GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal No: 15-24**

TO: Hospital Administrators and Discharge Planners and District and Out-of-State Nursing Facilities

FROM: Claudia Schlosberg, JD
Senior Deputy Director/State Medicaid Director

DATE: July 15, 2015

SUBJECT: Revision of the Preadmission Screening for Resident Review (PASRR)

This purpose of this transmittal is to update providers on Department of Health Care Finance's (DHCF) recent revision to the Level I Preadmission Screen for Resident Review for Serious Mental Illness and Intellectual Disability or Related Conditions (PASRR). The revised form includes several new sections and is attached for your review. The form aims to achieve the following objectives: Effective August 1, 2015.

1. To ensure the District is compliant with the federal requirement set forth in 42 CFR Part 483 and to comply with the Supreme Court's decision in *Olmstead vs. L.C.* which held that all individuals have the right to live in the least restrictive setting possible.

2. To ensure PASRR screening occurs regardless of payment source.

3. The PASRR is to ensure that all nursing facilities (NF) are thoroughly evaluated. Beneficiaries applying for or residing in nursing facilities are placed in a nursing facility only when appropriate, and that all beneficiaries receive necessary services while in the NF.

4. To ensure person-centered care planning by assuring that psychological, psychiatric, and functional needs are met along with personal goals and preference in planning long term care.

5. To ensure that uniform transition related efforts are used by the District providers to ensure that beneficiaries are placed in the most appropriate setting (whether residing in Medicaid-certified nursing facility or in the community); and receive assessments that identify appropriate services they need in those setting.

6. To establish general guidelines for conducting the requirements, necessary evaluations and determinations for Level I and Level II screening of Medicaid beneficiaries who are diagnosed with serious mental illness (SMI) and intellectual disability (ID) or related conditions (RC).

7. To ensure standards for developing, implementing and maintaining screening systems to help ensure diversion, so that the Medicaid beneficiary is receiving services in the most integrated setting appropriate to their needs and not inappropriately placed in a nursing facility.

District Government regulations require that everyone who applies for admission to a nursing facility (NF) must be screened for evidence of serious mental illness (SMI) and /or intellectual disabilities (ID), or Related Conditions (RC). A nursing facility (NF) must not admit a beneficiary who has MI and/or ID or RC unless the appropriate state agency has determined:

a. If the beneficiary needs the level of services that a NF provides.
b. If the beneficiary who needs NF services also needs high-intensity "specialized services".
c. The beneficiary is in the least restrictive and integrated environment.

There are two types of screens: Level I and Level II. The purpose of a Level I screen is to determine whether a beneficiary might have MI and/or ID or RC.
If the beneficiary tests positive at Level I, the subsequent Level II screen will:

1. Confirm or disconfirm the results of the Level I screen, and
2. For beneficiary who have MI, ID or RC, determine where they should be placed-whether in a NF or in the community- and identify the services they require to maintain and improve their functioning.

Level I

All beneficiaries who apply to reside in a Medicaid/Medicare-certified facility, regardless of payer source, are required to receive a Level I PASRR screen to identify MI, ID or RC.

Level II

Level II confirms whether the beneficiaries have MI, ID or RC. Level II assesses the beneficiary need for nursing facility services; and it also assesses whether the beneficiary requires specialized services or specialized rehabilitative services.

Beneficiary Reviews

The Centers for Medicare and Medicaid Services (CMS) no longer requires annual beneficiary reviews, PASRR is required whenever there is a significant change in the beneficiary's physical or mental condition, whenever there is a significant deterioration, significant improvement or when the beneficiary expresses a desire to return to the community. The notion of "significant

change" is defined by responses to the Minimum Data Set (MDS). The MDS is a survey of NF beneficiary status that must be administered to all beneficiaries of Medicaid-certified NFs.

If a beneficiary is considered to have a positive screen for intellectual disability or a related condition, the beneficiary will be referred to the District of Columbia Department on Disability Services for a Level II comprehensive screening.

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If a beneficiary is considered to have a positive screen for serious mental illness, the beneficiary will be referred to the District of Columbia Department of Department of Behavior Health (DBH).

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Thank you in advance for adherence to these policies and ensuring timely submission of required documents. If you have any questions about this transmittal, please contact Cavella Bishop, Program Manager, Division of Clinician, Pharmacy, and Acute Provider Services via telephone at (202) 724-8936, or via email at cavella.bishop@dc.gov or Pamela Hodge, Management Analyst via telephone at (202) 442-4622 or pamela.hodge@dc.gov.

Attachments: Revised PASRR

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: Preadmission Screening and Resident Review (PASRR)	**Policy No:** 15-24
Policy Scope: Health Care Delivery Management Administration	Number of Pages: 5
Responsible Office or Division: Health Care Delivery Management Administration	Number of Attachments: 1
Supersedes Policy Dated: N/A	Effective Date: August 1, 2015
Cross References and Related Policies: N/A	Expiration Date: N/A

I. PURPOSE

To establish general guidelines for conducting evaluations and determinations for Level I and Level II screening of beneficiaries who are diagnosed with Serious Mental Illness (SMI) and Intellectual Disability (ID) or Related Conditions (RC). (a) To ensure standards for developing, implementing and maintaining screening systems to help ensure diversion, so that the beneficiary is receiving services in the most integrated setting appropriate to their needs and not inappropriately placed in a nursing facility. (b) To ensure uniform transitions efforts are used by District of Columbia Government agencies and providers to ensure that beneficiaries are placed in the most appropriate setting (whether residing in Medicaid-certified nursing facility or in the community); and to ensure beneficiaries receive assessments that identify appropriate services needed in these settings. (c) To ensure that District of Columbia Government agencies are compliant with the federal requirement as set forth in 42 CFR Part 483. and with the Supreme Court decision, *Olmstead vs. L.C.* which held that all individuals have the right to live in the least restrictive setting possible. (d) To ensure person-centered care planning by assuring that psychological, psychiatric, and functional needs are met along with personal goals and preference in planning long term care. (e) To ensure PASRR screening occurs regardless of payment source.

II. AUTHORITY

The authority for this policy is governed by the Omnibus Reconciliation Act of 1987 (OBRA), P.L. 100-203, Section 4211(c)(7), OBRA 1990 and 1993, as amended by the Balanced Budget Amendment of 1996, 42CFR 483.100 et seq. Olmstead Community Integration Initiative, District of Columbia, April 2012

III. APPLICABILITY

This policy applies to providers contracted with DHCF to treat Medicaid beneficiaries, DHCF employees, seasonal employees and interns, hospital discharge planners, nursing facility administrators and/or registered nurses (RN), licensed social workers (LICSW), or physicians.

DEFINITIONS

Change in Condition – a change in status, either physical or mental, which results in a decline or improvement in the mental health or functional abilities of the beneficiary while in the nursing facility. This change could prompt an evaluation of the beneficiary's level of care and must involve a re-screening through Level I as a status change. A change in status can occur for beneficiaries with a newly discovered or existing diagnosis or symptoms of serious mental illness.

Serious Mental Illness (SMI) – refers to a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs the judgment, behavior, capacity of a beneficiary to recognize reality, or the ability to meet the ordinary demands of life. Major mental illness such as schizophrenia, bipolar disorder, major depression, or an anxiety disorder such as Obsessive Compulsive Disorder (OCD) are considered SMI.

Intellectual Disability (ID) – refers to a beneficiary with an IQ score of 60-69 who also has severe functional limitations in at least three of the following major life activities:

1. Self-care
2. Understanding and use of language
3. Functional academics
4. Social skills
5. Mobility
6. Self-direction
7. Capacity for independent living or health and safety issues accompanied by one of the following diagnoses: autism, cerebral palsy, prader will syndrome, or spinal bifada.

Related condition(RC) – refers to and may include a severe chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction learning, understanding/use of language, capacity for independent living (e.g., autism, seizure disorder, cerebral palsy, spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf, blindness or closed head injury. Beneficiaries with an RC may be known to have SMI, ID the treatment for which changes significantly.

CMS – Centers for Medicare and Medicaid Services.

Dementia – refers to an overall decline in intellectual function, including difficulties with language, simple calculations, planning and judgment, and motor (muscular movement) skills as well as loss of memory

Providers – refers to Department of Behavior Health (DBH) and Department on Disability Services (DDS) including any entity, public or private, which is licensed or certified by these agencies to provide services to Medicaid beneficiaries. These Providers have entered into a participation agreement with DHCF to participate in the D.C. Medicaid Program.

Level of Care (LOC) – a utilization management tool used by Medicaid to determine a beneficiary's level of disability and the appropriate level of care/ services required. A LOC assessment is required when a beneficiary is seeking Medicaid payment for certain services, in order for Medicaid to pay for Nursing Facility (NF) services.

Level I Screening – refers to the initial assessment/screening required for all beneficiaries regardless of payment source, before being admitted to any Medicaid certified nursing facility. The screening is conducted by hospitals, nursing facilities, DBH or DDA providers.

Level II Screening – refers to the assessment screening which must be performed when the Level I screening indicates the possibility of SMI or ID or RC. This requires a face-to-face in-depth evaluation that verifies the diagnosis of SMI, ID or RC and determines the level of services by the nursing facility including the appropriateness of specialized services. Evaluations are to be provided for that positive Level I screen, prior to the admission to the nursing facility as well as a significant change in the beneficiary physical or mental condition occurs.

Significant change – refers to a beneficiary's physical or mental condition, whenever there is a significant deterioration, significant improvement or when the beneficiary expresses a desire to return to the community. The notion of "significant change" is defined by responses to the Minimum Data Set (MDS). The MDS is a survey of NF beneficiary status that must be administered to all beneficiaries of Medicaid-certified NFs.

Nursing Facility (NF) – refers to a facility which provides beneficiary with skilled nursing care and related services for the rehabilitation of injured, disabled or sick person, or on a regular basic, health related care services above the level of custodial care to beneficiary with developmental disabilities.

Nursing Facility Level of Care – refers to a utilization management tool used by Medicaid to determine a beneficiaries level of disability and the appreciate level of care/ services they require. A LOC assessment is required when a person is seeking Medicaid payment for certain services in order for Medicaid to pay for NF services. The screening assessment conducted prior to admission for all Medicaid eligible beneficiaries and used to determine if a beneficiary's condition requires the level of services offered in a nursing facility or whether the recipient would quality for less restrictive services which may be community based.

Preadmission Screening and Resident Review (PASRR) – refers to the uniform screening which is a federal statutory requirement (see 42 CFR 483 Subpart C) that mandates the review of every beneficiary who applies to or resides in a Medicaid- certified nursing facility, regardless of the source of payment for nursing facility services. PASRR screenings must be performed prior to admission and when a significant change in the beneficiary's physical or mental condition occurs: significant deterioration, significant improvement and when a beneficiary expresses a desire to return to the community.

Psychologist – a specialist in psychology licensed to practice professional psychology (e.g., clinical or qualified to teach psychology as a scholarly discipline).

Psychiatrist – a physician with a medical specialty concerned with the diagnosis and treatment of mental disorders.

Qualis Health is the current contract agency for the District that determines the type of level of care designation for Medicaid eligible beneficiary only of the District of Columbia and gives the final authorization for NF placement for those beneficiaries. If Quails Health authorizes the NF placement (based on the referral package), Qualis Health will provide a NF Services Level of Care designation representing this approval. This approval is valid for thirty (30) calendar days and must be utilized within that period.

IV. POLICY

The revised policy will help streamline and secure the human-centric business process and provides the interfaces to achieve operational uniformity throughout the PASRR screening process.
This policy was revised to coordinate the aforementioned screening processes, to include: Level I Screens (which apply to all applicants and beneficiary of Medicaid certified Nursing Facility's; and Level II Screens (which apply to all applicants and beneficiary of Medicaid certified Nursing Facility's with suspected MI and/or ID/RC). The providers must contact DHCF with monthly data for preadmission screening. This policy and screening information may be accessed through email, or facsimile. Each provider shall ensure that the scope of application of its policies and practices relate to the PASRR systems includes its employees, contractors, consultants ,and volunteers that provide supports and services to the District Medicaid beneficiaries.

General compliance standards shall include the following and all applicable Medicaid regulations. Additional standard may be added in the future after notice to the provider community.

1. District providers will establish eligibility policies and procedures to ensure compliance with CMS PASSR guidelines related to referral and admission to nursing home placements for beneficiary with serious mental illness (SMI) and or intellectual disability (ID) or related condition (RC).

2. Services providers will ensure that the PASRR system include protocols for admissions, discharge, and transition processes to Medicaid-certified nursing facilities. Provisions must also include the beneficiary review evaluation process whenever significant change in the beneficiary's physical or mental condition changes occurs (significant deterioration and significant improvement).

3. District providers shall develop criteria for nursing facility placements for beneficiary who require 24 hours of nursing home care and supervision, due to chronic and or acute somatic illness and functional limitations: nursing facility level of care and subsequent placements.

4. Service providers shall ensure that appropriate training is provided to affected personnel assigned to support beneficiaries. This training shall occur prior to assignment to deliver direct care supports and at least annually thereafter.

5. District providers shall institute a process whereby nursing facility placements and readmission data is tracked for utilization and used to improve quality and reduce risk.

6. District providers shall ensure proper and prompt notification of all PASRR II, screenings to DHCF and other appropriate government agencies as required.

7. Services providers shall follow internal PASRR procedures and nursing facility instructions regarding determination of Medicare and/or Medicaid eligible beneficiaries' utilization of private

funds. Providers shall provide the necessary assistance to Medicare and non-Medicaid eligible beneficiaries.

8. All Public providers and Discharge Planners are required to electronically report nursing home placements to DHCF Quality Improvement Organization (QIO).

9. The District providers shall complete the PASRR request within seven (7) to nine (9) business days, from receipt of the requested provider. The initiating provider must determine eligibility in writing of the PASRR (e.g., provider or discharging hospital), unless the beneficiary is exempt from preadmission screening. PASRR approval expires thirty (30) calendar days from the date of determination.

10. District providers shall ensure that a PASRR Level II screening is conducted upon a significant change in the beneficiaries' physical or mental health condition. A significant change in condition may include a beneficiary's improved condition and desire or plan to leave the NF and return to the community.

11. District providers shall ensure a PASRR is completed each time a person is admitted to a nursing facility; however, if the beneficiary is not admitted during the thirty (30) days of approval, and no significant changes in the beneficiary's condition occurred during that time, contact the PASRR Coordinator to update the PASRR determination. Further, resubmit the DHCF level of Care Form to the DHCF QIO for approval.

12. District providers shall conduct resident reviews of beneficiaries already in a NF when an authorized representative notifies DBH or DDS of a significant change in the beneficiary's physical or mental condition.

13. DHCF will conduct periodic checks on completed referrals using specific protocols and guidelines to determine the accuracy of determinations and appropriateness of recommendations, if applicable and the quality of work related to the PASRR level II evaluations.

14. DHCF will develop ongoing recommendations toward quality improvement activities.

V. RESPONSIBILITY

The Division of Clinicians, Pharmacy, and Acute Provider Services is responsible for the implementation of this policy.

Carmela D. Bishop
Responsible Implementing Manager

July 15, 2015
Date

Medicaid Director Approval

July 15, 2015
Date

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID or Related Conditions

BENEFICIARY INFORMATION

Last Name:	First:	M.I.:	Gender: ❑ M ❑ F	Medicaid ID:	Social Security Number:

Date of Birth:	Assessment Type: ❑ Preadmission ❑ Significant Physical Change ❑ Significant Mental Change ❑ Suspicion of SMI or ID

LEGAL STATUS

❑ Commitment ❑ Legal Guardian-Conservator ❑ Legal Representative/POA	Location: ❑ Home ❑ Hospital ❑ Nursing Facility ❑ Other

Applicant agrees to legal guardian and/or family participation? ❑ Yes ❑ No	Interpreter Required? ❑ Yes ❑ No ❑ Spanish ❑ Amharic ❑ Chinese ❑ Korean ❑ Other	Interpreter Name:

Legal Guardian/Family Member:	Street Address:		
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? ❑ Yes ❑ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care? ❑ Yes ❑ No
Beneficiary is likely to require less than 30 days nursing facility services? ❑ Yes ❑ 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:	SIGN HERE → Physician Signature	Date:
Title:		

▪*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 ICD-10-CM Diagnosis Code_____ ❑ Yes ❑ No ❑ 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? ❑ Yes ❑ No ❑ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. →
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ❑ Yes ❑ No ❑ Unknown Specify diagnosis →

SMI Determination Based Upon: ❑ Documented History ❑ Behavioral Observation ❑ Medications ❑ 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.

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)

1. Beneficiary has diagnosis of ID or related condition? ❑ Yes ❑ No
2. Beneficiary diagnosed with ID prior to age 18? ❑ Yes ❑ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ❑ Yes ❑ No
4. Referred beneficiary deemed eligible for services by an agency which serves individuals with ID or related condition? ❑ Yes ❑ No
   a. If yes, what services are the beneficiary receiving? _____
   b. Name of service provider & contact information _____
5. 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
   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:

6. Is the beneficiary considered to have ID or a Related Condition? ❑ Yes ❑ 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 Name:	SIGN HERE	Date:
Title:		

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

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. (If checked specify DSM-5 or ICD codes:_____
- ❑ The following criteria were used to establish the basis for a dementia diagnosis: ❑ Mental Status Exam ❑ Neurological ❑ History Symptoms ❑ Other Diagnostics (specify):_____
- ❑ The physician documented dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: _____

**A primary diagnosis of dementia, including Alzheimers' 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. If there is no confirmed diagnosis of dementia, check* N/A❑. *Only if the boxes in front of ALL THREE statements above are checked is the beneficiary designated as having a primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary is not designated as having a primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. 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 (described in Section A)? ❑ Yes ❑ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ❑ Yes ❑ No
3 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? ❑ Yes ❑ No
3. Is this beneficiary being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. ❑ Yes ❑ No
4. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen).
5. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ❑ Yes ❑ 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 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 a Level II is conducted and forward to DBH. Date:
- ❑ Beneficiary has a possible positive screen and the Level II 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 :		
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:

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

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

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Upload this form via the Qualis Health Provider Portal at www.qualishealth.org. Then select one of the choices in the Healthcare Professional Drop-Down Menu: DC Medicaid or Provider Resources. You may obtain additional assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org