

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)  
LEVEL I ID SCREEN FOR  
MENTAL ILLNESS AND MENTAL RETARDATION OR RELATED CONDITIONS

NOTE: This form must be completed for all applicants to nursing facilities (NF) which participate in the Maryland Medical Assistance Program, regardless of applicant's payment source.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Actual /Requested Nursing Facility Adm. Date: \_\_\_\_\_

Current Location of Individual: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_ Tel. #: \_\_\_\_\_

A. EXEMPTED HOSPITAL DISCHARGE

1. Is the individual admitted to a NF directly from a hospital after receiving acute inpatient care? Yes  No
2. Does the individual require NF services for the condition for which he received care in the hospital? Yes  No
3. Has the attending physician certified before admission to the NF that the resident is likely to require less than 30 days NF services? Yes  No

**IF ALL THREE QUESTIONS ARE ANSWERED YES, FURTHER SCREENING IS NOT REQUIRED (PLEASE SIGN AND DATE BELOW) IF ANY QUESTION IS ANSWERED NO, THE REMAINDER OF THE FORM MUST BE COMPLETED AS DIRECTED.**

**IF THE STAY EXTENDS FOR 30 DAYS OR MORE, A NEW SCREEN AND ARR MUST BE PERFORMED WITHIN 40 DAYS OF ADMISSION.**

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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B. MENTAL RETARDATION (MR) AND RELATED CONDITIONS (see definitions)

1. Does the individual have a diagnosis of MR related condition?  
If yes, specify diagnosis \_\_\_\_\_ Yes  No
2. Is there any history of MR or related condition in the individual's past, prior to age 22? Yes  No
3. Is there any presenting evidence (cognitive or behavior functions) that may indicate that the individual has MR or related conditions? Yes  No
4. Is the individual being referred by, and deemed eligible for services by an agency which serves persons with MR or related conditions? Yes  No

Is the individual considered to have MR or a Related Condition? If the answer is Yes to one or more of the above, check "Yes". If the answers are No to all of the above check "No".

Yes  No

Name: \_\_\_\_\_

C. SERIOUS MENTAL ILLNESS (MI) (see definitions)

1. Diagnosis. Does the individual have a major mental disorder?  
If yes, list diagnosis and DSM III-R Code \_\_\_\_\_ Yes  No
2. Level of impairment. Has the disorder resulted in serious functional limitations in major life activities within the past 3-6 months (e.g., interpersonal functioning, concentration, persistence and pace; or adaptation to change)? Yes  No
3. Recent treatment. In the past 2 years, has the individual had more than one inpatient admission or an episode of significant disruption to the normal living situation where supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials? Yes  No

Is the individual considered to have a SERIOUS MENTAL ILLNESS? If the answer is Yes to all 3 of the above, check "yes". If the response is No to one or more of the above, check "No".

Yes  No

If the individual is considered to have MI or MR or a related condition, complete Part D of this form. Otherwise, skip Part D and sign below.

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

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 (describe in Part A) Yes  No
2. Does the individual have a terminal illness (life expectancy of less than six 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 could not be expected to benefit from specialized service? 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 day. Yes  No
5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? Yes  No

If the answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach. Additionally, if questions 1, 2 or 3 are checked "Yes", or if all answers in Part D are No, the individual must be referred to GES for a level II Evaluation.

I certify that the above information is correct to the best of my knowledge. If the initial ID screen is positive and a GES Level II evaluation is required, a copy of the ID screen has been provided to the applicant/resident and legal representative.

Name & Title \_\_\_\_\_ Date \_\_\_\_\_

FOR POSITIVE ID SCREENS, NOT COVERED UNDER CATEGORICAL DETERMINATIONS, check below.

- \_\_\_\_\_ This applicant has been cleared by the Department for nursing facility admission.  
\_\_\_\_\_ This applicant has been reviewed as part of the annual resident review process.

Local GES Office \_\_\_\_\_ Contact \_\_\_\_\_ Date \_\_\_\_\_