



LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Pilot Version -- For use only in Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion Parishes

Instructions: This screening must be completed for all persons applying for admission to a Medicaid certified nursing facility regardless of payment source. The Level of Care Eligibility Tool (LOCET) must also be completed in order for the Office of Aging and Adult Services to process admission requests. Fax the completed, signed form to 225-389-8198 or 225-389-8197.

Name of Hospital/ Nursing Facility/ Other Source Completing Level I Screen:			
Date:	Fax:	Phone:	
Printed Name and Title of Contact Person for Hospital/ Nursing Home/ Other:			
Email:			
If applicant is currently hospitalized, please indicate where they were admitted from: <input type="checkbox"/> Personal/ Family Residence or Apartment <input type="checkbox"/> Homelessness/ Homeless Shelter <input type="checkbox"/> Nursing Facility (Please provide name below.) <input type="checkbox"/> Other (please specify): _____			
Physician Name: (Please print.)		Physician Signature:	
SECTION I: Identifying Information for Applicant			
<input type="checkbox"/> Skip this section if ALL of the information requested below is provided on an ATTACHED face sheet.			
Applicant Name	First and Middle		
	Last		
Address (if other than NF)	Street		
	City	Zip	
Social Security #:	Date of Birth:	Medicaid #:	
Legally Authorized Representative/ Guardian Individual designated under State law to make decisions on the applicant's behalf, such as a curator, tutor, guardian or agent under a health care power of attorney.	Name		
	Street		
	City		
	State	Zip	
	Phone		
	E-mail		
<input type="checkbox"/> Anticipated NF	Name		
<input type="checkbox"/> Current NF	City		

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SECTION II: Mental Illness														
1.	Has the applicant ever been diagnosed as having a major mental illness? (Do not include dementia.) If yes, check all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Severe Anxiety Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Delusional Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Other Depressive Disorder <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Personality Disorder (specify): _____ <input type="checkbox"/> Other(specify): _____														
2.	Has the applicant shown any of the following symptoms THAT ARE NOT THE RESULT OF A MEDICAL ISSUE? If yes, check all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Self-injurious or self-mutilating behaviors <input type="checkbox"/> Danger to others, aggressive, assaultive <input type="checkbox"/> Danger to self, suicidal ideation, threats, or attempts <input type="checkbox"/> Serious loss of interest in things that used to be pleasurable <input type="checkbox"/> <u>Interpersonal functioning</u> : Serious difficulty interacting appropriately and communicating effectively with other persons; has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation <input type="checkbox"/> <u>Concentration, persistence and pace</u> : Serious difficulty in sustaining focused attention for a long enough period of time 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 <input type="checkbox"/> <u>Adaptation to change</u> : 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 <input type="checkbox"/> Other (specify): _____														
3.	Has the applicant had any of the following DUE TO A MENTAL ILLNESS? If yes, please provide as much of the information below as is known to you.	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Inpatient psychiatric treatment. Date(s):														
<input type="checkbox"/> Partial hospitalization / day treatment. Date(s):														
<input type="checkbox"/> Loss of housing / eviction. Date(s):														
<input type="checkbox"/> Law enforcement intervention. Date(s):														
4.	Has the applicant been diagnosed with a substance use or addictive disorder? If yes, please specify type(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No												
5.	Has the applicant taken any psychotropic medications on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: center;">Medication</th> <th style="width: 30%; text-align: center;">Reason Prescribed</th> <th style="width: 40%; text-align: center;">Diagnosis</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Medication	Reason Prescribed	Diagnosis									
Medication	Reason Prescribed	Diagnosis												
Continue on a separate sheet if necessary.														
Skip this box IF the medication list with diagnoses is SUBMITTED WITH this form.														
Comments:														

SECTION III: Intellectual Disability, Developmental Disability and Related Conditions		
6.	Does the applicant have a diagnosis of an intellectual disability (formerly referred to as mental retardation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, was there any information available to the screener that substantiates that this condition began prior to age 22?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Does the applicant have a diagnosis of a developmental disability or related condition other than an intellectual disability? (A related condition is a disability that impairs intellectual functioning or adaptive functioning and requires services normally delivered to individuals with intellectual disabilities.) If yes, please specify all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Autism <input type="checkbox"/> Genetic Syndrome Associated with Delay <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head Injury/TBI <input type="checkbox"/> Other (specify): _____	
	If yes, was there any information available to the screener that substantiates that this condition began prior to age 22?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Age at which the disability or condition began:	
8	Does the applicant have presenting evidence of intellectual disability, developmental disability or a related condition that has not been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	If "yes" was marked for questions 6, 7, and/ or 8, are there substantial functional limitations attributable to the suspected intellectual disability, developmental disability or related condition that are not attributable to a medical condition, dementia or mental illness? If yes, please specify all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mobility <input type="checkbox"/> Self-Direction <input type="checkbox"/> Self-Care <input type="checkbox"/> Learning <input type="checkbox"/> Understanding/ Use of Language <input type="checkbox"/> Capacity for Living Independently <input type="checkbox"/> Economic Self-Sufficiency (If the applicant is 18 years or older)	
10.	Is the applicant currently receiving services from an agency that serves people with Intellectual and Developmental Disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide as much of the information below as is known to you:	
	Agency: Dates:	
11.	Has the applicant received services in the past or been referred to an agency that serves people with Intellectual and Developmental Disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide as much of the information below as is known to you:	
	Agency: Dates:	

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SECTION IV. Categorical Determinations		SELECT ONE
Complete this section for individuals who have been determined to have or are suspected of having serious mental illness or an intellectual disability or a related condition in previous Sections.		
12.	<p>The applicant meets all of the following criteria for a hospital exemption.</p> <ul style="list-style-type: none"> • The individual is being admitted directly to a nursing facility after receiving acute care in a hospital; • AND the individual needs nursing facility services for the condition for which he/ she received care in the hospital; • AND the attending physician certifies by signing this form that the individual will require 30 days or less of nursing facility services. <p>What is the acute condition for which a hospital exemption is requested?</p>	
13.	<p>The applicant cannot be assessed because of delirium. (Records supporting a diagnosis of delirium must accompany this form.)</p>	
14.	<p>The applicant requires respite care for up to 30 calendar days.</p>	
15.	<p>The applicant has a terminal illness with a prognosis of a life expectancy of less than 6 months AND needs nursing care associated with the condition. (Records supporting this diagnosis must accompany this form.)</p>	
16.	<p>The applicant has a physical illness so severe (<i>such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure</i>) that the individual would be unable to participate in a program of specialized services. Describe the condition:</p> <p>(Records supporting this diagnosis must accompany this form.)</p>	
17.	<p>The applicant needs convalescent care for an acute physical illness that:</p> <ul style="list-style-type: none"> • Required hospitalization • AND does not meet all the criteria for an exempt hospital discharge. <p>What is the condition that requires convalescent care?</p> <p>How long will the applicant need convalescent care?</p> <p>(Records supporting the need for convalescent care must accompany this form.)</p>	
18.	<p>The applicant has a PRIMARY diagnosis of dementia or Alzheimer's disease that has progressed to the point that the individual would be unable to participate in a program of specialized services. How was the diagnosis determined? (e.g., MRI, CT, Comprehensive Mental Status Exam)</p> <p>(Records supporting this diagnosis must accompany this form.)</p>	