Instructions for Completion of Level 1 Preadmission Screening and Resident Review – HW0087

This process can begin when it has been identified that the individual has a suspected or actual MH/ID diagnosis and planned discharge to a Nursing Facility (NF).

Demographics

Complete all demographics

Section I: Mental Illness

- 1. For "suspected" or "yes" check all that apply, otherwise check "no"
- 2. For "suspected" or "yes" check all that apply, otherwise check "no"
- **3.** If "yes" is checked, write in the diagnosis(es)

Section II: Symptoms

- **4.** For questions 4-8: Every effort should be made to obtain history over the past 6 months. If this is impossible then use current information. If "yes" check all that apply
- 5. If "yes" check all that apply
- **6.** If "yes" check all that apply
- 7. If "yes" check all that apply
- 8. Describe symptoms

Section III: History of Psychiatric Treatment

- **9. For questions 9-11:** Every effort should be made to obtain history over the past 2 years. If this is impossible, then use current information.
 - a. If "yes" check all that apply
- **10.** If "yes" check all that apply
- 11. If "yes" is checked provide date. If available attach evaluation and /or name of institution.

Section IV: Dementia

- 12. Mark yes "only" if diagnosis of dementia or Alzheimer's disease is "Primary."
 - a. If "yes" is checked proceed to question #13
 - **b.** If "no" is checked proceed to question #15
- 13. If "yes" is checked, attach testing or information to support
- **14.** If an individual is taking more of a medication than the maximum dosage on the Beer's List, a Level I trigger occurs because higher dosages are often associated with Mental Illness

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Section V: Psychotropic Medications

15. Required PASRR documentation should include admission and discharge meds. In addition, please list any meds that resulted in adverse reactions. A physician must clearly identify those used for medical diagnosis(es)

Section VI: Intellectual Disability and Developmental Disabilities

- **16.** If "yes" check all that apply
- 17. This question indicates suspected or history of ID or DD without a definitive diagnosis(es).
- 18. If "yes" attach any supporting testing or information, if available
- 19. If "yes" please list agency

Signature Section

HW0087 is signed by the person completing (either Physician, Physician Extender or Discharge Planner) **OR** if not completed by a Physician or Discharge Planner it must be signed by both a **Qualified Mental Health Professional (QMHP) AND a Qualified Intellectual Disabilities Professional (QIDP)**

Forward to Bureau of Long Term Care (BLTC) if ANY of the following are marked YES:

1, 6, 7, 9, 10, 14, 15, 16, 17, 18, 19 **AND** attach the following:

- History and Physical
- Updating Documentation
- Level of Certification/information that indicates doctor is authorizing NF care
- Discharge Orders/Summary/medication usage medications ordered
- Functional/ADL Assessment
- If available, Psychiatric/Psychological evaluations

Information needs to be complete enough to make a determination whether any Exemptions or Categorical determinations apply, whether the individual meets NF level of care and whether the suspected MH/ID dx requires further evaluation by the State Mental Health and/or State Intellectual Disability Authority.

Notification of MH/DD Review

This area must be completed prior to forwarding to the BLTC

- The individual's name must be entered and the paragraph explained by the person completing the form.
- The individual should print their name, sign and date indicating their understanding and consent
- If applicable, a Legal Representative/Guardian should sign and date

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BLTC Regional Contacts			
	Contact	Phone	Fax
Region 1		208-769-1567 x8812	208-666-6856
Region 2	Lisa Deyoe	208-799-4434	208-799-5167
Region 3	Katie Sierra	208-455-7123	208-454-7625
Region 4	Marlena Hoffman	208-334-0948	208-334-0953
Region 5	Sue Harvey	208-732-1483	208-736-2116
Region 6	Sandy McArthur	208-239-6264	208-239-6269
Region 7	Michelle Finck	208-528-5753	208-528-5756