

**PASRR Level 1 Screening****Section A****Submitter Information (NF/LA only)**

A0100. Name		<input type="text"/>	
A0200A. Street Address		<input type="text"/>	
A0200B. City	<input type="text"/>	A0200C. State	<input type="text"/>
A0200D. ZIP Code	<input type="text"/>		
A0300. NPI/API	<input type="text"/>	A0400. Provider No.	<input type="text"/>
A0500. Vendor No.	<input type="text"/>	A0510. County	<input type="text"/>

**Referring Entity Information (Screener)**

A0600. Date of Assessment	<input type="text"/>		
A0700A. First Name	<input type="text"/>	A0700B. Middle Initial	<input type="text"/>
A0700C. Last Name	<input type="text"/>	A0700D. Suffix	<input type="text"/>
A0800. Position/Title	<input type="text"/>		
A0900A. Type of Entity	<input type="text"/>	A0900B. Other Type of Entity	<input type="text"/>
	1. Acute Care 2. Psychiatric Hospital 3. ICF/IID 4. Family Home 5. Nursing Facility 6. Physician (MD/DO) 7. Other		
A0900C. Physician First Name	<input type="text"/>	A0900D. Physician Middle Initial	<input type="text"/>
A0900E. Physician Last Name	<input type="text"/>	A0900F. Physician Suffix	<input type="text"/>
A1000A. Name	<input type="text"/>		
A1000B. Street Address	<input type="text"/>		
A1000C. City	<input type="text"/>	A1000D. State	<input type="text"/>
A1000E. ZIP Code	<input type="text"/>	A1000F. Phone Number	<input type="text"/>
A1100. Date of Last Physical Examination	<input type="text"/>		
A1200A. Certification of Signature	<input type="checkbox"/> I certify that to the best of my knowledge this information is true and accurate.		A1200B. Signature Date <input type="text"/>

**Section B****Personal Information (Individual being screened)**

B0100A. First Name	<input type="text"/>	B0100B. Middle Initial	<input type="text"/>
B0100C. Last Name	<input type="text"/>	B0100D. Suffix	<input type="text"/>
B0200A. Social Security No.	<input type="text"/>	B0200B. Medicare No.	<input type="text"/>
B0300. Medicaid No.	<input type="text"/>	B0400. Birth Date	<input type="text"/>
B0500. Age at Time of Screening	<input type="text"/>	B0600. Gender	<input type="text"/> 1. Male 2. Female
B0650. Individual is deceased or has been discharged?	<input type="text"/>		0. Deceased 1. Discharged
B0655. Deceased/Discharged Date	<input type="text"/>		

**Previous Residence**

B0700A. Previous Residence Type	<input type="text"/>	B0700B. Other Residence Type	<input type="text"/>
	1. Private Home 2. ICF/IID 3. Waiver Setting 4. Nursing Facility 5. Other 6. Unknown		
B0700C. Street Address	<input type="text"/>		
B0700D. City	<input type="text"/>		
B0700E. State	<input type="text"/>	B0700F. ZIP Code	<input type="text"/>
B0700G. County of Residence	<input type="text"/>		

Next of Kin	
<b>B0800A. Relationship to Individual</b> <input type="text"/> 1. Legally Authorized Representative 2. Spouse 3. Child 4. Parent 5. Sibling 6. Other	<b>B0800B. Other Relationship to Individual</b> <input type="text"/>
<b>B0800C. First Name</b> <input type="text"/>	<b>B0800D. Middle Initial</b> <input type="text"/>
<b>B0800E. Last Name</b> <input type="text"/>	<b>B0800F. Suffix</b> <input type="text"/>
<b>B0800G. Phone Number</b> <input type="text"/>	
<b>B0800H. Street Address</b> <input type="text"/>	
<b>B0800I. City</b> <input type="text"/>	<b>B0800J. State</b> <input type="text"/>
<b>B0800K. ZIP Code</b> <input type="text"/>	

## Section C

### PASRR Screen (Screener)

<b>C0100. Mental Illness</b>	Is there evidence or an indicator this is an individual that has a Mental Illness?	<input type="text"/>	0. No 1. Yes
<b>C0200. Intellectual Disability</b>	Is there evidence or an indicator this is an individual that has an Intellectual Disability?	<input type="text"/>	0. No 1. Yes
<b>C0300. Developmental Disability</b>	Is there evidence or indicators that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability (e.g., Autism, Cerebral Palsy, Spina Bifida)?	<input type="text"/>	0. No 1. Yes

### Local Authority Information (LA only)

C0400. LA - MI Provider No.	<input type="text"/>
C0500. LA - MI Vendor No.	<input type="text"/>
C0600. LA - MI NPI/API No.	<input type="text"/>
C0700. LA - IDD Provider No.	<input type="text"/>
C0800. LA - IDD Vendor No.	<input type="text"/>
C0900. LA - IDD NPI/API No.	<input type="text"/>

**Section D****Nursing Facility Choices - 1**

D0100A. Provider No.	<input type="text"/>	D0100B. Vendor No.	<input type="text"/>
D0100C. NPI	<input type="text"/>		
D0100D. Facility Name	<input type="text"/>		
D0100E. Street Address	<input type="text"/>		
D0100F. City	<input type="text"/>	D0100G. State	<input type="text"/>
D0100H. ZIP Code	<input type="text"/>	D0100I. Phone	<input type="text"/>
D0100J. NF Contact First Name	<input type="text"/>	D0100K. NF Contact Middle Initial	<input type="text"/>
D0100L. NF Contact Last Name	<input type="text"/>	D0100M. NF Contact Suffix	<input type="text"/>
D0100N. NF is willing and able to serve individual	<input type="text"/>	0. No 1. Yes	
D0100O. NF Admitted the Individual	<input type="text"/>	0. No 1. Yes	
D0100P. NF Date of Entry	<input type="text"/>		
D0100Q. Comments	<input type="text"/>		

Nursing Facility Choices - 2			
D0100A. Provider No.	<input type="text"/>	D0100B. Vendor No.	<input type="text"/>
D0100C. NPI	<input type="text"/>		
D0100D. Facility Name	<input type="text"/>		
D0100E. Street Address	<input type="text"/>		
D0100F. City	<input type="text"/>	D0100G. State	<input type="text"/>
D0100H. ZIP Code	<input type="text"/>	D0100I. Phone	<input type="text"/>
D0100J. NF Contact First Name	<input type="text"/>	D0100K. NF Contact Middle Initial	<input type="text"/>
D0100L. NF Contact Last Name	<input type="text"/>	D0100M. NF Contact Suffix	<input type="text"/>
D0100N. NF is willing and able to serve individual	<input type="text"/>	0. No 1. Yes	
D0100O. NF Admitted the Individual	<input type="text"/>	0. No 1. Yes	
D0100P. NF Date of Entry	<input type="text"/>		
D0100Q. Comments	<input type="text"/>		

**Nursing Facility Choices - 3**

D0100A. Provider No.	<input type="text"/>	D0100B. Vendor No.	<input type="text"/>
D0100C. NPI	<input type="text"/>		
D0100D. Facility Name	<input type="text"/>		
D0100E. Street Address	<input type="text"/>		
D0100F. City	<input type="text"/>	D0100G. State	<input type="text"/>
D0100H. ZIP Code	<input type="text"/>	D0100I. Phone	<input type="text"/>
D0100J. NF Contact First Name	<input type="text"/>	D0100K. NF Contact Middle Initial	<input type="text"/>
D0100L. NF Contact Last Name	<input type="text"/>	D0100M. NF Contact Suffix	<input type="text"/>
D0100N. NF is willing and able to serve individual		<input type="text"/>	0. No 1. Yes
D0100O. NF Admitted the Individual		<input type="text"/>	0. No 1. Yes
D0100P. NF Date of Entry	<input type="text"/>		
D0100Q. Comments	<input type="text"/>		

**Nursing Facility Choices - 4**

D0100A. Provider No.	<input type="text"/>	D0100B. Vendor No.	<input type="text"/>
D0100C. NPI	<input type="text"/>		
D0100D. Facility Name	<input type="text"/>		
D0100E. Street Address	<input type="text"/>		
D0100F. City	<input type="text"/>	D0100G. State	<input type="text"/>
D0100H. ZIP Code	<input type="text"/>	D0100I. Phone	<input type="text"/>
D0100J. NF Contact First Name	<input type="text"/>	D0100K. NF Contact Middle Initial	<input type="text"/>
D0100L. NF Contact Last Name	<input type="text"/>	D0100M. NF Contact Suffix	<input type="text"/>
D0100N. NF is willing and able to serve individual		<input type="text"/>	0. No 1. Yes
D0100O. NF Admitted the Individual		<input type="text"/>	0. No 1. Yes
D0100P. NF Date of Entry	<input type="text"/>		
D0100Q. Comments	<input type="text"/>		



**Nursing Facility Choices - 5**

D0100A. Provider No.

D0100B. Vendor No.

D0100C. NPI

D0100D. Facility Name

D0100E. Street Address

D0100F. City

D0100G. State

D0100H. ZIP Code

D0100I. Phone

D0100J. NF Contact First Name

D0100K. NF Contact Middle Initial

D0100L. NF Contact Last Name

D0100M. NF Contact Suffix

D0100N. NF is willing and able to serve individual

0. No  
1. Yes

D0100O. NF Admitted the Individual

0. No  
1. Yes

D0100P. NF Date of Entry

D0100Q. Comments

## Section E

### Alternate Placement Preferences (Screener)

E0100. Where would this individual like to live now? Check all that apply

- |                            |                          |  |                          |
|----------------------------|--------------------------|--|--------------------------|
| A. Live alone with support | <input type="checkbox"/> | B. A place where there is 24 hour care | <input type="checkbox"/> |
| C. A group home            | <input type="checkbox"/> | D. Family home                         | <input type="checkbox"/> |
| E. Other                   | <input type="checkbox"/> | F. Other Location                      | <input type="text"/>     |
| G. Unknown                 | <input type="checkbox"/> |  |                          |

E0200. Comments about where the individual would like to live

E0300. Living Arrangement Options Check all that apply

- |                  |                          |                          |                          |
|------------------|--------------------------|--------------------------|--------------------------|
| A. By themselves | <input type="checkbox"/> | B. With a roommate       | <input type="checkbox"/> |
| C. With family   | <input type="checkbox"/> | D. With a lot of friends | <input type="checkbox"/> |
| E. Other         | <input type="checkbox"/> | F. Other Individual      | <input type="text"/>     |
| G. Unknown       | <input type="checkbox"/> |                          |                          |

E0400. Comments about with whom the individual would like to live

**Alternate Placement Disposition (Screener)**

E0500A. Admitted To <input type="text"/> 1. Community Program 2. ICF/IID 3. Own home/family home 4. Other	E0500B. Admitted to Other <input type="text"/>
E0600A. Community Program <input type="text"/> 1. CLASS (SG 2) 2. CBA (SG 3) 3. PACE (SG 11) 4. DBMD (SG 16) 5. MDCP (SG 18) 6. STAR+Plus (SG 19) 7. HCS (SG 21) 8. TxHmL (SG 22) 9. YES (DSHS Waiver) 10. Other	E0600B. Other Community Program <input type="text"/>
E0700. Name of ICF/IID Facility	<input type="text"/>
E0800. Own Home/Family Home Comments	<input type="text"/>
E0900. Alternate Placement Date of Entry	<input type="text"/>

## Section F

### Admission Category (RE/LA)

#### F0100. Exempted Hospital Discharge

Has a physician certified that individual is likely to require less than 30 days of NF services?  
(For individuals being admitted from acute care in the hospital)

0. No  
1. Yes

#### F0200. Expedited Admission

Does this individual meet any of the following categories for an expedited admission into the nursing facility?

**(Please select one category below)**

0. Not Expedited Admission

1. Convalescent Care: Individual is admitted from an acute care hospital to an NF for convalescent care with an acute physical illness or injury which required hospitalization and is expected to remain in the NF for greater than 30 days.
2. Terminally Ill: Individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. An individual's medical prognosis is documented by a physician's certification, which is kept in the individual's medical record maintained by the nursing facility.
3. Severe Physical Illness: An illness resulting in ventilator dependence or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.
4. Delirium: Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.
5. Emergency Protective Services: Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the nursing facility not to exceed 7 days.
6. Respite: Very brief and finite stay of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with MI or ID is expected to return following the brief NF stay.
7. Coma: Severe illness or injury resulting in inability to respond to external communication or stimuli, such as coma or functioning at brain stem level.