MORSELIFE
HEALTH SYSTEM
INNOVATION | PASSION | COMPASSION

PHILOSOPHY:
The Joseph L Morse Health Center is a Not-For-Profit Company that is a non-sectarian facility designed and dedicated to service the specialized needs of the elderly. The Center shall operate its Dietary Department according to the tradition of Kashruth. Religious services are conducted according to Jewish customs and traditions. Individuals who are assessed to need rehabilitative or long-term care services will be considered for admission. Residents admitted to this facility are rendered services without distinction due to race, color, nation origin, or handicapping condition. This facility complies fully with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

ELIGIBILITY:
A. Each individual will be assessed for the ability of the Center to meet his/her needs.
B. No resident who is suffering from communicable disease shall be admitted or retained unless the Medical Director or attending physician certifies that adequate or appropriate isolation measures are available to control transmission of the disease.
C. Residents may not be retained in the facility that require services beyond those for which the facility is licensed or has the functional ability to provide as determined by the Medical Director and the Senior Vice President of Health Center in consultation with the facility Administrator.
D. All applicants must be at least sixteen (16) years of age.

ORDER OF ADMISSIONS:
Applicants will be offered admission by the appropriate bed availability.

FINANCIAL ARRANGEMENTS:
All residents receive the necessary care, service and room placements without regard to financial status. All financial information relating to applicants and residents is kept strictly confidential.

When financial assistance is required, the resident, family or other responsible parties are expected to provide a full disclosure of assets and to cooperate and start the application process for financial assistance with the Department of Children and Families.

SPECIAL PRIORITY ADMISSIONS:
Applicants who meet the criteria for special priority admission are residents on the Campus in our independent/assisted living or are Holocaust Survivors. These applicants will be considered for placement and put at the top of the waitlist for the appropriate bed availability. We must be able to meet all of the applicants needs for placement.

SEXUAL OFFENDER BACKGROUND CHECKS:
In conjunction with the admissions process, the Center will conduct a sexual offender background check using the nation predator website (http://www.nsopr.gov). A copy of the findings will be kept in the resident's admission file prior to admission.

Joseph L Morse Health Center
Instructions/Checklist for Application Completion

Resident Name:_____ **Date:**_____

Please complete the attached application in its entirety. A checklist is provided below for the documentation required with the application. Please refer to the Fee Schedule for the current costs. A minimum of one month payment is required prior to admission. ***Additional documents may be required.***

- ☐ Proof of Residency:
  - Driver's license, tax assessment or voter's registration for the applicant
- ☐ Insurance Cards (copy of front and back):
  - Medicare OR Primary Insurance Card
  - Supplemental Insurance Card(s)
- ☐ Social Security Card
- ☐ Advance Directives (if any):
  - Durable Power of Attorney
  - Living Will, and/or Health Care Surrogate Designation
  - Guardianship Documentation (if applicable)
- ☐ Irrevocable Trust and/or Qualified Income Trust Document(s)
- ☐ Bank Statements: If family is assuming financial responsibility we will require verification of the source of payment. For private pay, a minimum of 3 months of statements are required for **all** accounts.
  - CD
  - Savings
  - Checking
  - Securities
  - Stocks, Bonds
  - Money Markets, IRA/401k
  - Burial Policy(s)
  - Cash Value Life Insurance Policies
  - Income related to: Social Security Benefits, Pension Benefits, Interest or Dividends from Investments, Long Term Care Insurance Policy(s)
- ☐ Federal Income Tax Returns – full copy of the most recently filed returns
- ☐ Real Estate Tax Assessment
- ☐ Medical Documentation to be completed by the applicant's primary care physician:
  - History & Physical
  - List of Current Medications including dosage
  - PASRR Form
  - 3008 Form
  - Chest x-ray or PPD results
  - Copy of COVID Vaccination Card
- ☐ Pacemaker card (if applicable)

IF THE APPLICANT CURRENTLY HAS HMO INSURANCE COVERAGE:

- Prior to admission to the facility, the applicant must disenroll from this coverage and re-enroll in the traditional Medicare program.

IF THE APPLICANT CURRENTLY HAS COMMUNITY OR DIVERSION MEDICAID:

- Applicant must disenroll from this coverage and apply for ICP/nursing home Medicaid. We will require a copy of the Notice of Case Action stating that the applicant is approved for ICP/nursing home Medicaid. Applicant must be approved for ICP Medicaid prior to admission or private pay financial requirements apply.

JOSEPH L MORSE HEALTH CENTER
4847 David S. Mack Drive
West Palm Beach, FL 33417
(561) 472-2900
Fax (561) 615-0949

APPLICATION FOR ADMISSION

Date Received in Admissions Office _____ Received By (Admission Personnel) _____

PLEASE COMPLETE ALL INFORMATION BELOW IN TYPE OR PRINT

Last Name _____ First Name _____ Middle _____

Sex _____ Race _____ Date of Birth _____ Social Security Number _____

Current Street Address _____ City _____ State _____ Zip _____

County _____ Telephone # _____ Holocaust Survivor? Yes/No _____

Birthplace _____ Citizen of (Country) _____ Social Security Number _____

Marital Status _____ Military Service _____

Primary Care Physician _____ Telephone Number _____

Applicant's Religion _____ Church/Synagogue _____ Telephone # _____

Funeral Home Arrangements _____ Address _____ Telephone # _____

Emergency Contacts:

1. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

2. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

3. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

If "Yes" to any of the Advance Directives, please provide a copy to the Admissions Office:

Yes	No	
		Health Care Surrogate
		Durable Power of Attorney
		Living Will

List below all previous admissions to hospitals, psychiatric institutions or nursing homes within the previous five years:

	Institution Name	Date (Adm/Disch)	Reason for Admission
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Does applicant manage own finances? _____Yes _____No

If no, designated family member(s) assuming financial liability for applicant:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Business Phone: _____

Email: _____

FINANCIAL DATA INFORMATION

List below **ALL monthly income:**

Source	Amount
Social Security	_____
SSI	_____
Railroad Retirement	_____
Pension	_____
Rental Income	_____
Interest Income	_____
Annuity	_____
Other:	_____
Other:	_____

List below all bank accounts including savings, checking, IRA's, etc.:

	Account Number	Bank	Balance
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

List below all securities, stocks, etc.:

	Type	Estimated Value
1.	_____	_____
2.	_____	_____
3.	_____	_____

REQUIRED INSURANCE INFORMATION

PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS (FRONT AND BACK).

Primary Insurance:

Name: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Plan Type (HMO / PPO): _____

Supplemental Insurance:

Name: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Plan Type (HMO / PPO): _____

Prescription Insurance:

Name: _____

Policy Number: _____

Phone # _____

If Medicaid Pending, please complete the below for the Elder Care Planner/Attorney or individual that is completing the Medicaid application. Please note that Joseph L Morse Health Center is not a Medicaid pending facility:

_____

Name Address Telephone Number

_____ _____ _____

ICP Medicaid Number State Providing Coverage Initial Eligibility Date

List below all life insurance policies:

	Company	Beneficiary	Face Value	Yearly Premium
1.				
2.				
3.				

List below all real estate:

	Description and Location	Assessed Value	Current Mortgage Amount
1.			
2.			
3.			
4.			

Person(s) Completing this Form:

Name: _____

Address: _____

Telephone Number: _____ Cell Phone: _____

Email Address: _____

Relationship to Resident: _____

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Fall Education

Resident Name: _____ DOB_____/____/____

Joseph L Morse Health Center committed to maintaining the highest level of physical, psychosocial and emotional well-being of our residents.

Fall Facts:

- Approximately 30% of adults aged 65 or older fall each year, often resulting in serious injury or death. (Center for Disease Control and Prevention)
- A decline in mobility, balance, loss of muscle mass, strength, cognitive decline, history of falling, recent hospitalization and a changed environment (among other conditions), contribute to the likelihood of falling.
- Acute and chronic medical conditions and medications increase the likelihood of falling.
- Falls are the number one cause of injury or death in the elderly
- All falls cannot be prevented

Please understand that Joseph L Morse Health Center cannot prevent all falls.

- Interventions will be put in place, as appropriate, to attempt to limit falls and to reduce the risk of injury or death when a fall occurs.
- Joseph L Morse Health Center does not provide one to one staff to supervise or provide services to residents.
- In order to "least restrict" and promote the highest level of function and activity, MorseLife rarely uses bed or chair alarms and MorseLife does not physically or chemically restrain patients/residents.
- The resident and their family can engage the services of a private sitter or caregiver if 1:1 staff is desired.

I UNDERSTAND THAT JOSEPH L MORSE HEALTH CENTER DOES NOT PROVIDE 1:1 CARE, RARELY USES ALARMS, AND IS RESTRAINT FREE. IF I WISH FOR SUCH LEVEL OF SUPERVISION, I HAVE THE RIGHT TO RETAIN A SITTER OR CARE GIVER TO PROVIDE 1:1 SERVICES.

I AM RESPONSIBLE TO PAY FOR THOSE RETAINED SERVICES. IF I RETAIN AN INDIVIDUAL TO PROVIDE 1:1 SUPERVISION, I WILL ADVISE JOSEPH L MORSE HEALTH CENTER OF THE IDENTITY OF THE INDIVIDUAL RETAINED AND UNDERSTAND THAT JOSEPH L MORSE HEALTH CENTER IS NOT REPSONSIBLE FOR THAT INDIVIDUAL'S ACTS OR OMISSIONS.

Resident/Patient Signature:_____ Date: _____/____/_____

Family Member Signature:_____ Date: _____/____/_____

Print Name:_____

MorseLife Representative Signature: _____ Date:_____/____/_____

Print Name:_____

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Joseph L Morse Health Center has a tradition of providing excellent care for our residents. As part of our continuing efforts to ensure that our care meets the needs of our residents and their family members, we are asking you to please take a few minutes to complete this questionnaire. We will contact you to review this information prior to admission into the facility.

Resident Name:_____ Date of Birth:_____

1. What precipitated this admission? Please be specific: Wandering ☐ Behaviors ☐

   Incontinence ☐ Decline ☐ Cannot meet needs at home ☐ Other ☐ _____

   _____

2. What are your goals for care upon admission?

   1._____

   2._____

   3._____

3. Is your family member admitting from another facility? If yes, what is the specific reason for the transfer:_____

   _____

4. How often has your family member routinely seen a Physician in the last year?

   Daily ☐ Weekly ☐ Monthly ☐ Every other month ☐ Annually ☐

5. How often do you expect a Physician to see your family member at the Center?

   Daily ☐ Weekly ☐ Monthly ☐ Every other month ☐ As needed ☐

6. Does your family member have a diagnosis of Dementia? Yes ☐ No ☐ Unsure ☐

   - If yes, please indicate the level: Mild ☐ Moderate ☐ Severe ☐
   - If yes, has a physician formally educated you on the disease process? Yes ☐ No ☐

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7. Please check or list all other diagnosis related to your family member's condition:

   Parkinson's ☐ Stroke ☐ Heart condition ☐ Arthritis ☐ Fracture ☐

   Renal Disease ☐ Respiratory ☐ Diabetes ☐History of falls ☐ Osteoporosis ☐

   History of skin conditions (i.e. wounds, rashes, skin tears) ☐ Easily bruised ☐

   Other ☐ (please list)_____

   _____

8. Indicate any changes in your family member's weight during the last 6 months?

   Lost weight ☐ No change ☐ Gained weight ☐

9. How many times has your family member fallen in the last 6 months?

   0 ☐ 1 ☐ 2 ☐ 3 + ☐

10. Please check the box that describes your feelings about the likelihood that your family member will fall while a resident at MorseLife?

    Very likely ☐ Somewhat likely ☐ Somewhat unlikely ☐ Very unlikely ☐

11. How has your family member's general condition changed in the last 6 months?

    Improved greatly ☐Improved slightly ☐ No change ☐Declined slightly☐

    Declined greatly ☐

12. What are your expectations for your family member's general condition after admission to Joseph L Morse Health Center?

    Improved greatly ☐ Improved slightly ☐ No change ☐ Declined slightly ☐

    Declined greatly ☐

Reviewed with (Name)_____ on (date)_____ by (Staff Name)_____

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Facility or Primary Care Physician

The below medical documents are required prior to admission to Joseph L Morse Health Center. The documents must be completed and submitted from either the current facility or the primary care physician. All documents must be dated within the last 30 days.

a. History and Physical
b. List of Current Medications
c. PPD or Chest X-Ray
d. 3008 Form (attached)
e. PASRR Form (attached)
f. COVID Vaccination Documentation/Card

Please fax the documents to the admissions department at 561-615-0949.

If you have any questions, please contact the admissions department at 561-472-2900.

Thank you.

4847 David Mack Drive
West Palm Beach, FL 33417
(561) 472-2900
(561-615-0949

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: *Last 4 SSN: *DOB:

*A. PATIENT INFORMATION

*Gender: ☐ Male ☐ Female
*Hispanic Ethnicity: ☐ Yes ☐ No
*Race: ☐ White ☐ Black ☐ Other: _____
*Language: ☐ English ☐ Other:

*B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Deaf ☐ Normal ☐ Impaired
☐ Blind ☐ Hearing Aid L ☐ R ☐

C. DECISION MAKING CAPACITY (PATIENT)

☐ Capable to make healthcare decisions ☐ Requires a surrogate

*D. EMERGENCY CONTACT

Name: _____ Name: _____
Phone: Phone:

*E. MEDICAL CONDITION

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____

Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

*G. PATIENT RISK ALERTS

☐ *None Known ☐ *Harm to self ☐ *Difficulty swallowing
☐ *Elopement ☐ *Harm to others ☐ *Seizures
☐ *Pressure Ulcers ☐ *Falls ☐ *Other: _____

RESTRAINTS: ☐ Yes ☐ No
Types:
_____
Reasons for use:
_____

ALLERGIES: ☐ None Known ☐ Yes, List below:
_____
Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DO NOT Resuscitate (DNR)	☐ Yes	☐ No
DO NOT Intubate	☐ Yes	☐ No
DO NOT Hospitalize	☐ Yes	☐ No
No Artificial Feeding	☐ Yes	☐ No
Hospice	☐ Yes	☐ No

I. TRANSFERRED FROM

Facility Name:
Date: Unit:
Phone: Fax:
Discharge Nurse: Phone:
Admit Date: Discharge Date:
Admit Time: AM ☐ PM ☐ Discharge Time: AM ☐ PM ☐

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:	AM ☐ PM ☐
☐ Antibiotics	Date:	Time:	AM ☐ PM ☐
☐ Insulin	Date:	Time:	AM ☐ PM ☐
☐ Other:	Date:	Time:	AM ☐ PM ☐

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time: AM ☐ PM ☐

*N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders	☐ Treatment Orders
☐ Discharge Summary	☐ Includes Wound Care
☐ Medication Reconciliation	☐ Lab reports
☐ Discharge Medication List	☐ X-ray ☐ EKG
☐ PASRR Forms	☐ CT Scan ☐ MRI
☐ Social and Behavioral History	☐ History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: *Last 4 SSN: *DOB:

O. VITAL SIGNS

Date: Time Taken: AM ☐ PM ☐

HT: FEET INCHES WT:

Temp: BP: /

HR: RR: Sp02:

*P. PATIENT HEALTH STATUS

***Bladder:** ☐ Continent ☐ Incontinent

☐ Ostomy ☐ Catheter Type:_____ **date inserted:** _____

Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____

Indications for use:

☐ Urinary retention due to:_____

☐ Monitoring intake and output

☐ Skin Condition:_____

☐ Other:_____

Attempt to remove catheter made in hospital? ☐ Yes ☐ No

Date Removed: _____

***Bowel:** ☐ Continent ☐ Incontinent ☐ Ostomy

Date of Last BM:_____

Immunization status:

Influenza: ☐ Yes ☐ No Date:_____

Pneumococcal: ☐ Yes ☐ No Date:

*Q. NUTRITION / HYDRATION

***Dietary Instructions:**

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG

Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

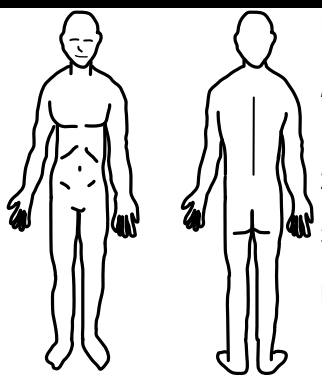
☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

*S. PHYSICAL FUNCTION

***Ambulation:**	***Transfer:**
☐ Not ambulatory	☐ Self
☐ Ambulates independently	☐ Assistance
☐ Ambulates with assistance	☐ 1 Assistant
☐ Ambulates with assistive device	☐ 2 Assistants
Devices:	**Weight-bearing:**
☐ Wheelchair (type):	Left:
☐ Appliances:	☐ Full ☐ Partial ☐ None
☐ Prosthesis:	Right:
☐ Lifting Device:	☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers

(Indicate stage and location(s) of lesions using corresponding number:

1.

2

3.

List any other lesions or wounds:

*U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions

☐ Alert, disoriented, but can follow simple instructions

☐ Alert, disoriented, and cannot follow simple instructions

☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:

☐ IV / PICC / Portacath Access - Date inserted:

Type:_____

☐ Internal Cardiac Defibrillator ☐ Pacemaker

☐ Wound Vac

☐ Other:_____

Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP

☐ Nebulizer ☐ Other:_____ ☐ Nasal Cannula

☐ Mask: Type_____

☐ Oxygen - liters: ____% ☐ PRN ☐ Continuous

☐ Trach Size:_____ Type:_____

Ventilator Settings:_____

☐ Suction

W. PERSONAL ITEMS

☐ Artificial Eye	☐ Prosthetic	☐ Walker
☐ Contacts	☐ Cane	☐ Other
☐ Eyeglasses	☐ Crutches	
☐ Dentures	☐ Hearing Aids	
☐ U ☐ L ☐ Partial	☐ L ☐ R	

X. COMMENTS (Optional)

Signature:_____

Printed Name:_____

*Y. PHYSICIAN CERTIFICATION

☐ *I certify the individual requires nursing facility (NF) services.

☐ The individual received care for this condition during hospitalization.

☐ *I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

*Effective date of medical condition: _____ *Physician/ARNP/PA License #: _____

*Physician/ARNP/PA Signature: _____ *Date: _____

*Printed Physician/ARNP/PA Name & Title:_____ *Phone Number: _____

Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____

Preadmission Screening and Resident Review (PASRR) Level I Screen Form

Instructions

A. Acronyms and abbreviations:

a. AHCA – Agency for Health Care Administration
b. CARES – Florida Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services Program
c. CFR – Code of Federal Regulations
d. CMAT – Children's Multidisciplinary Assessment Team
e. DOH – Florida Department of Health
f. DOEA – Florida Department of Elder Affairs
g. F.A.C. – Florida Administrative Code
h. HIPAA – Health Insurance Portability and Accountability Act
i. ID – Intellectual Disability or Related Conditions
j. MI – Mental Illness
k. MID – Medicaid Identification Number
l. MM/DD/YYYY – Month, Day, Year
m. N/A – Not Applicable
n. NF – Medicaid-certified Nursing Facility
o. PASRR – Preadmission Screening and Resident Review
p. RR – Resident Review
q. SMI – Serious Mental Illness

B. Instructions

The Level I PASRR Screen, AHCA MedServ Form 004 Part A, March 2017, must be fully and accurately completed, and distributed in accordance with Rule 59G-1.040, F.A.C. Incomplete submissions will not be accepted, and may prohibit Florida Medicaid payment for nursing facility services. Information inserted manually must be legible. Any illegible information will result in the Level I Screen Form being deemed unacceptable.

Steps to Complete the Screen:

Page 1

Fill in the blanks with the individual's demographics, screening site, insurance information, etc. Check the boxes to best answer the individual's current location at time of screening, and include the individual's parent, guardian, or legal representative's information, if applicable.

Enter the Medicaid or 'Other Health Insurance' identification information if available.

Enter up to three NFs (if uncertain), in the section entitled 'Requesting Admission to'.

Page 2

Fill in the name of the individual being evaluated and date of birth at the top of this page and each page going forward.

Section I: PASRR Screen Decision-Making

1. Review any pertinent medical information available for condition(s) to consider for a suspicion or diagnosis of SMI, ID or both.

   Check the appropriate box(es) in column A for history or suspicion of an MI and specify, if applicable, any other diagnosis or condition that is not listed on the form.

Check applicable box(es) in column B for history or suspicion of ID and specify, if applicable, any other diagnosis or condition that is not listed on the form.

2. Check the appropriate box if the individual has, has had, or has been referred for services from an agency or entity that serves individuals with an intellectual or developmental disability such as the Agency for Persons with Disabilities (APD), or provides services for an MI.
3. Include additional information if necessary pertaining to MI or ID history.

Indicate the source of all the information gathered for the individual's Level I PASRR screen.

Page 3

Section II: Other Indications for PASRR Screen Decision-Making

Check 'Yes' or 'No' in the box after each question as it pertains to the individual.

The boxed text contains additional information in relation to the decision-making process, throughout the Level I PASRR screen.

If the box checked in question four of Section II is 'Yes,' a Level II evaluation must be requested.

Page 4

Section II: Other Indications for PASRR Screen Decision-Making, continued

Continue to check the appropriate box pertaining to the individual concerning questions five through seven.

The boxed text contains additional information in relation to the decision-making process.

Section III: PASRR Screen Provisional or Hospital Discharge Exemption.

If the individual being admitted is not a provisional admission, check the box indicating such and proceed to Section IV.

If the individual being admitted is a provisional admission, or a hospital discharge exemption, check the appropriate box. Check only one box.

Check the box for the type of provisional admission. Fill in the blank where indicated with the anticipated Level II evaluation completion date based on the type of provisional admission.

If the individual is being admitted under the hospital discharge exemption, check the box and ensure the section is signed by the attending physician. A hospital discharge exemption only pertains to the timeframe for completion of the Level II PASRR evaluation and determination. The box for a hospital discharge exemption is not to be checked if the individual has no diagnosis or suspicion of SMI, ID, or both. An individual being admitted with no diagnosis or suspicion of SMI, ID or both, is not a hospital discharge exemption according to PASRR regulations.

Page 5

Section IV: PASRR Screen Completion

1. Determine whether the individual may, or may not, be admitted to an NF and check the applicable box indicating the finding.
2. Fill in the information fields pertaining to the person who has completed the screen.
3. If the individual requires a Level II evaluation, forward the Level I PASRR along with other required documentation, to the appropriate Level II screener as follows:
    - CARES for individuals age 21 years and older
    - DOH for individuals under the age of 21 years

Complete the distribution area of the form indicating where the Level I PASRR screen and accompanying documents must be sent, as appropriate. Check all that apply.

Obtain the signature for consent for the Level II evaluation and determination, if applicable, from the individual being assessed or the individual's legal representative.

If an individual is unwilling or unable, and has no legal representative or health care agent to sign the consent for a Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented.

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

_____ _____ _____
Name of Individual Being Evaluated (print) Social Security Number* Date of Birth

☐ Male ☐ Female _____ _____
Age Individual's or Residency Phone Number

_____ _____ _____
Present Location of Individual Being Evaluated Street Address, City State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other_____

_____ _____ _____
Legal Representative's Name (if applicable) Street Address, City State, Zip

Representative's Phone Number _____

_____ _____
Medicaid Identification Number if Applicable Other Health Insurance Name and Number if Applicable

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

Name of Individual Being Evaluated _____ Date of Birth _____

Section I:PASRR Screen Decision-Making

A. MI or suspected MI (check all that apply):

☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Dissociative Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ Psychotic Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Somatic Symptom Disorder
☐ Substance Abuse
☐ Other (specify):_____

B. ID or suspected ID (check all that apply):

☐ Current diagnosis of an ID, mild, moderate, severe or profound.
☐ IQ of 70 or less, if available.
☐ Onset prior to 18 years of age. Age of onset: _____
☐ Impaired adaptive behavior

Related Condition:

☐ Onset prior to 22 years of age. Age of onset: _____
☐ Autism
☐ Cerebral Palsy
☐ Down Syndrome
☐ Epilepsy
☐ Muscular Dystrophy
☐ Prader Willi
☐ Spina Bifida
☐ Traumatic Brain Injury
☐ Other (specify): _____

Functional Criteria:

☐ Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (**check all that apply**):

☐ Capacity for independent living
☐ Learning
☐ Mobility
☐ Self care
☐ Self direction
☐ Understanding and use of language

Services:

☐ Currently receiving services for MI.
☐ Previously received services for MI.
☐ Referred for MI services.

☐ Currently receiving services for ID.
☐ Previously received services for ID.
☐ Referred for ID services.

Additional Information: _____

Finding is based on (check all that apply):

☐ Documented History ☐ Behavioral Observations ☐ Individual, Legal Representative or Family Report

☐ Medications ☐ Other (specify): _____

Name of Individual Being Evaluated _____ Date of Birth _____

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. ☐Yes ☐No

B. 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, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation, for which 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

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a 'yes' checked in Section II.1, II.2, or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

Name of Individual Being Evaluated _____ Date of Birth _____

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:

Dementia? ☐Yes ☐No
Related Neurocognitive Disorder (including Alzheimer's disease)? ☐Yes ☐No

6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?

☐Yes ☐No

7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?

☐ No

☐ Yes (**Check all that apply.** Send accompanying documentation with completed Level I PASRR screen):

- ☐ Dementia work-up
- ☐ Comprehensive mental status exam
- ☐ Medical/functional history prior to onset
- ☐ Other – Specify: _____

A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.128(m)(2)(i) or 42 CFR §483.128(m)(2)(ii).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

☐ **Not a provisional admission**
☐ **Provisional admission (choose one)**
☐ **Hospital Discharge Exemption**

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID or both, and the box in Section II.4 is checked 'no'. A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES for adults or DOH*** for individuals under the age of 21 years within the time frames indicated in this section.**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14-day time limit, on or before (date): _____

☐ The individual is being admitted under the 30-day hospital discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _____

An attending physician's signature is required for those individuals admitted under a 30-day hospital discharge exemption.

_____ _____
ATTENDING PHYSICIAN'S SIGNATURE DATE

Name of Individual Being Evaluated _____ Date of Birth _____

Section IV: PASRR Screen Completion

Individual <u>may</u> be admitted to an NF (check one of the following):	**Individual <u>may not</u> be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.	☐ SMI ☐ ID ☐ SMI and ID
☐ Provisional admission	
☐ Hospital Discharge Exemption	

******Incomplete forms will not be accepted******

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

_____ _____
Screener's Name (Printed) **Signature**

_____ _____ _____
Credentials **Date** **Phone**

_____ _____
Place of Employment **Fax**

Completed Level I screen **distributed to (check all that apply)**:

☐ Local DOH*** office, for individuals under the age of 21 years

☐ Accompanying documents attached

Date:_____

☐ Local CARES** office, for adults age 21 years or older

Date: _____

☐ Accompanying documents attached

☐ Nursing Facility

Date: _____

☐ Discharging Hospital (if applicable):

Date: _____

Name: **Date:**

Consent for Level II Evaluation and Determination
In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history.
I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

If the individual requires a Level II PASRR evaluation, submit the completed Level I PASRR screen, documented informed consent, completed AHCA 5000-3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation, or supporting documentation to CARES or DOH for facilitation to the state authority for SMI or ID.

If an individual is unwilling, unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

_____

_____

_____

_____

_____

****Florida Department of Elder Affair's Comprehensive Assessment and Review for Long-Term Care Services**

*****Florida Department of Health**