

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Marital Status: M S W D

Gender: Male Female Race: Caucasian African American Asian Hispanic Other: _____

Payment Method: Medicare Private Pay Medicaid Pending Medicaid # _____

Living Situation Prior to Current Placement: NF Assisted Living Group home Hospital Other _____

Current Location: _____ Admission Date: _____

Medical Facility Psychiatric Facility Nursing Facility Community Other: _____

Location Address: _____ City: _____ State: _____ Zip: _____

Admitting Nursing Facility: _____ Date Admitting: ____/____/____

Admitting Nursing Facility Address: _____ City: _____ State: _____ Zip: _____

Review Type: Preadmission Status Change Conclusion of a Time Limited Approval

Why is this individual seeking admission to or continued stay in a nursing facility?

- Physical problems require NF care and mental illness or substance abuse disorder, *if present*, has no impact on the need for NF care.
- Mental illness or substance abuse disorder requires NF care, but no significant physical problems are present.
- NF care is primarily required because the individual's mental illness or substance abuse disorder prevents proper handling of physical problem(s) outside a NF setting. Without a mental illness or substance abuse disorder, the individual's physical problem(s) would not require NF care.

Section I: MENTAL ILLNESS

<p>1. Does the individual have any of the following Major Mental Illnesses (MMI)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply)</p> <p><input type="checkbox"/> Yes: (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Psychotic/Delusional Disorder <input type="checkbox"/> Bipolar Disorder (manic depression) <input type="checkbox"/> Paranoid Disorder 	<p>2. Does the individual have any of the following mental disorders?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply)</p> <p><input type="checkbox"/> Yes: (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Depression (mild or situational) 	<p>3a. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, list diagnosis(es) below):</p> <p><input type="checkbox"/> Diagnosis 1: _____</p> <p><input type="checkbox"/> Diagnosis 2: _____</p> <p>3b. Does the individual have a substance related disorder?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, complete remaining questions in this section)</p> <p>3b.1 List substance related diagnosis(es)</p> <p>Diagnosis _____ Diagnosis _____</p> <p>Diagnosis _____ Diagnosis _____</p> <p>3b.2 Is NF need associated with this diagnosis? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3b.3 When did the most recent substance use occur?</p> <p><input type="checkbox"/> Less than 7 days <input type="checkbox"/> 7-14 days <input type="checkbox"/> 15-30 days</p> <p><input type="checkbox"/> 31 days-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-12 months</p> <p><input type="checkbox"/> Greater than 12 months <input type="checkbox"/> Unknown</p>
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Section II: SYMPTOMS

<p>4. Interpersonal— Currently or in the past, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions, or unstable employment <input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers <p>If yes, how recent:</p> <p><input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months</p> <p><input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years</p> <p><input type="checkbox"/> Greater than 5 years</p>	<p>5. Concentration/Task related symptoms – Currently or in the past, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty completing tasks that she/he should be capable of completing <input type="checkbox"/> Required assistance with tasks for which s/he should be capable <input type="checkbox"/> Substantial errors with tasks in which she/he completes <p>If yes, how recent:</p> <p><input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months</p> <p><input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years</p> <p><input type="checkbox"/> Greater than 5 years</p>
<p>Adaptation to change—Currently or in the past, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? <input type="checkbox"/> No (proceed to Section III) <input type="checkbox"/> Yes (complete 6-8)</p>	

Last Name _____ First Name _____ DOB _____

<p>6. <input type="checkbox"/> Self-injurious or self-mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p> <p>If yes, how recent: <input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years <input type="checkbox"/> Greater than 5 years</p>	<p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p> <p>If yes, how recent: <input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years <input type="checkbox"/> Greater than 5 years</p>	<p>8. <input type="checkbox"/> Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms: _____)</p> <p>If yes, how recent: <input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years <input type="checkbox"/> Greater than 5 years</p>
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Section III: HISTORY OF PSYCHIATRIC TREATMENT

<p>9. Currently or in the past, has the individual received any of the following mental health services? <input type="checkbox"/> No <input type="checkbox"/> Yes (the individual has received the following service[s]): <input type="checkbox"/> Inpatient psychiatric hospitalization(if yes, provide date: _____) <input type="checkbox"/> Partial hospitalization/day treatment(if yes, provide date: _____) <input type="checkbox"/> Residential treatment (if yes, provide date: _____) <input type="checkbox"/> Other: _____ (if yes, provide date: _____)</p> <p>If yes, how recent: <input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years <input type="checkbox"/> Greater than 5 years</p>	<p>10. Currently or in the past, has the individual experienced significant life disruption because of mental health symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply): <input type="checkbox"/> Legal intervention due to mental health symptoms (date: _____) <input type="checkbox"/> Housing change because of mental illness(date: _____) <input type="checkbox"/> Suicide attempt or ideation (date[s] _____) <input type="checkbox"/> Current Homelessness <input type="checkbox"/> Homelessness within the past 6 months but not current <input type="checkbox"/> Other: _____ (date: _____)</p> <p>If yes, how recent: <input type="checkbox"/> Current or within past 30 Days <input type="checkbox"/> 2-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 13-24 months <input type="checkbox"/> 25 months-5 years <input type="checkbox"/> Greater than 5 years</p>
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11. Has the individual had a recent psychiatric/behavioral evaluation? No Yes (date: _____)

Section IV: DEMENTIA

<p>12. Does the individual have a primary diagnosis of dementia or Alzheimer's disease? <input type="checkbox"/> No (proceed to 14) <input type="checkbox"/> Yes <input type="checkbox"/> No, the individual has dementia but it is not primary (proceed to 14)</p>	<p>13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply): <input type="checkbox"/> Dementia work up <input type="checkbox"/> Comprehensive Mental Status Exam <input type="checkbox"/> Other (specify): _____</p>
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Section V: PSYCHOTROPIC MEDICATIONS

14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months? No Yes (list below)
[use separate sheet if necessary]

Medication	Dosage MG/Day	Diagnosis	Discontinued
			<input type="checkbox"/>

VI: INTELLECTUAL DISABILITIES AND RELATED CONDITIONS

<p>15. Does the individual have a diagnosis of intellectual disability (ID)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>17. Is there presenting evidence of a cognitive or developmental impairment that occurred prior to age 18? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>19. Does the individual have a diagnosis which affects intellectual or adaptive functioning? <input type="checkbox"/> No <input type="checkbox"/> Yes (Check all that apply) <input type="checkbox"/> Autism <input type="checkbox"/> Epilepsy <input type="checkbox"/> Blindness <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head Injury <input type="checkbox"/> Deaf <input type="checkbox"/> Other: _____</p> <p>21. If yes to #19, did this condition develop prior to age 22? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>18. Has the individual ever received services from an agency that serves people with ID? <input type="checkbox"/> No <input type="checkbox"/> Yes – agency: _____</p> <p>20. Are there substantial functional limitations in any of the following? <input type="checkbox"/> No <input type="checkbox"/> Yes (Check all that apply) <input type="checkbox"/> Mobility <input type="checkbox"/> Self-Care <input type="checkbox"/> Self-Direction <input type="checkbox"/> Learning <input type="checkbox"/> Understanding/Use of Language <input type="checkbox"/> Capacity for living independently</p>
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Last Name _____ First Name _____ DOB _____

VII: EXEMPTION AND CATEGORICAL DECISIONS (SECTION VII APPLIES ONLY TO PERSONS WITH KNOWN OR SUSPECTED MI AND/OR ID/RC)
 (Ascend must approve use of categories and exemptions prior to admission)

22. Does the admission meet criteria for Hospital Exemption?

- No
 Yes (meets all the following **and** has a known or suspected SMI or ID/RC):
- Admission to NF directly from hospital after receiving acute inpatient medical care, and
 - Need for NF is required for the condition treated in the hospital (specify condition: _____), and
 - The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services **and** the individual's symptoms or behaviors are stable. Physician Name: _____
 Physician Phone: _____
 Physician Licenses #: _____

23. Additional Comments: _____

24. Does the admission meet the criteria for Terminal Illness?
 No
 Yes (Has a known or suspected SMI or ID/RC **and** MD has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted to Ascend via facsimile within 6 business hours of submission of this form)

25. Does the admission meet the criteria for Severity of Illness?
 No
 Yes (Has a known or suspected SMI or ID/RC **and** is ventilator dependent or comatose/unresponsive)

26. Does the admission meet criteria for 30 day Respite?
 No
 Yes (Has a known or suspected SMI or ID/RC **and** is in need of respite stay for up to 30 calendar days in caregiver's absence)

27. Does the admission meet criteria for 7 day EPS Admission?
 No
 Yes (Has a known or suspected SMI or ID/RC and is in imminent need for short-term placement to ensure safety **and** no other placements are available)

28. Does the admission meet criteria for Dementia/MI?
 No
 Yes (Has a known or suspected MI **and** Dementia is primary)

29. Does the admission meet criteria for Dementia/ID?
 No
 Yes (Has a known or suspected ID/RC **and** Dementia is primary)

Section VIII: Guardianship & Physician Information (Required only for individuals with known or suspected Level II conditions)

30. Does the individual have a legal guardian? No legal guardian. Yes, information is below:

Legal Guardian Last Name _____ First Name _____ Phone: _____
 Street _____ City _____ State _____ Zip _____

31. Primary Physician's Name: _____ Phone: _____ Fax: _____
 Street _____ City _____ State _____ Zip _____

Section IX: REFERRAL SOURCE SIGNATURE:

By signing my name below, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a health care professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, social workers (with a B.S. degree or higher), physicians, or home health agency clinical staff. Social service staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to Ascend. I understand that NE DHHS considers knowingly submitting inaccurate, incomplete, or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge.

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Ascend Use Only: Reviewer Individualized Service Recommendations (applies if categorical approval [#26-27 or 29] was issued).

<input type="checkbox"/> Evaluate psychopharmacologic medications	<input type="checkbox"/> Training in ADLs	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Supportive counseling	<input type="checkbox"/> Explore/prepare for lower level of care	_____
<input type="checkbox"/> Medication education	<input type="checkbox"/> Training in self-health care management	_____
<input type="checkbox"/> Foreign language services	<input type="checkbox"/> Obtain prior behavioral health records to clarify need	<input type="checkbox"/> No recommendations at this time

The outcome will be reflected on the computerized screen.