Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT **Preadmission Screening and Resident Reviews (PASRR)**		
POLICY NUMBER **DBH Policy 511.3D**	**DATE** AUG 0 2 2019	**TL#** 326

Purpose. These policy and procedures establish the Preadmission Screening and Resident Reviews (PASRR) for individuals referred for nursing facility (NF) placement and those who experience a change in condition in the District of Columbia (District). The primary change in this revision is the inclusion of the new Exhibit 1, Level 1 Pre-Admission Screen/Resident Review (PASRR) for SMI, or Related Conditions, and Exhibit 3, Prescription Order Form (POF) for Long Term Care (LTC) Services and Supports.

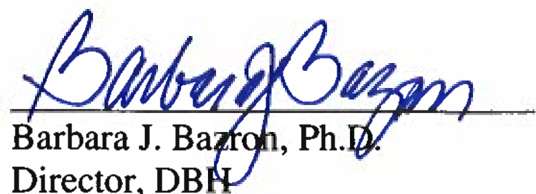
Applicability. Applies to all Department of Behavioral Health (DBH)-certified providers, Saint Elizabeths Hospital (SEH), other hospitals in the District, and entities which refer persons for transfers from facility in the community (e.g., Community Residential Facilities (CRF), private home) to a NF. PASRR applies to anyone in the District entering a NF, regardless of payment source (Medicaid, Medicare or private pay).

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

Effective Date. This policy is effective immediately. Questions regarding this policy may be addressed to DBH through the provider agency's Network Development Specialist.

Superseded Policy. DBH Policy 511.3C, Preadmission Screening and Resident Review (PASRR), dated September 28, 2017.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Please contact Ana Veria at ana.veria@dc.gov or Keri Nash at keri.nash@dc.gov for a Word version of this policy. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.



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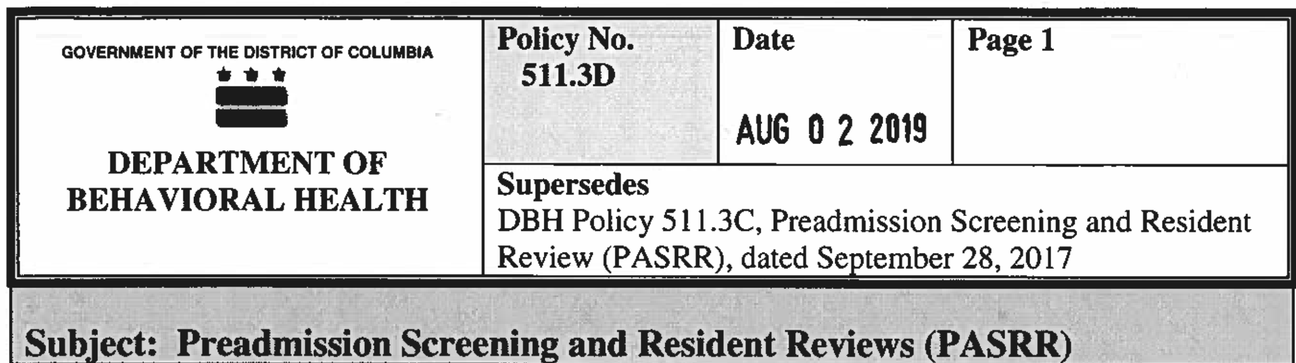

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 511.3D	Date AUG 0 2 2019	Page 1
	Supersedes DBH Policy 511.3C, Preadmission Screening and Resident Review (PASRR), dated September 28, 2017		

Subject: Preadmission Screening and Resident Reviews (PASRR)

1. **Purpose**. These policy and procedures establish the Preadmission Screening and Resident Reviews (PASRR) for individuals referred for nursing facility (NF) placement and those who experience a change in condition in the District of Columbia (District).

2. **Applicability**. Applies to all Department of Behavioral Health (DBH)-certified providers, Saint Elizabeths Hospital (SEH), other hospitals in the District, and entities which refer persons for transfers from facility in the community (e.g., Community Residential Facilities (CRF), private home) to a NF. PASRR applies to anyone in the District entering a NF, regardless of payment source (Medicaid, Medicare or private pay).

3. **Background**. PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in a NF for long term care. PASRR requirements[1] include: (1) All applicants to a Medicaid-certified NF be evaluated for mental illness (MI) and/or intellectual disability (ID) or related condition (RC); (2) Individuals be offered the most appropriate setting for their needs in the community, a NF, or acute care settings; and (3) Individuals receive the services they need in those settings.

DBH serves as the State PASRR agency 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.

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; 42 CFR § 483.100 *et seq.*; the Department of Behavioral Health Establishment Act of 2013, D.C. Code § 7 – 1141.01 *et seq.*; and the District of Columbia's Olmstead Community Integration Plan.[2]

5. **Definitions/Abbreviations.**

5a. Change in condition. A change in status in the individual, either physical or mental, which results in decline or improvement in the mental health or functional abilities.

5b. Consumer. Adults, children, or youth who seek or receive mental health services or mental health supports funded or regulated by DBH.

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[1] PASRR requirements are contained in Title 42, Code of Federal Regulations, § 483.100 to 138.
[2] https://dcoa.dc.gov/publication/olmstead-community-integration-plan

5b. Consumer. Adults, children, or youth who seek or receive mental health services or mental health supports funded or regulated by DBH.

5c. DBH-certified providers. Providers with a Human Care Agreement (HCA) who have been certified by DBH to deliver services that support individual recovery. A provider must comply with local and federal rules and regulations.

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

5e. History and Physical Exam Form (Exhibit 5). The form that captures any and all diagnoses that could support the resident's need for PASSR services, especially the adaptive living skills that could impact services/plan of care.

5f. Independent Psychiatrist. A psychiatrist not affiliated with the hospital or NF where the consumer resides.

5g. Level 1 Pre-admission Screen/Resident Review for SMI, ID, or Related Conditions (Exhibit 1). The initial screening required for all individuals prior to admission to a Medicaid certified NF, regardless of payer source, to determine whether they might have MI, ID or RC.

5h. Nursing Facility (NF). One of many settings for LTC, including other services and supports outside of an institution, provided by Medicaid or other state agencies.

5i. PASRR Level II: Psychiatric Evaluation (Exhibit 2). A comprehensive evaluation that verifies the diagnosis of mental illness from Level I screening. Level II determines the individual's needs, appropriate setting, and recommendations for the plan of care, including specialized services. Evaluations are of two types: those that occur prior to an NF admission and those during an NF stay whenever there is a significant change in the resident's physical and/or mental status (*See* §5a above).

5j. Prescription Order Form (POF) for Long Term Care Services and Supports (Exhibit 3). An order by a clinician to verify that an individual needs LTC services.

5k. Psycho-social Assessment (Exhibit 4). An assessment of IQ (for PASRR/ID) performed by a PhD psychologist, or an assessment of psychiatric history (for PASRR/MI) performed by a qualified assessor (e.g., a psychiatrist, a psychiatric social worker, or a nurse with substantial psychiatric experience). Note: A test of intellectual functioning (IQ test) is not required by PASRR regulations.

5l. Quality Management Reviewer. Contractor hired by the District to serve as the quality management reviewer for PASRR.

5m. Representative Payee. An individual or organization that receives payments from various funding sources for someone who is incapable of managing or directing someone else to manage his/her financial affairs.

5n. Specialized Services. Any service or support recommended via a Level II determination of a NF resident, owing to their SMI, ID or RC, that supplements the scope of services the NF must provide under reimbursement as NF services.

6. **Policy**.

6a. Individuals referred for admission to a NF must be screened for evidence of MI and/or ID or RC. Entries are based on whether the individual has the following:

(1) Diagnosis of MI or a history of MI or a co-occurring MI and a substance use disorder; and

(2) Substantiated need for 24-hour nursing care and supervision due to chronic and/or acute somatic illness and/or impaired self-care ability.

6b. The referring provider must complete the PASRR Level I Screening (Exhibit 1). If the result is positive for MI, the provider must conduct the Level II Psychiatric Evaluation (Exhibit 2). Both screenings shall be submitted to the DBH PASRR Coordinator.

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 SMI, and for those with a primary diagnosis of ID or RC, the referral must be directly submitted to the Quality Management Reviewer without a Level II screening for individuals with Medicaid eligibility. It does not have to be sent to the DBH PASRR coordinator.

6c. The DBH-certified providers or referring providers must conduct follow-up and transition planning in addressing the individual's mental health needs when admitted to a NF.

6d. For residents enrolled with a DBH-certified provider, the provider must be a part of the community re-integration planning team when an individual's discharge to the 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 MI who are considered appropriate for NF placement.

(2) Ensure that PASRR Level II determinations are based on physical and mental evaluation by an independent psychiatrist (*See* §5f above) which substantiates MI and need for a NF [*See* §7c (4) a] below.

(3) Coordinate actions to obtain the services of an independent psychiatrist to perform assessments of individuals getting treatment at SEH.

(4) Establish whether individuals with MI require the level of services provided by a NF and whether specialized services are needed. After review and analysis of all data, provide approval where appropriate.

(5) Identify the required services in comparison to what the NF provides:

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

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

c. Provide justification for the conclusions; and

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

(6) Convey, within seven (7) work days, from receipt of a complete referral package (*See* §8), 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 (*See* Exhibit 1 – Section A, Exempting Criteria).

NOTE: The PASRR must be done each time a person is admitted to an NF. **PASRR approval expires thirty (30) days from the date of the determination**; however, if the individual is not admitted during the thirty (30) days of approval, and no significant changes in condition occurred during that time, the PASRR Coordinator must be contacted to update the PASRR determination. Further, the Request for Medicaid Nursing Facility Level of Care Form (Exhibit 3) must be resubmitted to DHCF for the Quality Management Reviewer's approval.

(7) Facilitate resident reviews for individuals 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).

7b. The DBH PASRR Coordinator will:

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

(2) Coordinate the review of nursing referral packages sent to DBH. These referrals are sent for PASRR Level II evaluation and approval for individuals with MI who screened positive in PASRR Level I screening 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 DBH-certified provider (*See* §5c above) 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 individual has been observed to have signs of MI and is being referred to DBH for PASRR Level II Evaluation (Exhibit 2).

(4) Complete the PASRR Level II Evaluation (Exhibit 2).

Note: If a different form from Exhibit 2 is utilized, it must address all items noted in Exhibit 2.

a. SEH is required to obtain an evaluation of individuals by an independent psychiatrist for the DBH PASRR Level II Evaluation. The psychiatrist must determine the appropriateness of NF referral and document this 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. SEH 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 which include PASRR Level I screening (Exhibit 1) to the DBH PASRR Coordinator except for referrals for individuals with a primary diagnosis of dementia; or for those with a primary diagnosis of ID or RC (also, see section 7c, 14 below).

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

(8) Forward a copy of the referral package for DBH PASRR Level II evaluation to:

DBH PASRR Coordinator
Department of Behavioral Health
64 New York Ave., NE (3rd Floor)
Washington, DC 20002
Fax #: (202) 671-2972
Contact Telephone Number: (202) 673-6450
Email: chaka.curtis@dc.gov

(9) Retain the original referral package so that copies can be made available later for the NF and Quality Management Reviewer.

(10) Obtain a Level II evaluation 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 (Exhibit 2) to the individual being referred to NF and his or her legal representative, if any.

(12) For Medicaid eligible consumers, after obtaining DBH PASRR approval, the referral package and the Level II evaluation written approval must be submitted to the Quality Management Reviewer.

(13) After obtaining PASRR approval of the referral package for individuals 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 SMI, and for those with a primary diagnosis of ID or RC, the referral must be directly submitted to the Quality Management Reviewer without a Level II screening for individuals 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 evaluation (Exhibit 2) in the individual'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 items that are to be considered under Medicaid/Medicare and PASRR: (1) determination of NF eligibility, (2) incompetency and consent issues, (3) financial issues[3] (Medicaid eligibility, spend down of income, use of private funds), (4) burial funds, and (4) transportation.

8. **NF Referral Package Requirements Summary.** The DBH-certified providers must complete a NF 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 the Quality Management Reviewer and direct referrals to NF 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) Prescription Order Form (POF) (Exhibit 3): Signed by a psychiatrist within thirty (30) days of submission of the referral package to DBH for Medicaid eligible consumers.

[3] https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html

(4) Psycho-social Assessment (Exhibit 4): Current within ninety (90) days of submission of the referral package to DBH. Exhibit 4 or a different form that includes the same information can be used. This document will not serve as the diagnostic assessment; 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 DBH from the provider must be provided promptly considering the timelines in § 8 above.

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

9a. The referring 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) If the consumer provides informed consent compliant with HIPAA and the Mental Health Information Act, 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 of the NF.

(4) Request that the receiving NF initiate the change of representative payee (See §5m above) 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 referred from SEH, SEH must notify the DBH-certified provider responsible for the consumer of the nursing home placement. If the consumer is not connected to a provider, the SEH social worker will facilitate the referral of the person to the NF in coordination with the PASRR Coordinator.

(6) Conduct ongoing mental health services during and throughout transitions into and out of NFs, including 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 DBH-certified provider shall consult with the PASRR Coordinator and the NF prior to discharge or disenrollment. The DBH Community Services Administrator/designee, in consult with the PASRR Coordinator, must approve the discharge/disenrollment.

10. **Resident Review when there is a significant change**

10a. If there is a significant change in status, the NF will contact the DBH PASRR Coordinator for a Level II evaluation, to be done by an independent psychiatrist. Consumers who screen positive for intellectual disability or a related condition will be referred to the DC Department on Disability Services for a Level II evaluation (see section 7b above).

10b. When DBH is notified by a NF, a referral source or through its outreach efforts, the PASRR Coordinator will:

(1) Review 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; and

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

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

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

(4) Refer the person to the DBH Community Services Administration.

(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.

10c. The DBH Community Services Administration/designee will:

(1) Ensure that the individual has been referred to the D.C. Office on Aging/Aging and Disability Resource Center (DCOA/ADRC) if the NF has not previously done so.

(2) Convene a treatment team meeting with all the identified members, including the DBH-certified provider representative, as applicable, to develop the initial transition plan.

(3) Monitor progress and with the assigned DBH-certified provider, facilitate the acquisition of resources needed for the consumer's transition.

(4) Monitor progress 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 to support their 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 NFs, those never admitted to nursing facilities, and those admitted for hospitalizations.

11b. The DBH Accountability Administration/designee will:

(1) Conduct periodic checks on NF related to provider certification.

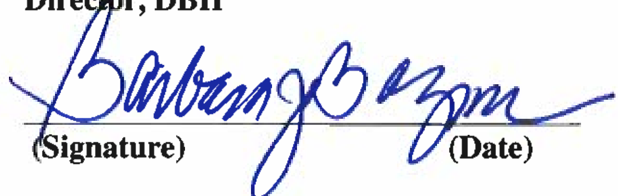
(2) Develop recommendations toward quality improvement activities.

12. **Exhibits.**

Exhibit 1 – Level 1 Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions
Exhibit 2 - PASRR Level II: Psychiatric Evaluation
Exhibit 3 – Prescription Order Form (POF) for Long Term Care Services and Supports
Exhibit 4 - Psychosocial Assessment
Exhibit 5 - History and Physical Exam Form for PASRR Reviews

Approved By:

Barbara J. Bazron, Ph. D.
Director, DBH



(Signature) (Date)

Government of the District of Columbia

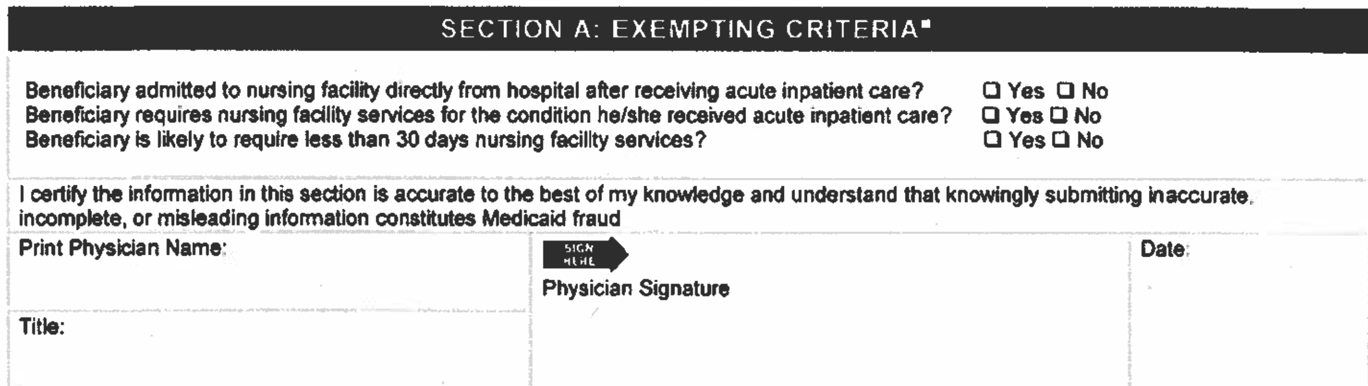
Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

BENEFICIARY INFORMATION

Last Name:	First:	M.I.:	Gender: ❑ M ❑ F	Medicaid ID:	Social Security Number:
Date of Birth:	Assessment Type: ❑ Preadmission ❑ Significant Physical Change ❑ Significant Mental Change ❑ Suspicion of SMI or ID				

LEGAL STATUS

❑ Commitment ❑ Legal Guardian-Conservator ❑ Legal Representative/POA	Location: ❑ Home ❑ Hospital ❑ Nursing Facility ❑ Other		
Applicant agrees to legal guardian and/or family participation? ❑ Yes ❑ No	Interpreter Required? ❑ Yes ❑ No ❑ Spanish ❑ Amharic ❑ Chinese ❑ Korean ❑ Other	Interpreter Name:	
Legal Guardian/Family Member:	Street Address:		
Telephone:	City:	ST:	ZIP Code:
Power of Attorney:	Street Address:		
Telephone:	City:	ST:	Zip Code:



SECTION A: EXEMPTING CRITERIA*

Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care?	❑ Yes ❑ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care?	❑ Yes ❑ No
Beneficiary is likely to require less than 30 days nursing facility services?	❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Physician Name:	SIGN HERE Physician Signature	Date:
Title:		

Further completion of this form IS NOT NECESSARY if the beneficiary meets* ***all* *of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days , the Level II evaluation must be completed no later than the 40th day of admission, on or before the date:*

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI)♦

1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code__________________
   ❑ Yes ❑ No ❑ Unknown
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? ❑ Yes ❑ No ❑ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. ➔
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ❑ Yes ❑ No ❑ Unknown
   Specify diagnosis ➔

SMI Determination Based Upon: ❑ Documented History ❑ Behavioral Observation ❑ Medications ❑ Individual/Legal Guardian/Family Report

♦The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes". With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.

SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? ❑ Yes (❑ Current ❑ Past: When) ❑ No

Check box preceding description if any subcategories below are applicable:

❑ ***Interpersonal functioning.*** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

❑ ***Concentration, persistence, and pace.*** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

❑ ***Adaptation to change.*** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

❑ experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or:

❑ due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

Narrative information including dates: ______________________________

____

____

____

The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? ❑ Yes ❑ No

If questions 1 and 2 in Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

1. Does the beneficiary have a diagnosis of ID or related condition (mild, moderate, severe, or profound)? ❑ Yes ❑ No
   List diagnosis (es) or evidence: ______________________________
2. Beneficiary diagnosed with ID prior to age 18? ❑ Yes ❑ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ❑ Yes ❑ No
4. Is the beneficiary registered for services with an agency which serves individuals with ID or related conditions? ❑ Yes ❑ No
   a. If Yes, describe the services the beneficiary is receiving: ______________________________
   b. Name of service provider and contact information: ______________________________
   c. If No, is the beneficiary interested in receiving services? ❑ Yes ❑ No
5. Has the beneficiary ever been a resident of a state facility including a state hospital, a state school, or other state facility?
   ❑ Yes ❑ No ❑ Unknown
   If Yes, indicate the name of the facility and the date(s): ______________________________
6. Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? ❑ Yes ❑ No
   Condition: ❑ autism ❑ seizure disorder ❑ cerebral palsy❑ spina bifida ❑ fetal alcohol syndrome ❑ muscular dystrophy ❑ deaf ❑ blindness ❑ closed head injury ❑ other: ______________
   Impairment: ❑ mobility ❑ self-care ❑ self-direction ❑ learning ❑ understanding/use of language ❑ capacity for independent living.
   Was the date of onset prior to age 22? ❑ Yes ❑ No If yes, explain: ______________________________

Beneficiary is considered to have a positive screen for ID or related condition if one or more of the above questions in the above section are answered Yes. As a result, the beneficiary must be referred to the District of Columbia Department of Disability Services for Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or related condition.

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:		Date:
Title:		

SECTION E: DEMENTIA*

- ❑ The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD. (If checked specify DSM-5 or ICD codes:____________________
- ❑ The following criteria were used to establish the basis for a dementia diagnosis: ❑ Mental Status Exam ❑ Neurological ❑ History Symptoms ❑ Other Diagnostics (specify):____________________
- ❑ The physician documented dementia as the primary diagnosis OR that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: ____________________

******A primary diagnosis of dementia, including Alzheimer's disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness. If there is no confirmed diagnosis of dementia, check* N/A❑. *Only if the boxes in front of ALL THREE statements above are checked, is the beneficiary designated as having primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary is not designated as having primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. Is the beneficiary 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 Section A)? ❑ Yes ❑ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ❑ Yes ❑ No
3. Does the beneficiary have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services? ❑ Yes ❑ No
4. Is this beneficiary being provisionally admitted pending further assessment due to an emergency requiring protective services? The stay will not exceed 7 days. ❑ Yes ❑ No
5. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen)
6. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:		Date:

°If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral. ↑

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

- ☐ Beneficiary has negative screen for serious mental illness and no further action is necessary.
- ☐ Beneficiary has negative screen for ID or related conditions and no further action is necessary.
- ☐ Beneficiary has a positive screen for serious mental illness and has been referred to DBH for a Level II evaluation. Date:
- ☐ Beneficiary has a possible positive screen and the Level 1 form has been forwarded to DBH for review. Date:
- ☐ Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
- ☐ Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative ☐ Yes ☐ No Date :

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:		Date:

The District of Columbia Department on Disability Services is the contact agency for a **Level II** evaluation:

DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
Independence Square Building
250 E Street, SW
Washington, DC 20024
dds.hw@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for **Level II** evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-2972 (fax)
chaka.curtis@dc.gov

For individuals who wish to be enrolled in Medicaid-certified nursing facility, please fax this form along with the Prescription Order Form to Liberty Healthcare Corporation. The fax # is (202) 698-2075.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: ______________________________

PASRR 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

____

____

____

____

ICD-I0-CM Diagnosis:

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) ____________________________

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DEPARTMENT OF BEHAVIORAL HEALTH

Name: ______________________

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 all 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

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

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DEPARTMENT OF BEHAVIORAL HEALTH

Name: ______________________________

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:

____

____

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).

____

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DEPARTMENT OF BEHAVIORAL HEALTH

Name: ______________________________

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).

6. Psychiatric Impressions:

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DEPARTMENT OF BEHAVIORAL HEALTH

Name: ______________________________

____

7. Medical events contributing to this referral?

____

____

____

8. Recommendations:

____

____

____

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

____

____

____

Printed Name: ______________________________ Title: ______________________________

Signature: ______________________________ Date: ______________________________

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION ORDER FORM (POF)
FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be faxed to Liberty Healthcare Corporation at 202-698-2075.

This Prescription Order Form (POF) is required by the District of Columbia's Department of Health Care Finance (DHCF) to authorize Medicaid-funded long term care services and supports. Prior to submission, the following items (indicated with a **) **must** be completed.

- Patient Medicaid Number (if available)
- Patient full name
- Patient date of birth
- Patient telephone number
- Provider name
- Provider telephone number
- Patient's chronic medical conditions
- Reason for referral to assessment
- Signature of ordering physician / APRN

Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be accessed at www.dcpdms.com by clicking "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted and will not be part of the Medicaid-eligible providers' directory.

SECTION I: PATIENT INFORMATION

A. **Patient DC Medicaid Number (8 digits).
If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

B. **Patient Name (Last, First):

C. **Date of Birth (MM/DD/YYYY):

D. **Telephone Number:

E. Secondary Telephone Number:

F. ** Current Address:

G. Permanent Address (if different than above)

H. Emergency Contact Name:

I. Telephone Number:

SECTION II. DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s) / ICD-10 diagnosis(es):

B** Reason for referral to assessment: ☐ Hospital Discharge ☐ Reassessment ☐ Initial assessment ☐ Change in patient condition

C. **If "Change in patient condition" was checked in section B, please indicate how this patient's condition has changed significantly since his/her most recent assessment:

SECTION III: PHYSICIAN/APRN INFORMATION

A. **Provider Name (Last, First):

B. **DC Medicaid Provider Number:

C. **Telephone Number:

D. **National Provider Identifier (NPI) Number:

E. **Provider Address:

F. **Fax Number:

I have examined this patient and certify that long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN:

Date:

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:		Date(s) of Interview:
iCAMS ID#:	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:

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Department of Behavioral Health

PART 5 DEVELOPMENTAL HISTORY
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		

Consumer Name: *iCAMS Identification #:*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Substance Name	Amount & Frequency of Use	Route of Administration	Date of first use	Date of last use	Length of use	Longest Abstinence	Attempts to stop using	Effect on Life and Relationships

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

PART 8 DIAGNOSTIC IMPRESSION

ICD 10 CM

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:

Consumer Name: *iCAMS Identification #:*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Benefits/Financial Entitlement:		
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	

Consumer Name: *iCAMS Identification #:*

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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

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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: