

## Preadmission Screening and Resident Review (PASRR) Program Training Certification

### I. Hospital Contact Information

Please provide hospital name, National Provider Identification (NPI) number, address, and a single hospital contact (person's name, phone number, and e-mail address) who will be the primary contact for the Department of Health Care Services' (DHCS) PASRR Program training.

Hospital Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**It is the responsibility of the hospital to notify DHCS within ten (10) business days of any changes to the hospital's primary contact by emailing updated contact information to [PASRR@dhcs.ca.gov](mailto:PASRR@dhcs.ca.gov).**

### II. PASRR Training & Level 1 Screening Requirements

The purpose of the PASRR Program is to determine if individuals with serious mental illness and/or intellectual/developmental disability or related conditions require nursing facility services (considering the least restrictive setting) and/or specialized services.

The PASRR process consists of a Level 1 Screening, Level 2 Evaluation, and a final Determination.

**All acute care hospitals that discharge patients to a Medicaid Certified Skilled Nursing Facility are required to enroll in and complete PASRR training by April 30, 2023. After training is complete, each facility is required to submit all Level 1 Screenings via the PASRR Online System.**

### III. Acknowledgement

I have read and understand the above PASRR enrollment, training, and Level 1 Screening requirements. This document is intended to provide abbreviated information about hospital responsibilities for California's PASRR Program and is not a complete or exhaustive list of all hospital responsibilities. By signing, the authorized hospital representative acknowledges his/her authority to certify that PASRR Online System enrollment and training has been completed for the above hospital and the hospital is operationally prepared to initiate and process PASRR Level 1 Screenings. **The certification form must be electronically signed and dated by an executive-level hospital administrator. Then, it must be submitted to DHCS at: [PASRR@dhcs.ca.gov](mailto:PASRR@dhcs.ca.gov).**

\_\_\_\_\_  
Authorized Hospital Representative (Print Name)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### DHCS Use Only

Date Initial Training Completed: \_\_\_\_\_