a major mental illness? _____ Yes _____No
If yes, list diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM):
_____
2. Has the above diagnosis resulted in serious functional limitations in major life activities within the past 3 to 6 months? _____Yes _____No
3. In the past 2 years has the client had psychiatric treatment more intensive than outpatient care more than once? _____ Yes _____No

(Part B Continued)

MENTAL RETARDATION

(Please check off the appropriate answers to the following four questions)

The client is considered to have a **positive screen for mental retardation or a related condition** if one or more of the four questions below are answered **'yes'**. If **all** of the questions are answered **'no'**, the client has a negative screen for mental retardation or a related condition. With a positive screen, the client needs to be referred to the DC Developmental Disabilities Administration for a Level II evaluation.

1. Does client have a diagnosis of mental retardation or a related condition? ___Yes ___No
2. Was client diagnosed with mental retardation or a similar related condition prior to age 18? _____Yes _____No
3. Is there any presenting evidence (cognitive or behavior functions) that indicate that the client has mental retardation or a related condition? _____Yes _____No
4. Is the client being referred by and deemed eligible for services by an agency, which serves individuals with mental retardation or a related condition? _____Yes _____No

Part C: EXEMPTING CRITERIA FOR POSITIVE SCREENS
(CATEGORICAL ADVANCE GROUP DETERMINATION)
Please Answer ALL questions if Individual is Positive for MI or ID

Based upon Part B, if the individual is considered to have MI or ID, complete Part C of this form. Otherwise skip Part C and complete Part D. **If any questions are checked "yes" there is no need for referral for Level II evaluation**

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness, which required hospitalization and does not meet **all** criteria for an exempt hospital discharge? (Described in Part A) _____Yes _____No
2. Does the individual have a terminal illness (life expectancy less than 6 months) as certified by a physician? _____Yes _____No
3. Does the individual have a severe physical illness, which results in a level of impairment so severe that the individual cannot be expected to benefit from specialized services? _____Yes _____No
4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. _____Yes _____No
5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? _____Yes _____No

Part D. RESULTS OF MENTAL ILLNESS/MENTAL RETARDATION SCREENING

(Please check all that apply)

_____ Client has a negative screen for mental illness and no further action is necessary.
_____ Client has a negative screen for mental retardation and no further action is necessary.
_____ Client has a positive screen for mental illness and has been referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.
_____ Client has a positive screen for mental retardation and has been referred to the DC Developmental Disabilities Administration for a Level II evaluation.
_____ I certify that the information is true and accurate to the best of my knowledge.

Signature of the licensed health professional completing this form _____
Title _____ Date_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

PASSR LEVEL II: PSYCHIATRIC EVALUATION

Section I

Name: _____ _____ _____
Last First M.I.

Gender: _____ DOB: _____ Age: _____ SSN: _____

Facility Name: _____ Original Admission Date: _____

Is there a legal Guardian? ☐ Yes ☐ No If "Yes," please complete the following:

Name: _____ Phone: _____

Street Address: _____City/State/Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Academic Skills: ☐ Can read/write simple words ☐ Can read/recognize 3 – 4 word sentences.
☐ Can read at newspaper level ☐ Can perform simple mathematics

Last full-time employment position held/day program type: _____

Reasons for this admission (Check all that apply): ☐ Psychiatric ☐ Medical ☐ Other

_____

_____

_____

_____

DSM-IV Current Diagnoses:
AXIS I: Primary _____
AXIS I Secondary _____
AXIS II: Related Condition _____
AXIS III _____
AXIS IV _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

Section II Behavioral/Psychiatric Assessment

1. Affective Behavior Observations

a. Physical Features (mark all that apply):
☐ Clean/Tidy ☐ Poor hygiene/Unwashed ☐ Well groomed
☐ Careless/Disheveled/Sloppy ☐ Normal street dress ☐ Wearing bedclothes
☐ Makeup or jewelry ☐ No apparent effort at personal appearance
☐ Non-seasonal clothing ☐ Other (Specify) _____

b. Level of Consciousness (mark all that apply):
☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other (Specify:
_____

c. Manner (Mark all that apply):
☐ Warm ☐ Shy ☐ Threatening ☐ Concerned about others
☐ Outgoing nature ☐ Silly ☐ Sincere ☐ Apathetic
☐ Aggressive ☐ Sense of humor ☐ Suspicious ☐ Easily frustrated
☐ Childlike ☐ Reluctant to Respond
☐ Others (Specify) _____

d. Mood and Affect (Mark all that apply):
☐ Appropriate in quality and intensity to stated themes ☐ Flat or blunted

	Mild	Moderate	Severe
Depressed			
Anxious, fearful or worried			
Angry, belligerent or hostile			
Delusional			
Suicidal			
Homicidal			
Other (Specify)			

e. Form of Thought (Mark all that apply):
☐ Coherent ☐ Incoherent/Illogical ☐ Blocking ☐ Tangentiality
☐ Relevant ☐ Irrelevant/Rambling ☐ Impoverished ☐ Circumstantiality
☐ Logical ☐ Loose Associations ☐ Perseveration ☐ Pressured

f. Orientation
☐ Orientated X3; clear at al times ☐ Orientated X3; forgetful at times
☐ Oriented to person and place ☐ Oriented to person
☐ Oriented to bathroom/bed ☐ Confused at times in day
☐ Confused at times at night ☐ Disoriented X3
☐ Nonresponsive ☐ Unable to Determine

g. Communication Ability (Mark all that apply):
☐ No problems ☐ Reads ☐ Writes ☐ Speech unclear/slurred
☐ Gestures/aids ☐ Inappropriate content ☐ Stammer/stutter/impediment
☐ Eye contact ☐ Unresponsive

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

h. Socialization (Mark all that apply):
☐ Appropriately responds to others' initiations
☐ Appropriately initiates contacts with others
☐ Inappropriate responses/interactions (Describe): _____
☐ Withdrawn

i. Attitude (Mark one):
☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

2. Chart of Behavior (Instructions: Complete the chart, based on all available information for the last three (03) months, including information from the individual's medical records and staff comments). Check Category and Rate Frequency from 1 to 5 (1 least frequent, 5 Most frequent)

Category	Frequency	Category	Frequency
☐ Dangerous smoking behavior		☐ Destroys property	
☐ Refuses medications		☐ Exposes self	
☐ Uncooperative diet		☐ Is sexually aggressive	
☐ Uncooperative hygiene		☐ Abuses – verbally	
☐ Refuses activities		☐ Threatens – verbally	
☐ Refuses to eat		☐ Threatens – physically	
☐ Self-induces vomiting		☐ Strikes others – provoked	
☐ Impatient/demanding		☐ Strikes others – unprovoked	
☐ Frequent/continuous yelling		☐ Talk of suicide	
☐ Wanders		☐ Suicidal threats	
☐ Tries to escape		☐ Suicidal attempts	
☐ Seclusiveness		☐ Injures self	
☐ Suspicious of others		☐ Others (Specify)	
☐ Lies purposefully		☐ Others (Specify)	
☐ Steals deliberately		☐ None	

3. Placement in Seclusion/Physical Restraints/Behavior Change (s)
Instructions: In the last sixty (60) days, has the individual been placed in seclusion or other physical restraints to control dangerous behaviors?

☐ YES ☐ NO

If "yes," describe the behavior changes and type of restraints, if applicable:

_____

_____

4. Comments:

_____

_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

5. Functional Assessment Summary (Instructions: Describe current functional status-improvement or decline, etc. Identify any strengths or weaknesses which may impact the individual's participation in specialized services):

a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross-motor skills).

_____

_____

_____

b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others).

_____

_____

_____

c. Personal Living (Pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.):

_____

_____

_____

d. Community Living (Addresses skills to handling money, telling time, acting responsibly, preparing meals, doing laundry, etc.).

_____

_____

_____

e. Broad Independence (Addresses the individual's overall ability to take care of him/herself and interact in his environment).

_____

_____

_____

f. Problem Behaviors (Describe behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that can cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior).

_____

_____

_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

6. Psychiatric Impressions:

_____

_____

_____

7. Medical events contributing to this referral?

_____

_____

_____

8. Recommendations:

_____

_____

_____

9. Findings/Summary - Appropriate for Nursing Facility placement? ☐ YES ☐NO

_____

_____

_____

Printed Name: _____ Title: _____

Signature: _____ Date: _____

Government of the District of Columbia
Department of Health Care Finance
Request for Medicaid Nursing Facility Level of Care

Please Print Clearly and Be Sure to Complete All Sections

Level of Care Requested:	❑ Nursing Facility	❑ Adult Day Treatment	❑ Elderly and Individuals with Physical Disabilities (EPD) Waiver

Reason for Request for Nursing Facility (NF) Services:		**Reason for Request for Adult Day Treatment Services:**	**Reason for Request for EPD Waiver Services:**
❑ Return from Hospital within Medicaid Bedhold Days (Number of Bedhold Days Left _____)	❑ Initial NF Placement	❑ Initial Assessment	❑ Initial Assessment
❑ Return from Hospital after Medicaid Bedhold has Expired	❑ Conversion from Any Other Pay Source to Medicaid (Start On ____/____/_____)		❑ Annual Reassessment
❑ Transfer from EPD Waiver to NF	❑ Transfer from NF to NF		❑ Transfer from NF to EPD Waiver

Part A

Date of Request ___/ ___/ _____ Name _____
Last First Middle Initial

SS# _____ - _____ - _____ Medicaid # (if not available, state if pending) _____

Permanent Address (include name of NF, if applicable)

_____

Phone (_____) _____ – _____ Date of Birth _____ / _____ / _____ Sex _____

Legal Representative (Power of Attorney or Legal Guardian). Indicate N/A, if applicable.

_____
Last First

Address _____

Present Location of Individual (Name and Address of Hospital/NF/Community if Different From Above)

_____

Part B

(Please check one box in each row below)

Activities	Only Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement or cueing **OR** highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff **OR** cannot do for self at all)
Activities of Daily Living (ADLs)			
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Overall Mobility	❑	❑	❑
Eating	❑	❑	❑
Toilet Use	❑	❑	❑
Instrumental Activities of Daily Living (IADLs)			
Medication Management	❑	❑	❑
Meal Preparation	❑	❑	❑
Housekeeping	❑	❑	❑
Money Management	❑	❑	❑
Using Telephone	❑	❑	❑

Name _____ Medicaid #_____

Is the individual ventilator-dependent? ❑ Yes ❑ No

If additional supporting documents are included please list them here: _____

_____

Name of Person Completing Form _____ Title_____

Phone (_____) _____ – _____

Signature of Person Completing Form _____ Date _____ / _____ / _____

Part C - Must be Completed by a Physician, Physician Assistant, or Nurse Practitioner Responsible for Patient Care

The information presented above appropriately reflects the patient's functional status.

			Please check appropriate box:
Name	_____	❑	Physician
		❑	Physician Assistant
		❑	Nurse Practitioner
Address	_____	Phone	(_____) _____ - _____
	_____	NPI *	_____
Signature	_____	Date	____/____/_____

*Physician assistants should include their supervising physician's NPI number

Part D - To be completed by the Quality Improvement Organization (if needed)

Level of Care	_____	Certification Period (for EPD Only)	_____
Authorized Signature	_____	Date	____/____/_____

Comments _____

_____

Delmarva Foundation, Inc.
9240 Centreville Rd.
Easton, MD 21601
Telephone: (800) 999-3362

ALL FORMS ARE TO BE FAXED TO THE FOLLOWING NUMBER:
1-800-971-8101

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

PSYCHOSOCIAL ASSESSMENT
SAMPLE FORMAT

PART 1 BASIC INFORMATION			
Consumer Name:			Date of Assessment:
Date of Birth:	Gender: ☐ Male ☐ Female		Date(s) of Interview:
eCura #:	Social Security Number:		
Primary Language:			
English Proficiency: ☐ Not at all ☐ Limited ☐ Proficient *Translator Need? ☐ Yes ☐ No			
Homeless ☐ Yes ☐ No			
Living Arrangements/Type of Housing Prior to Nursing Care Facility Placement (describe):			
Street address:	City:	State:	Zip Code:
Phone:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			
Emergency Contact/Guardian/Conservator			
Name	Relationship	Address	Phone
Family Members and/or Significant Others			
Name	Relationship	Address	Phone
Reason for Admission to Nursing Care Facility:			

PART 2 CURRENT RESOURCES			
Does the Consumer have health insurance? ☐ Yes ☐ No			
If yes, what type of insurance?			
☐ Medicaid #: Effective Date: Expiration Date:	☐ Medicare #: Effective Date: Expiration Date:	☐ Medicare-D #: Provider Name: Effective Date: Expiration Date:	☐ Other Type of Insurance (explain)
Does the Consumer receive disability benefits? ☐ Yes ☐ No			
If yes, what type of benefits? ☐ SSI ☐ SSDI ☐ Other (explain)			
Amount of benefit:			
Does the Consumer have a representative payee? ☐ Yes ☐ No			

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

If yes, record the following for the representative payee: Name:			
Street address:	City:	State:	Zip Code:
Does the Consumer have any other sources of income?			
Source:	Amount:		

PART 3 CONSUMER PERSPECTIVE (in Consumer's own words)
Reason for the referral/Presenting Problem:
Consumer's strengths:
Consumer's attitude toward placement:
Goals for treatment:
Goals for discharge:

PART 4 CULTURAL CONSIDERATIONS
Race/Ethnicity:
Religious Preferences/Involvement in Spiritual Activities:
Cultural Identification and Involvement:
Community Involvement and Activities:
Interests/Hobbies:

PART 5 DEVELOPMENTAL HISTORY

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Family of Origin:
History of Relationships:
History of Any Trauma:
Medical History:
Psychiatric History:
Significant Events:

PART 6 SOCIAL HISTORY		
Educational History:		
Employment History:		
Military History:		
Sexual History: (e.g. sexual orientation, sexual abuse)		
Is there a history of physical/emotional abuse and neglect? ☐ Yes ☐ No If yes, describe		
Is there a history of psychiatric hospitalizations? ☐ Yes ☐ No If yes, describe		
Is there a history of medical hospitalizations? ☐ Yes ☐ No If yes, describe		
Is there a legal history? ☐ Yes ☐ No If yes, describe.		
Case(s) pending:		
Attorney		
Name:	Address:	Phone:
Describe daily activities prior to placement in nursing care facility:		

PART 7 DRUG AND ALCOHOL ABUSE HISTORY								
Current Substance Abuse ☐ Yes ☐ No ☐ N/A								
History of Substance Abuse ☐ Yes ☐ No ☐ N/A								
Substance Name	Amount & Frequency	Route of Administration	Date of first	Date of last use	Length of use	Longest Abstinence	Attempts to stop	Effect on Life and

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

	of Use		use				using	Relationships

Describe Prior Substance Treatment History (e.g. detox, rehab etc.)

PART 8 DIAGNOSTIC IMPRESSION
Axis I
Axis II
Axis III
Axis IV
Axis V GAF
Overall Summary/Recommendations:
Medications:
Level of Functioning: (e.g. ambulation, ADL skill level, requires durable medical equipment, etc.)

PART 9 COMMUNITY SUPPORT NEEDS (applicable for step down from nursing care facility)		
Community Support Agency:	Community Support Worker:	Phone:
Benefits/Financial Entitlement:		

Consumer Name: *eCura#*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Housing Level of Care Needed: (include appropriateness to return to previous living arrangements)
Day Activity Recommendation(s): (day program, education, volunteer, employment etc.)
Religious Spiritual Preferences Recommendations: (if desired)
Substance Abuse Program: (as applicable)
Medical Follow Up: (as applicable)
Psychiatric Follow Up: (as applicable)
Other:

SIGNATURES		
Social Work	Signature	Date
	Print Name	
Other Discipline	Signature	Date
	Print Name	

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

CLINICAL RECORD

History and Physical Exam Form For PASRR Reviews

Patient Name:	Hospital No:	Unit:
Date of assessment:		

PART I: HISTORY OF PRESENT ILLNESS

Most recent diagnosis:

Current medications:

Substance abuse history:

ALLERGIES/ADVERSE REACTIONS:

Current PPD status:

Chest x-ray:

PART II: PAST MEDICAL HISTORY

Childhood illnesses (including developmental issues):

Adult illnesses (resolved), past hospital admissions:

Surgeries:

Injuries (head):

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

Family history:				
IMMUNIZATIONS				
Influenza:	☐ Yes	☐ No	☐ Refused	☐ N/A
Pneumovax:	☐ Yes	☐ No	☐ Refused	☐ N/A
Tetanus:	☐ Yes	☐ No	☐ Refused	☐ N/A

PART III: REVIEW OF SYSTEMS

Constitutional symptoms:		
ENT (Ear, Nose and Throat): If abnormal, describe:	☐ Normal	☐ Abnormal
Respiratory: If abnormal, describe:	☐ Normal	☐ Abnormal
Cardiovascular: If abnormal, describe:	☐ Normal	☐ Abnormal
Gastrointestinal: If abnormal, describe:	☐ Normal	☐ Abnormal
Genito-Urinary: If abnormal, describe:	☐ Normal	☐ Abnormal
Gynecological: If abnormal, describe:	☐ Normal	☐ Abnormal
Lymphadenopathy: If abnormal, describe:	☐ Normal	☐ Abnormal
Musculo-Skeletal: If abnormal, describe:	☐ Normal	☐ Abnormal
Neurological: If abnormal, describe:	☐ Normal	☐ Abnormal
Psychiatric: If abnormal, describe:	☐ Normal	☐ Abnormal

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

PART IV: PHYSICAL EXAMINATION

Height:	**Weight:**	**Temperature:**	**Pulse:**	**Blood Pressure:**
General Appearance:				
Orientated (time, place, person): ☐ Yes ☐ No If no, describe:				
Affect: ☐ Full range ☐ Expansive ☐ Labile ☐ Flat ☐ Constricted ☐ Blunted Describe:				
Eyes: ☐ WNL ☐ Abnormal If abnormal, describe:				
Nose: ☐ WNL ☐ Abnormal If abnormal, describe:				
Mouth: ☐ WNL ☐ Abnormal If abnormal, describe:				
Throat: ☐ WNL ☐ Abnormal If abnormal, describe:				
Teeth: ☐ WNL ☐ Abnormal If abnormal, describe:				
Chest: ☐ WNL ☐ Abnormal If abnormal, describe:				
Cardiovascular: ☐ WNL ☐ Abnormal If abnormal, describe:				
Abdominal: ☐ WNL ☐ Abnormal If abnormal, describe:				
Prostate: ☐ WNL ☐ Abnormal If abnormal, describe:				
Musculoskeletal: ☐ WNL ☐ Abnormal If abnormal, describe:				
Extremities/Nails: ☐ WNL ☐ Abnormal If abnormal, describe:				
Skin: ☐ WNL ☐ Abnormal If abnormal, describe:				

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DEPARTMENT OFBEHAVIORAL HEALTH

Lymphatics: If abnormal, describe:	☐ WNL	☐ Abnormal

PART V: NEUROLOGICAL EXAM

Sensory: If abnormal, describe:	☐ WNL	☐ Abnormal
Motor: If abnormal, describe:	☐ WNL	☐ Abnormal
Reflexes: If abnormal, describe:	☐ WNL	☐ Abnormal
Strength: If abnormal, describe:	☐ WNL	☐ Abnormal
Romberg: If abnormal, describe:	☐ WNL	☐ Abnormal
Gait: If abnormal, describe:	☐ WNL	☐ Abnormal

Cranial Nerves			
I:	II:	III:	IV:
V:	VI:	VII:	VIII:
IV:	X:	XI:	XII:

Assessment:

Plan:

SIGNATURE

Physician	Signature	
	Name	Date: