



**California Department of Health Care Services
Preadmission Screening and Resident Review (PASRR)**

Level I Assessment Guide

January 12, 2023

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New Level 1 Screening

Facility Information (auto-populated by system)

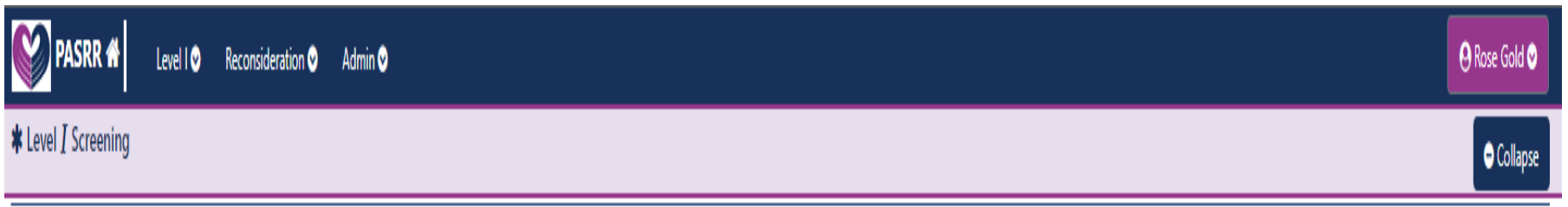
This section auto-populates with date, name and address of the facility, and name of the person completing the form.

Date Started

- Cannot be edited or backdated.

Facility information

- Name and address of facility.
- Name and email of staff completing the form.
- If this is not your facility or name, please stop and contact DHCS IT Service Desk.



Facility Name	Facility Address	Phone
VILLA MARIA SNF	20 VILLA MARIA NOVATO CA 94927	(415) 892-8215
Date Started	Name of Person Completing Level I Screening	
07/08/2022	Rose Gold	

Section I- Individual Information

Questions 1-3

This section helps identify the individual, and the screening type.

Question 1. Red Asterisk (required information)

- Name of individual.

Question 2. Red Asterisk (required information)

- Date of birth.

Question 3. Screening type: PAS or RR

- Select screening type and admission date. **GACH- new screening (PAS) NF- Resident Review (RR)**
- This question checks for duplicate screenings.

Section I - Individual Information

1 Last Name * First Name * Middle Name

2 Date Of Birth *
MM/DD/YYYY

3 Screening Type * Admission Date *
 Initial Preadmission Screening (PAS) Resident Review (RR) (Status Change)
MM/DD/YYYY

Please Note: Once this section is completed and saved, the PASRR CID# is automatically assigned and the case status changes to “In Progress”.

- “In Progress” cases can be edited with the pencil icon from the Dashboard or Level I Cases list.
- Screenings left “In Progress” will be **deleted from the PASRR system if not submitted within two weeks.**

Section II- Intellectual or Developmental Disability (ID)/ (DD) or Related Condition (RC)

Questions 4-9

This section helps identify a suspected or diagnosed intellectual/developmental disability (ID/DD). If “yes”, then it is automatically sent to the California Department of Developmental Services (DDS). Please contact DDS at (916) 654-1954 for questions related to this section.

Question 4

- Is there a suspected or diagnosed ID/DD/RC?

Question 5

- Does the individual have a history of a substantial disability prior to 22 years of age?

Question 6, 7, and 8

- Has the individual received or been referred for ID/DD/RC services through-Regional Center Services or from other agency or facility?

Question 9

- Due to ID/DD or RC, does the individual experience functional limitations?

Section II – Intellectual or Developmental Disability or Related Conditions (ID/DD/RC)

4 The Individual has or is suspected of having a primary diagnosis of ID/DD/RC. ID/DD/RC include disabilities that originated before the age of 18, are expected to continue indefinitely, and constitute a substantial disability for an individual. This includes intellectual disability, cerebral palsy, epilepsy, autism, and closely related disabling conditions, but shall not include handicapping conditions that are solely physical in nature. *

Yes No Unknown

5 The Individual has a history of a substantial disability prior to the age of 22. *

Yes No Unknown

6 The Individual has received services through a Regional Center. *

Yes No Unknown

7 The Individual has received ID/DD services, from another agency or facility *

Yes No Unknown

8 Has the Individual ever been referred to Regional Center Services? *

Yes No Unknown

9 Because of ID/DD, the Individual experiences functional limitations. Examples of functional limitations include mobility, self-care, self-direction, learning/understanding/using language, capacity for living independently. functional limitations ⓘ *

Yes No Unknown

Section III- Serious Mental Illness

Questions 10-12

This section helps determine if the individual may have a serious mental illness and benefit from specialized services.

Question 10. Diagnosed Mental Illness

- Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance?
- If “yes”, there will be a text box question provide the type of mental illness. #11 is not required.
- If “no”, proceed to #11

Question 11. Suspected Mental Illness

- If no diagnosis, do you suspect a mental illness or did the individual engage in community mental health services?
- If “yes”, a text box will appear for you to provide more details regarding the suspected mental illness or community mental health services.

Question 12. Psychotropic Medication

- If “yes” a text box will appear to list all the names of prescribed psychotropic medications for mental illness.

Section III - Serious Mental Illness - Definition ?

Diagnosed Mental Illness ?

10 Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? *

Yes No

Suspected Mental Illness

11 After observing the Individual or reviewing their records, do you believe the Individual may be experiencing serious depression or anxiety, unusual or abnormal thoughts, extreme difficulty coping, or significantly unusual behaviors or does the individual actively engage in community mental health services?

Yes No

Psychotropic Medication ?

12 The Individual has been prescribed psychotropic medications for mental illness. ? *

Yes No

Section IV-Categorical Determination

Questions 13-16

This section helps identify if an individual has a categorical condition, thus preventing them from benefiting from specialized services.

Questions 13 and 13a

- Does the individual require less than a 15 day stay?
- If “yes”, in 13a select the reason for the brief stay (required).

Question 14

- Does the individual have a diagnosis of delirium?

Questions 15 and 15a

- Due to the severe physical condition, will the individual have difficulty communicating their needs?
- If “yes”, 15a must be answered. Please provide the physical diagnoses that causes the individual to require NF care, followed by the specific conditions or reasons that prevent the individual from participating in specialized services.

If questions 13, 14 or 15 are answered “yes”, question #16 is required.

Question 16 (Election of hospice status is only available if question #15 is “yes”)

- Select data source for basis for the categorical application.

Section IV-Categorical Determination

Section IV – Categorical Determination ⓘ (Only one out of 13-15 can be selected as “Yes”)

Brief Stay ⓘ

13 The Individual requires less than 15 days stay.

Yes No

13a Please select the reason for brief stay *

- Protective services (Stay is not expected to exceed 6 days)
- Providing temporary respite for the in-home caregiver (respite case less than 15 days)

If none of the above reasons apply, you must select “no” for 13 and continue screening. *

Delirium ⓘ

14 The individual has a diagnosis of delirium. Further diagnosis cannot be made until delirium clears.

Yes No

Severe Physical Condition ⓘ

15 The individual could not benefit from specialized (mental health) services ⓘ because there is a severe physical condition such as coma, ventilator dependence, or neurocognitive disorder (dementia) that prevents the individual from engaging with others, communicating effectively, and/or participating in mental health care; Or the Individual has a terminal illness that is currently being treated under palliative, comfort, or hospice care.

Yes No

16 Please select the data source that is the basis for the above categorical application *

Hospital/Facility records Physician's evaluation Records of community mental health centers Records of community intellectual disability or developmental disability providers

Categorical?

Yes → If one “Yes” is selected for #13 - #15 → Complete #16 → Complete Section V → Submit Screening → Sent to State Contractor → Case closed & Categorical letter generated

No → If all “No” selected for #13 - #15 → Continue to Current Physical Diagnosis & Bed Type Section, and Exempted Hospital Discharge

Section V- Current Physical Diagnoses and Bed Type, and Exempted Hospital Discharge

Questions 17-19

This section helps identify current physical diagnosis and bed type, and if individual qualified for Exempted Hospital Discharge.

Questions 17

- Please indicate the physical diagnosis/diagnoses that requires NF level of care.

Question 18

- Select type of bed the resident is currently residing in. If you select “other”- add a brief description, address, and phone number where the resident currently resides.

Question 19

- Does the individual qualify for the Exempted Hospital Discharge (all 3 criteria below must be met)? If yes, screening will close with Exempted Hospital Discharge Letter.
 1. The individual is admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital; **AND**
 2. The individual requires NF services for the same condition for which the individual was being treated for at the hospital; **AND**
 3. The attending physician has certified before admission that the individual’s stay will not exceed 30 days at the NF.

Section V - Current Physical Diagnoses, Bed Type, and Exempted Hospital Discharge

17 Please indicate the physical diagnosis/diagnoses that requires NF level of care. *

18 What type of bed is the resident currently residing in? *

- General Acute Care Hospital Skilled Nursing Facility Group Home/Assisted Acute Psychiatric Hospital/Unit Special Treatment Program/Institution for Mental Disease Intermediate Care Facility Other - specify

19 Exempted Hospital Discharge ? *

- Yes No Unknown

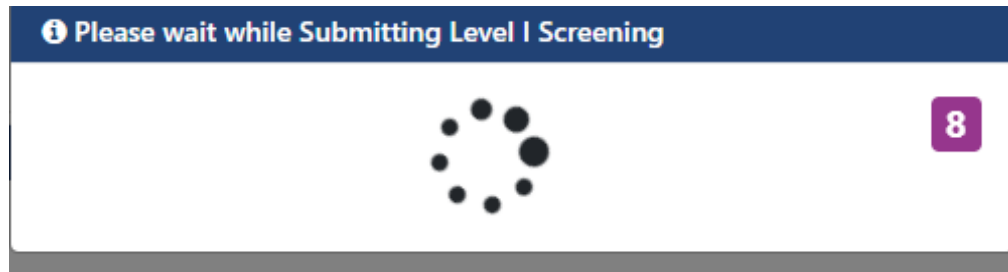
- Click the Submit button to submit screening. Pop up message will appear after completed.

Confirm Submission [X]

You are about to submit this screening to DHCS. Do you wish to continue?

Submitting Level I Screening [X]

Based on the information you provided, it appears that a Level II Mental Health Evaluation referral is required. Please provide the resident and conservator (if available) with the "Notice of Need" letter. Please select "OK" to finish submitting your screening.



Do not close out of your browser early. Allow the system to refresh to the Level I Cases list and verify your case is now visible.

Level I Corrections

The Level I Screening should always reflect the individual's current condition. We recommend checking if a Resident Review is needed during a facility's annual or quarterly MDS reviews.

"In Progress" Screenings:

- Can be edited by clicking on the pencil icon on your Dashboard or Level I Cases list.
- Will automatically delete from the PASRR system after two weeks if not submitted.

Submitted Screenings:

- Cannot be edited, even by DHCS.
- SNF & GACH - for minor demographic errors, such as misspelling of the first name or entering the wrong date of birth, make handwritten corrections and initial on the printed Level I Screening for your records and TAR submission.
- SNF & GACH - for major demographic and/or clinical errors, such as entering the wrong last name or selecting the wrong option during the clinical questions, submit a new screening as a PAS for screenings completed in the GACH and complete a screening as a Resident Review (RR) in the SNF.