



BENEFICIARY INFORMATION					
Last Name:	First:	M.I.:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Medicaid ID:	Social Security Number:
Date of Birth:		Assessment Type: <input type="checkbox"/> Preadmission <input type="checkbox"/> Significant Physical Change <input type="checkbox"/> Significant Mental Change <input type="checkbox"/> Suspicion of SMI or ID			

LEGAL STATUS			
<input type="checkbox"/> Commitment <input type="checkbox"/> Legal Guardian-Conservator <input type="checkbox"/> Legal Representative/POA		Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other	
Applicant agrees to legal guardian and/or family participation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Spanish <input type="checkbox"/> Amharic <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other	
Legal Guardian/Family Member:		Interpreter Name:	
Telephone:		City:	ST: ZIP Code:
Power of Attorney:		Street Address:	
Telephone:		City:	ST: Zip Code:

SECTION A: EXEMPTING CRITERIA [■]	
Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary is likely to require less than 30 days nursing facility services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud	
Print Physician Name:	Date:
Title:	Physician Signature

■ Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days, the Level II evaluation must be completed no later than the 40th day of admission, on or before the date:

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI) [♦]	
1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. →	
3. Does the beneficiary have a history of any substance-related disorder diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify diagnosis →	
SMI Determination Based Upon: <input type="checkbox"/> Documented History <input type="checkbox"/> Behavioral Observation <input type="checkbox"/> Medications <input type="checkbox"/> Individual/Legal Guardian/Family Report	
♦ The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes". With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.	

1 Beneficiary Name:	Date of Birth:
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SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? Yes (Current Past: When) No

Check box preceding description if any subcategories below are applicable:

- Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.
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, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.
Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

- experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or integrated Case Management Services); and/or:
due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

Narrative information including dates:

The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? Yes No

If questions 1 and 2 In Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

- Does the beneficiary have a diagnosis of ID or related condition (mild, moderate, severe, or profound)? Yes No
List diagnosis (es) or evidence:
Beneficiary diagnosed with ID prior to age 18? Yes No
Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? Yes No
Is the beneficiary registered for services with an agency which serves individuals with ID or related conditions? Yes No
a. If Yes, describe the services the beneficiary is receiving:
b. Name of service provider and contact information:
c. If No, is the beneficiary interested in receiving services? Yes No
Has the beneficiary ever been a resident of a state facility including a state hospital, a state school, or other state facility? Yes No Unknown
If Yes, indicate the name of the facility and the date(s):
Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? Yes No
Condition: autism seizure disorder cerebral palsy spina bifida fetal alcohol syndrome muscular dystrophy
deaf blindness closed head injury other:
Impairment: mobility self-care self-direction learning understanding/use of language capacity for independent living.
Was the date of onset prior to age 22? Yes No If yes, explain:

2 Beneficiary Name: | Date of Birth:



Beneficiary is considered to have a positive screen for ID or related condition if one or more of the above questions in the above section are answered Yes. As a result, the beneficiary must be referred to the District of Columbia Department of Disability Services for Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or related condition.

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name: [SIGN HERE] Date:
Title:

SECTION E: DEMENTIA

- The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD.
The following criteria were used to establish the basis for a dementia diagnosis:
The physician documented dementia as the primary diagnosis OR that dementia is more progressed than a co-occurring mental illness diagnosis.

*A primary diagnosis of dementia, including Alzheimer's disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness.

SECTION F: ADVANCE GROUP DETERMINATION

- Is the beneficiary being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge?
Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician?
Does the beneficiary have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services?
Is this beneficiary being provisionally admitted pending further assessment due to an emergency requiring protective services?
Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis.
Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite?

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Print Name: [SIGN HERE] Date:

*If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral.



SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

- Beneficiary has negative screen for serious mental illness and no further action is necessary.
Beneficiary has negative screen for ID or related conditions and no further action is necessary.
Beneficiary has a positive screen for serious mental illness and has been referred to DBH for a Level II evaluation. Date:
Beneficiary has a possible positive screen and the Level 1 form has been forwarded to DBH for review. Date:
Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative Yes No Date :

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Print Name:



Date:

The District of Columbia Department on Disability Services is the contact agency for a Level II evaluation:

DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
Independence Square Building
250 E Street, SW
Washington, DC 20024
dds.hw@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for Level II evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-2972 (fax)
chaka.curtis@dc.gov

For individuals who wish to be enrolled in Medicaid-certified nursing facility, please fax this form along with the Prescription Order Form to Liberty Healthcare Corporation. The fax # is (202) 698-2075.