PREADMISSION SCREEN RESIDENT REVIEW (PASRR)
NYS LEVEL II ADULT MENTAL HEALTH EVALUATION REPORT

The evaluator must send a copy of this Evaluation Report to the individual and his/her legal representative, the New York State Office of Mental Health, the admitting or retaining Residential Health Care Facility (RHCF), the individual's attending physician and the discharging hospital if the individual is seeking RHCF admission from a hospital. The state may convey its determination verbally to the RHCF and the individual, and confirm the determination in writing.

Individual's Name: _____

Medicaid Number: _____**PASRR Case Number**_____

Current Location: _____

Telephone Number: _____

Name of Evaluator (Please Print): _____

Evaluator Signature: _____

Professional Title of Evaluator: _____

Date of Evaluation: _____

_____ It has been determined that this individual does not require a PASRR Level II Evaluation at this time.

Summary Findings: _____

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This evaluation report is based on a comprehensive history of the individual; a physical examination, functional assessment, psychosocial evaluation and psychiatric evaluation of the individual; the individual's H/C PRI and SCREEN; social service and discharge planning documentation for the individual; interviews and other information as needed.

Summary of the Medical History: _____

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Summary of the Social History, including positive traits, or developmental strengths and weaknesses, or developmental needs of the evaluated individual:

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RECOMMENDATION FOR COMMUNITY SETTING, NURSING FACILITY LEVEL OF CARE, OR NURSING FACILITY SERVICES

After assessing the individual's total needs, mark the recommended placement option below with an X.

1. _____The individual's total needs are such that his or her needs can be met in the appropriate community setting.

2. _____The individual's total needs are such that they can be met through placement in a home and community-based waiver program, and such a program is available to the individual. A waiver program provides support and services to assist individuals with disabilities and seniors toward successful inclusion in the community, when otherwise inpatient care would be required.

3. _____The individual's total needs are such that placement in a home and community-based waiver program was considered, but determined not to be appropriate or feasible at this time. Inpatient care is appropriate and desired, and the nursing facility is an appropriate setting for meeting the individual's needs.

If placement option #3 is marked with an "X", explain the rationale for that recommendation, and describe the specific services required below:

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RECOMMENDATION FOR MENTAL HEALTH SERVICES OF LESSER INTENSITY

If placement option #3 is marked with an "X", and mental health services of lesser intensity (SLI) are recommended, mark the level below:

_____ Level 1

- Psychiatric and medication evaluation by a psychiatrist or MD, with psychiatric consultation within 1 week after admission
- Development of a written, person-centered, psychiatric plan of care.
- Ongoing psychiatric consultation and medication management by a psychiatrist or licensed prescriber every 2 weeks to monitor side effects of medication and to attain the highest efficacy with the lowest toxicity.
- Weekly recovery oriented clinical counseling focused on goal achievement by overcoming barriers due to the individual's mental illness.
- Therapeutic group interventions at least twice weekly that will assist in addressing the emotional, cognitive and behavioral symptoms of a mental health disorder.

_____ Level 2

- Psychiatric and medication evaluation by a psychiatrist or MD, with psychiatric consultation within 1 week after admission
- Development of a written, person-centered, psychiatric plan of care.
- Ongoing psychiatric consultation and medication management by a psychiatrist or licensed prescriber every 4 weeks to monitor side effects of medication and to attain the highest efficacy with the lowest toxicity.
- Bi-monthly recovery oriented clinical counseling focused on goal achievement by overcoming barriers due to the individual's mental illness.
- Therapeutic group interventions at least weekly that will assist in addressing the emotional, cognitive and behavioral symptoms of a mental health disorder.

_____ Level 3

- Psychiatric and medication evaluation by a psychiatrist or MD, with psychiatric consultation within 1 week after admission
- Development of a written, person-centered, psychiatric plan of care.
- Ongoing psychiatric consultation and medication management by a psychiatrist or licensed prescriber every 8 weeks to monitor side effects of medication and to attain the highest efficacy with the lowest toxicity.
- Bi-monthly recovery oriented clinical counseling focused on goal achievement by overcoming barriers due to the individual's mental illness.
- Therapeutic group interventions at least bi-monthly that will assist in addressing the emotional, cognitive and behavioral symptoms of a mental health disorder.

RECOMMENDATION FOR SPECIALIZED SERVICES

_____ Inpatient care is appropriate and desired but the nursing facility is not the appropriate setting for meeting the individual's needs. Another setting, such as an Institution For Mental Diseases (IMD), providing services to individuals aged 65 and older, or a psychiatric hospital, is an appropriate institutional setting for meeting those needs. Specialized Services (Active Treatment) are recommended and described below. For mental illness, specialized services means the services specified by the State Mental Health Authority which result in an individualized plan of care that demands hospitalization.

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You have the right to appeal this determination. If you wish to appeal this determination, you may contact The New York State Office of Temporary and Disability Assistance, Attention: Louise Finkle, Office of Administrative Hearings, 1 Commerce Plaza, 12th Floor, Albany, New York 12210. If you have any questions, you may call the Office of Administrative Hearings at (518) 473-4969.

The referring entity interpreted and explained this PASRR Level II Evaluation Report to the individual, and where applicable, the individual's legal representative on:

Date: _____

Signature of the Referring Entity Representative: _____

A copy of this Evaluation Report was sent to:

The individual: _____ Date: _____

Legal representative: _____ Date: _____

NYSOMH: _____ Date: _____

RHCF: _____ Date: _____

Attending physician: _____ Date: _____

Discharging hospital: _____ Date: _____