South Dakota PASRR Program
SCREENING FORM

Updated 08/24

FORM INSTRUCTIONS

1. This form must be completed on all individuals admitted to a Medicaid certified swing bed or nursing facility
2. Ensure all handwriting is legible if completing in written format
3. Facility names should be spelled out- no abbreviations
4. If any questions in either the Serious Mental Illness -or- Intellectual/Developmental Disabilities sections are 'Yes' or 'Suspected', email Maximus at PASRR@state.sd.us with the completed Screening Form and supporting documentation
5. If all questions in the Serious Mental Illness -or- Intellectual/Developmental Disabilities sections are 'No', the individual may be admitted without further evaluation and this form is saved in the individual's file.
6. An incomplete form will not be processed and will be returned to sender for corrections

SCREENING TYPE

SELECT ONE: ☐ PRE-ADMISSION ☐ RESIDENT REVIEW

IF **PRE-ADMISSION** WAS SELECTED, ARE ANY CATEGORICAL OUTCOMES BEING REQUESTED?	IF YES, WHICH ONE?
☐ YES ☐ NO	☐ TERMINAL ILLNESS ☐ SEVERE PHYSICAL ILLNESS ☐ CONVALESCENT 100 DAYS ☐ RESPITE 30 DAYS ☐ 75 AGE OR OLDER

IF **RESIDENT REVIEW** WAS SELECTED, WHICH REASON?

☐ SHORT TERM CATEGORICAL OR EXEMPTED HOSPITAL DISCHARGE CONCLUDES

☐ TIME LIMITED APPROVAL BY STATE INTELLECTUAL DISABILITY AUTHORITY (SIDA) CONCLUDES

☐ SIGNIFICANT CHANGE IN STATUS

IF SHORT TERM CATEGORICAL OR EXEMPTED HOSPITAL DISCHARGE CONCLUDES LIST TYPE:	END DATE OF CURRENT PASRR
IF TIME LIMITED APPROVAL BY SIDA CONCLUDES, HAS ID/DD LEVEL II FORM BEEN COMPLETED? ☐ YES ☐ IF NO, WHY: (should always be completed and sent with this screening form for prompt review)	END DATE OF CURRENT PASRR
IF SIGNIFICANT CHANGE IN STATUS, DESCRIBE CHANGE TO BE EVALUATED: (refer to the SD PASRR manual for details on what constitutes a change in status)	DATE OF NOTED CHANGE IN STATUS

APPLICANT DEMOGRAPHICS

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

SOCIAL SECURITY NUMBER	MEDICAID NUMBER (IF APPLICABLE)	PRIMARY LANGUAGE

LEGAL GUARDIAN? ☐ YES ☐ NO (submit supporting documentation if applicable)	TYPICAL LIVING SITUATION: ☐ HOMELESS ☐ HOME ALONE ☐ HOME W/ FAMILY ☐ HOME W/ SERVICES ☐ ASSISTED LIVING ☐ NURSING FACILITY ☐ GROUP HOME ☐ OTHER:

MAILING ADDRESS (if known)

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CURRENT LOCATION OF APPLICANT		
FACILITY NAME (must write full name- no abbreviations)	CITY	STATE
FACILITY ADDRESS		FAX
PRIMARY CONTACT	CONTACT EMAIL	CONTACT PHONE
SECONDARY CONTACT	SECONDARY CONTACT EMAIL	SECONDARY CONTACT PHONE

ADMITTING FACILITY (only for Pre-Admission)		
ADMITTING FACILITY IS UNKNOWN ☐ (If marked, skip rest of this section)	TYPE OF FACILITY: ☐ SWING BED ☐ NURSING FACILITY	
FACILITY NAME (must write full name- no abbreviations)	FACILITY ADDRESS (CITY, SD, ZIPCODE)	
PRIMARY CONTACT EMAIL	SECONDARY CONTACT EMAIL	

ADMITTING DIAGNOSES
PRIMARY DIAGNOSES (include any neurocognitive diagnoses such as dementia/Alzheimer's)

INTELLECTUAL/DEVELOPEMENTAL DISABILITY SCREENING	YES	NO	SUSPECTED
Does this individual have a diagnosis or evidence of an intellectual or developmental disability? Evidence includes: severe, chronic disability attributable to intellectual disability, cerebral palsy, epilepsy, head injury, brain disease, autism, or any other disorder, other than mental illness, that is closely related to intellectual disability and requires treatment or services similar to those required for individuals with intellectual disabilities. Such a condition must cause impairment of general intellectual functioning or adaptive behavior. In addition, the disability must have manifested itself before the individual reached age 22 and the disability is likely to continue indefinitely. Specify diagnosis(es): If a diagnosis(es) are listed above, then mark Yes for the overall question.	☐	☐	☐
Is there evidence, based on available documentation, observations, interviews, and history that the individual has received the following services: ☐ Services from an agency that provides supports to individuals with intellectual or developmental disabilities ☐ Special education services If any of the above are checked, then mark Yes for the overall question.	☐	☐	☐
Has the following testing ever been completed: ☐ Psychological Evaluation with full-scale IQ and adaptive testing	☐	☐	☐

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SERIOUS MENTAL ILLNESS SCREENING	YES	NO	SUSPECTED
Does this individual have a diagnosis or evidence of a serious mental illness limited to the following disorders? (check which disorder): ☐ Schizophrenia ☐ Schizoaffective ☐ Atypical psychosis ☐ Mood- Bipolar and Major Depressive Type ☐ Panic or Severe Anxiety Disorder ☐ Somatoform/Delusion/Paranoid Disorder ☐ Personality Disorder ☐ Other psychotic disorder (not otherwise specified) If a diagnosis(es) are checked above, then mark Yes for the overall question.	☐	☐	☐
Is there evidence, based on available documentation, observations, interviews, and history that the individual has noted difficulty in the following areas: ☐ Interpersonal Functioning- difficulty interacting with others; altercations; evictions; unstable employment, frequently isolated; avoids others ☐ Completing Tasks- serious difficulty completing tasks; requires assistance with tasks; errors with tasks; difficulty with concentration; persistence and pace ☐ Adaptation to Change- self injurious or self-mutilation; suicidal; physical violence or threats; appetite disturbance; serious loss of interest; tearfulness; irritability; withdrawal If any of the above are checked, then mark Yes for the overall question.	☐	☐	☐
Based on available documentation, observations, interviews, and history, within the last 2 years has the individual experienced any psychiatric treatment episodes such as inpatient psychiatric care; referred to a mental health crisis center; has attended partial care/hospitalization; or has received mental health case management services.	☐	☐	☐

SUPPORTING DOCUMENTATION CHECKLIST	
PRE-ADMISSION ☐ Screening Form ☐ Demographic Face Sheet ☐ History & Physical or Physician Progress Note in Last 30 Days ☐ Current Medication List If requesting a categorical, please submit: ☐ Terminal Illness- medical provider statement ☐ Severe Physical Illness- medical provider statement ☐ 100 Day Convalescent- order by medical provider ☐ 30 Day Respite- order by medical provider	RESIDENT REVIEW Required: ☐ Copy of Original Screening Form ☐ Demographic Face Sheet ☐ History & Physical or Physician Progress Note in Last 30 Days ☐ Current Medication List- including notes on self-administration ☐ Copy of order for new diagnosis, medication, status change request reason (if applicable) If SIDA Renewal Required: ☐ ID/DD Level II Evaluation Form ☐ Current Care Plan ☐ Skilled Therapy Notes ☐ Challenging Behavior Notes (if present) ☐ Activities of Daily Living documentation Urinary & Bowel Continence ☐ documentation Skin Integrity Notes (if ☐ applicable) ☐ Recent Hospitalization Notes (if applicable) ☐ BIMS Results (if applicable) ☐ Psychological Evaluation (if applicable) ☐ Other Relevant Medical Records

Are any questions under the Intellectual/Developmental Disability -or- Serious Mental Illness sections marked 'YES' or 'SUSPECTED'?

☐ No – This individual may be admitted without further evaluation and this form is to be saved in the individual's file.
☐ Yes – This individual needs to be referred to Maximus at PASRR@state.sd.us for further evaluation.

Referred to Maximus on _____ at _____
(date) (time)

_____ _____
Signature of Designated Facility Representative Date Signed