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:

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:

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

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.

   You may qualify for Office of Mental Health housing including/but not limited to: apartment housing (living alone or with others); congregate housing (living with other people); or family care (living with a family care provider in their home).

   Services you may qualify for include/but are not limited to: health services at your home (nurses, home health aides and physical therapists); personal care (help with bathing, dressing and grocery shopping); Adult Day Health Care; specialty health (audiology, dental, optometry and podiatry); transportation to medical appointments; home delivered meals; peer support; vocational rehabilitation; and continuing mental and/or behavioral health services. **Your Social Worker will work with you to initiate these services and obtain appropriate housing to provide you with a safe discharge.**

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:

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

If Specialized Services are recommended mark with an "X", and describe below:

☐ 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.

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: _____

Please read the next page concerning your right to appeal this determination.

You have a right to appeal your PASRR determination.

Right to a Fair Hearing: If you believe that this determination is wrong, you may request a State Fair Hearing by contacting the New York State Office of Temporary and Disability Assistance (OTDA).

1. Telephone: You may call the statewide toll-free number: **800-342-3334.** (Please have this Report with you when you call.); OR

2. Fax: First, fill in the information below and then send a copy of this page to fax number: **(518) 473-6735**; OR

3. On-line: Complete and send the online request form at **http://www.otda.ny.gov/oah/forms.asp**; OR

4. Write: First, complete the information below and then send copy of this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201. Please keep a copy for yourself.

You have 60 days from the date of this Report to request a fair hearing.

☐ I want a Fair Hearing. This determination is wrong because:

_____

_____

Print Name: _____ PASRR Case Number: _____

Address:_____ Telephone:_____

If you request a Fair Hearing, the OTDA will send you a Notice of Fair Hearing that tells you when and where the hearing will be held and provides additional information about your rights.

You have the right to be represented by an attorney, a relative, a friend or other person. If your representative is not a lawyer, they must bring to the hearing a written letter, signed by you, saying that you want that person to represent you.

If you need free legal help, you may be able to obtain that help by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or other legal advocate group in the yellow pages of your phone book.

At the hearing, you, your attorney or your representative will have a chance to explain why you think this determination is wrong, to present written and oral evidence to demonstrate why it is

wrong, as well as an opportunity to question any people who appear at the hearing. Also, you have a right to bring witnesses to the hearing to speak in your favor. You should bring to the hearing any documents that might be helpful in presenting your case, such as medical records.

You have a right to look at documents from your case file to the extent consistent with state or federal law or regulation. You or your representative may be asked to submit an Authorization for Release of Information Form. To ask for documents or find out how to look at your file, call **1-800-633-9441** or write to: IPRO, PASRR Department, 1979 Marcus Avenue, Lake Success, NY 11042-1002, Attn: Diane Thorp, Assistant Director. Documents will not be sent to you unless you make a specific request for them.

You have the right to have a language or sign interpreter provided to you at no cost at the hearing. To secure an interpreter, call OTDA at **800-342-3334** or write to OTDA at the address above.

If you are homebound and unable to travel to the hearing, you may appear at the hearing through a representative. If you have no representative or wish to participate directly in the hearing, a telephone hearing may be scheduled for you. At the time you request a Fair Hearing, you should tell the interviewer at OTDA or explain in your letter or fax that you are homebound. You will then be contacted by OTDA with more information. You will be asked to provide medical documentation that states that you cannot travel to the regular hearing location.

If you have questions about the Fair Hearing process, contact OTDA at **800-342-3334,** or go to **www.otda.ny.gov/oah**.