



TEXAS

Health and Human Services

Detailed Item by Item Guide for Completing the PASRR Evaluation (PE)

Table of Contents

Table of Contents	2
1. Overview	3
2. Purpose	4
3. When to Perform and Submit a PASRR Evaluation	5
4. How to Perform and Submit a PASRR Evaluation	7
PE submission procedure.....	8
5. Alzheimer’s Disease and Dementia in PASRR.....	9
6. PASRR Evaluation Retention Period	10
7. Documenting and Submitting an IDT Meeting into the LTC Portal....	11
8. Coding Conventions	12
9. Form Assistance	13
10. Item by Item steps for completing the PASRR Evaluation Form	14
Section A.1: Submitter Information	14
Section A.2: Evaluation Information	14
Section A.3: IDD Information	15
Section A.4: MI Information	16
Section A.5: Setting of Assessment	18
Section A.6: Personal Information	19
Section A.7: Previous Residence.....	20
Section A.8: Next of Kin.....	21
Section A.9: Additional Contact Information	22
Section B.1: Individuals suspected of having Intellectual Disability or	24
Developmental Disability	24
Section B.2: Determination for PASRR Eligibility (IDD).....	24
Section B.3: Specialized Services Determination/Recommendations	25
Section C.1: Individuals suspected of having Mental Illness	30
Section C.2: Determination for PASRR Eligibility (MI).....	30
Section C.3: Recent Occurrences.....	33
Section C.4: Specialized Services and Recommendations	34
Section D: Nursing Facility Level of Care Medical Assessment	36
Section E: Nursing Facility Level of Care Functionality Assessment	46
Section F: Return to Community Living	58

1. Overview

This guide is to be used in conjunction with the Texas Medicaid & Healthcare Partnership (TMHP) Long-Term Care (LTC) Online Portal. This document provides complete step-by-step instructions for completing the PASRR Evaluation Form (PE) Portable Document Format (PDF) printable form. The PASRR Evaluation Form (PE) can be completed on the paper, but ultimately the information collected must be submitted on the Long-Term Care (LTC) online portal.

The term "person" is used in this document in some places to replace the term "individual".

2. Purpose

Preadmission Screening and Resident Review (PASRR) is a federally mandated program that is applied to all individuals seeking admission to a Medicaid-certified nursing facility, regardless of funding source.

PASRR must be administered to identify:

- individuals who have a mental illness (MI), an intellectual disability (ID) or a developmental disability (DD) (also known as related conditions),
- the appropriateness of placement in the nursing facility, and
- the individual's eligibility for specialized services.

If documentation entered on the PL1 indicates suspicion of MI, ID or DD, a PE must be completed.

The PASRR Evaluation (PE) is designed to validate the suspected diagnosis of Mental Illness (MI), Intellectual Disability (ID) or a Developmental Disability (DD) also referred to as Related Conditions, indicated on the PASRR Level 1 (PL1) Screening.

The PE is designed to ensure the individual is appropriate for placement in a nursing facility and receiving the specialized services needed to improve and maintain the individual's level of functioning.

The term "perform" has specific meaning in this document. It means the Local Authority (Local Intellectual (Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA)) will meet face to face with the individual/LAR, complete a medical record review, interview collateral contacts who are knowledgeable about an individual's situation and who may support or corroborate information provided by the individual in order to gather information to fill out all required fields on a blank hardcopy version of the PE.

The PE can only be performed by an LA face to face. A PE cannot be conducted via telephone.

This document will describe details for completing the PE form only.

3. When to Perform and Submit a PASRR Evaluation

The PE must be performed and submitted via the LTC Online Portal for every person with a PL1 that indicated a suspicion of MI, ID or DD.

To complete the PE, the LA must:

- Initiate the face-to-face visit for the PE within 72 hours of notification from the LTC Online Portal.
- Complete and submit the PE on the LTC Portal within 7 days of notification.

The Local Authority **must** travel to:

- the location of the Referring Entity (RE) to perform the PE in a Preadmission.
 - the NF to perform the PE in an Exempted Hospital Discharge or Expedited Admission.
1. **Expedited Admission**—An individual can be admitted to the NF directly from an acute care hospital or another nursing facility if they are suspected of having MI, ID or DD **AND** they fall into one of the seven categories listed: Terminally Ill, Severe Physical Illness, Convalescent Care, Delirium, Respite, Emergency Protective Services or Coma.
In Expedited Admissions, the PL1 is submitted by the NF on the date of admission of the individual. The PL1 cannot be submitted until the individual is physically present at the NF. Depending on the admission category, the LA will receive an alert from the LTC Online Portal to perform the PE within 7-14 days.
 2. **Exempted Hospital Discharge**—An individual can be admitted to the NF directly from an acute care hospital if they are suspected of having MI, ID or DD **AND** a physician has certified that they will likely require less than 30 days of NF care for the same condition they were hospitalized for.

In Exempted Hospital Discharges the PL1 is submitted by the NF on the date of admission of the individual. The PL1 cannot be submitted until the individual is physically present at the NF. If the individual remains in the NF longer than 30 days, the LA will receive an alert from the LTC Online Portal to perform the PE within 7 days.

Preadmission—The Preadmission Process occurs when an NF admission is coming from an RE in the community (such as from home, a group home, psychiatric hospital, jail, etc.) that is not Expedited Admission, Exempted

Hospital Discharge, or the individual is negative for PASRR eligibility. The PE must be completed prior to admission to the NF.

The RE faxes the PL1 to the LA. This serves as the notification for the LA to enter the PL1, initiate the 72-hour face to face contact and submit the PE into the LTC Portal within 7 days.

The PE must be completed and submitted on the LTC Portal prior to admission to the NF.

3. **Resident Review**-When a resident has been residing in an NF and experiences a significant change in medical status, the NF will submit an updated MDS assessment referred to as a Significant Change in Status Assessment (SCSA) into the LTC online portal. When an SCSA is submitted, the LTC online portal will issue an alert to the LA to conduct a resident review within **seven calendar days** after receiving the alert.

The LA will use the same form used to conduct a PE and submit the resident review in the same manner as the PE on the LTC online portal. The resident review is conducted to:

- assess the resident's need for continued care in a NF;
- assess the resident's need for specialized services as the need may have changed due to the significant change in medical condition; and
- identify alternate placement options.

The NF must convene the IDT meeting within **14 calendar days** after the LTC online portal generated an automated notification to the LIDDA to conduct a resident review.

4. How to Perform and Submit a PASRR Evaluation

The PE can only be performed and submitted on the LTC Online Portal by an LA. The LTC Online Portal can be accessed via www.tmhp.com. A log-on identification number is required to access the LTC Online Portal for PE submissions and corrections. Access details can be found on the TMHP website.

- The LA must check the LTC Online Portal daily for PE alerts.
- The LA must have a single, identified fax line to receive PL1 notifications to perform the PE.
- The LA must check the fax line daily to ensure all PL1 notifications for PE completion are acted on promptly.
- The individual/Legally Authorized Representative (LAR) should always be given the opportunity for translator services. The LA will arrange, or work in cooperation with the RE, for translator services as needed.
- The LA should conduct a state-wide historical record review for any records that are available to them.
- The LA should always call the RE or NF prior to travelling to the RE or NF to perform the PE to ensure that the individual is available and alert for the evaluation.
- The LA should always carry proper identification provided by their agency.
- The LA should always take a copy of a release to obtain the individual/LAR consent to obtain additional information as needed in collateral contacts. LA must ensure the individual/LAR receives a copy of the HIPPA Privacy notice.
- The LA should use the medical information or documentation in the person's medical record to determine whether the person has a diagnosis for ID, DD, or MI. The LA should seek assistance and clarification of documentation from available medical staff as needed, and record only what is documented in the medical record.
- The LA should notify HHSC Complaint and Incident Intake at 800-458-9858 immediately if they are prevented from seeing an individual or reviewing the medical record. See page 9 for program staff contact information.

If a person and/or LAR refuses participation in the PE, the LA should request assistance from NF staff that have the greatest knowledge and rapport with the person/LAR in explaining the process to the person/LAR. If the person or LAR continues to refuse, the LA will complete the PE solely from chart review and will document the person's/LAR's refusal in a comment field of the PE located within Section F1000.

PE submission procedure

1. The PE can be completed on the paper or electronic version, but ultimately the information collected must be submitted on the LTC online portal by the LIDDA within the seven-day timeframe.
2. The PE must include the address of the person or LAR, or the address where the person or LAR can be contacted.

5. Alzheimer's Disease and Dementia in PASRR

The PASRR definition of Mental Illness according to the Code of Federal Regulations (CFR) 483.102 is:

(A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but

(B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

As indicated, this definition does not include individuals with a primary diagnosis of dementia. Dementia is a broad terminology and Alzheimer's disease is a sub diagnosis of dementia.

Dementia is a neurologically driven disease that through evaluation is not indicative of Mental Illness. If the mental illness is primary, which is diagnosed before the dementia, then a PASRR Evaluation must take place. Dementia can cause secondary symptomology such as psychosis, depression, anxiety; therefore, the mental illness must be diagnosed prior to dementia in order to be a true indication of mental illness

If the Mental Illness was not diagnosed before dementia, then a PASRR Evaluation is not needed

If the person has IDD and/or MI and dementia, a PE is still required. In the case of MI only, if the person has a primary of dementia (as noted in C0100), the result will be a negative PE for MI and the rest of the PE still needs to be completed.

6. PASRR Evaluation Retention Period

Due to current litigation, all LIDDA/LMHA and LBHA's must keep all handwritten PE documentation in the person's record until notified otherwise by HHSC Legal Services. The electronic version of the PE will be retained in the LTC online portal system.

7. Documenting and Submitting an IDT Meeting into the LTC Portal

For an individual with a positive PE, the interdisciplinary team (IDT) meeting is held within 14 days of an individual's admission into the nursing facility to determine whether the person is best served in a facility or community setting and identify which of the specialized services recommended for the resident that the person, or LAR on the person's behalf, wants to receive. The IDT meeting is documented on the PASRR Comprehensive Service Plan (PCSP) Form and information from the PCSP is entered into the LTC Portal.

The interdisciplinary team consists of:

- the individual;
- the individual's Legally Authorized Representative (LAR), if any;
- a registered nurse from the nursing facility with responsibility for the person;
- a representative of the Local Authority (LA) or Local Mental Health Authority (LMHA)\Local Behavioral Health Authority (LBHA); and
- others as follows:
 - ▶ concerned persons whose inclusion is requested by the person or LAR;
 - ▶ persons specified by the person or LAR, nursing facility, or LA or LMHA, as applicable, who are professionally qualified or certified or licensed with special training and experience in the diagnosis, management, needs, and treatment of people with MI, ID, or DD; and
 - ▶ if the person is school eligible, representatives of the appropriate school district as requested by the individual or LAR.

As a required member of the IDT, a representative of the LIDDA or LMHA/LBHS will confirm their attendance at the meeting (in person or by phone) and that the specialized services listed on the PCSP were those agreed to during the IDT meeting.

For additional assistance on documenting and submitting IDT meeting information into the LTC Online Portal, please refer to the Detailed item by item guide for Completing PASRR Comprehensive Service Plan (PCSP) Form. The PCSP form can be located on the [TMHP LTC Online Portal](#)

8. Coding Conventions

The following coding conventions should be used when submitting the PE:

- All fields with red dots are required fields. The form cannot be submitted without populating these fields.
- Not all fields are required. Some fields are conditionally required. Answers to various fields determine what downstream fields are required. For example: 'Other Type of Setting' (A2200) is only required if an answer of "6. Other" is entered for 'Type of Setting' (A2100).
- When completing the paper version of the PE to be used for data entry, capital letters may be easiest to read. Print legibly.
- You can enter a date automatically by clicking the date picker icon next to the field you need to complete, and then select the appropriate date. For manual date entry, use the following format: "mm/dd/yyyy". For example, July 6, 2018 would be recorded as 07/06/2018 or 07/06/2018 (the leading zeroes are not necessary).
- Click on the appropriate check boxes (or use a check mark on the paper form of the PE) where the instructions state to "check all that apply" or "check only one" if the specified condition is met; otherwise these boxes remain blank.
- "Unknown" is a response option to several items. Check this response when none of the other responses apply. It should not be used to signify lack of information about the item.

9. Form Assistance

Call **TMHP** at 1-800-626-4117, Option 1 for:

- General Inquiries
- PASRR Evaluation (PE) Form Status
- Claim Forms
- Claim Submissions

Contact **HHSC IDD PASRR Unit** at 1-855-435-7180 or email PASRR.Support@hhsc.state.tx.us for:

- Assistance with locating information to complete the PE
- Assistance/cooperation from a Referring Entity hospital, Local Authority or Nursing Facility
- Assistance locating forms, LIDDAs or additional training resources
- Policy guidance on Specialized Services

How to prevent **Timing Out** of the TMHP LTC Online Portal:

It is important to note that when submitting the PE on the LTC Online Portal, the system will time-out after 20 minutes of no activity. To prevent this from happening, the submitter has the following options:

- Start and finish (submit or save as draft) within 20 minutes
- Click on a different tab of the PE and then return to the tab you are working on. This will reset the timer for another 20 minutes

10. Item by Item steps for completing the PASRR Evaluation Form

Section A.1: Submitter Information

INTENT: The purpose of this section is to document the identifying and contact information for the LA/LMHA submitting the PE.

Steps for Assessment

1. Fields A0100-A0500 will be disabled and auto populated with LA/LMHA submitter identifying information linked to the submitter's TMHP LTC Online Portal logon access.

A0100. Name—Agency name under which the submitter provides services.

A0200A. Street Address—Current mailing address, including street or P.O. Box, of the submitter's agency.

A0200B. City—City of the submitter.

A0200C. State—State of the submitter.

A0200D. ZIP Code—ZIP Code of the submitter.

A0300 NPI/API—National Provider Identifier or Atypical Provider Identifier for the agency under which the submitter provides services.

A0400 Contract No.—Contract number for the agency under which the submitter provides services.

A0500 Vendor No.—Vendor number for the agency under which the submitter provides services.

Section A.2: Evaluation Information

INTENT: The purpose of this section is to document the type of assessment being performed. This field is auto populated based on the suspected diagnosis of the associated PL1. However, this field is enabled if you need to change the type of assessment.

Steps for Assessment

Field A0600 "Type of Assessment" will be auto populated with information from the linked PL1.

If the individual is dually diagnosed, the IDD Local Authority will complete the IDD section of the PE, and the LMHA will complete the MI section.

A0600 Type of Assessment—; select "1. IDD only" for Intellectual Disability and/or Development Disability"; "2. MI only" for Mental Illness"; or "3. IDD and MI" for dually diagnosed Intellectual Disability/Developmental Disability and Mental Illness.

1. BLANK
2. IDD only
3. MI only
4. IDD and MI

Section A.3: IDD Information

INTENT: The purpose of this section is to document the identifying and contact information for the LA who performed the IDD evaluation.

Steps for Assessment

Fields A0700-A0900 will be disabled and auto populated with LA identifying information linked to the PL1 that is associated to this PE.

Fields A1000 through A1300 will be disabled if the type of assessment is "2. MI only" or blank.

A0700. LA-IDD Contract No. — Intellectual/Developmental Disability Local Authority contract number under which the evaluator provides services.

A0800. LA-IDD Vendor No. —Intellectual/Developmental Disability Local Authority vendor number under which the evaluator provides services.

A0900. LA-IDD NPI/API—Intellectual/Developmental Disability Local Authority National Provider Identifier or Atypical Provider Identifier under which the evaluator provides services.

A1000. Date of IDD Assessment—Enter the date of IDD Assessment via the date picker, or enter it manually using the "mm/dd/yyyy" format.

A1100A. Evaluator-IDD Assessment-First name—Enter the first name evaluator completing the IDD Assessment.

A1100B. Evaluator-IDD Assessment-Middle initial—Enter the middle initial of the evaluator completing the IDD Assessment. This is an optional field

A1100C. Evaluator-IDD Assessment-Last name—Enter the last name of the evaluator completing the IDD Assessment.

A1100D. Evaluator-IDD Assessment-Suffix—Enter the suffix of the evaluator completing the IDD Assessment. This is an optional field.

A1200. Position/Title-IDD Assessment—Enter the position or title of the evaluator completing the IDD Assessment.

A1300A Type of Credential for Evaluator-IDD Assessment—Select the type of credential for the evaluator completing the IDD Assessment from the list provided below.

1. Qualified Intellectual Disability Professional (QIDP)
2. Qualified Developmental Disability Professional (QDDP)
3. Registered Nurse (RN)
4. Licensed Clinical Social Worker (LCSW)
5. Licensed Professional Counselor (LPC)
6. Licensed Marriage and Family Therapist (LMFT)
7. Licensed Psychologist
8. Advanced Practice Nurse (APN)
9. Physician (MD or DO)
10. Other

A1300B Other Type of Credential for IDD Evaluator—This is a required field to indicate another type of credential for the evaluator completing the IDD Assessment when “10. Other” was chosen in A1300A.

Section A.4: MI Information

INTENT: The purpose of this section is to document the identifying and contact information for the LMHA who performed this MI evaluation.

Steps for Assessment

Fields A1400 through A1600 will be disabled and auto populated with LMHA identifying information linked to the PL1 that is associated to this PE.

Fields A1700 through A2000 will be disabled if the type of assessment is “1. IDD only” or blank.

A1400. LMHA-MI Contract No. —Local Mental Health Authority contract number under which the evaluator provides services.

A1500. LMHA-MI Vendor No. —Local Mental Health Authority vendor number under which the evaluator provides services.

A1600. LMHA-MI NPI/API—Local Mental Health Authority National Provider Identifier or Atypical Provider Identifier under which the evaluator provides services.

A1700 Date of MI Assessment—Enter the date of the MI Assessment via the date picker, or enter it manually using the “mm/dd/yyyy” format.

A1800A. Evaluator-MI Assessment-First name—Enter the first name of the evaluator completing the MI Assessment.

A1800B. Evaluator-MI Assessment-Middle initial—Enter the middle initial of the evaluator completing the MI Assessment. This is an optional field.

A1800C. Evaluator-MI Assessment-Last name—Enter the last name of the evaluator completing the MI Assessment.

A1800D. Evaluator-MI Assessment-Suffix—Enter the suffix of the evaluator completing the MI Assessment. This is an optional field.

A1900 Position/Title-MI Assessment—Enter the position or title of the evaluator completing the MI Assessment.

A2000A Type of Credential for Evaluator-MI Assessment—Indicate the type of credential for the evaluator completing the MI Assessment from the list provided below.

1. Qualified Mental Health Professional (QMHP)
2. Registered Nurse (RN)
3. Licensed Clinical Social Worker (LCSW)
4. Licensed Professional Counselor (LPC)
5. Licensed Marriage and Family Therapist (LMFT)
6. Licensed Psychologist
7. Advanced Practice Nurse (APN)
8. Physician (MD or DO)
9. Other

A2000B Other Type of Credential for MI Evaluator—This is a required field to indicate another type of credential for the evaluator completing the MI Assessment when “9. Other” was chosen in A2000A.

Section A.5: Setting of Assessment

INTENT: The purpose of this section is to document the type and address of the setting where the evaluation was performed. This section is also used to populate PASRR determination letters for individuals who have been evaluated.

Steps for Assessment

1. Fields A2100 and A2300 are required.

A2100 Type of Setting—Indicate the type of setting in which the PE was performed.

1. Acute Care
2. Psychiatric Hospital
3. Intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID)
4. Own Home/Family Home
5. Nursing Facility
6. Other

A2200 Other Type of Setting—Enter, in text form, the type of setting the PE was performed in if it is not shown in the drop-down list of A2100. This field is only available if A2100 = “6. Other”.

A2300A. Setting of Assessment-Name—Enter the name of the assessment setting.

A2300B. Setting of Assessment-Street Address—Enter the current mailing address, including street address or P.O. Box, of the assessment setting.

A2300C. Setting of Assessment-City—Enter the city of the assessment setting.

A2300D. Setting of Assessment-State—Enter the state of the assessment setting.

A2300E. Setting of Assessment-ZIP Code—Enter the ZIP Code of the assessment setting.

A2300F. Setting of Assessment-County—Enter the county of the assessment setting.

A2300G. Setting of Assessment-Phone Number—Enter the ten-digit phone number of the LA/LMHA evaluator completing the PE.

Section A.6: Personal Information

INTENT: The purpose of this section is to document the identifying and contact information for the individual who the evaluation is being performed on. Most of these fields will be auto populated from the associated PL1. Some of these fields will be disabled, and some of them will allow user input.

Steps for Assessment

1. The information requested in this section is required, unless otherwise indicated.

A2400A. Individual's Name-First name—The individual's first name.

A2400B. Individual's Name-Middle initial—The individual's middle initial and suffix.

A2400C. Individual's Name-Last name—The individual's last name.

A2400D. Individual's Name-Suffix—The individual's suffix.

A2500A. Social Security Number—Enter the individual's nine-digit Social Security Number, if blank.

A2500B. Medicare Number—Enter the individual's Medicare Number, if available.

A2600. Medicaid No. — The individual's Medicaid Number.

A2700. Birth Date— The individual's date of birth.

A2800. Age at Time of Screening—The individual's age at the time of the evaluation.

A2900. Gender—This field is disabled, and it will be auto populated from the associated PL1 with one of the following:

1. Male
2. Female

A3000. Height—Enter the individual’s current height in feet and inches. This is an optional field.

A3100. Weight—Enter the individual’s current weight in pounds. This is an optional field.

Section A.7: Previous Residence

INTENT: The purpose of this section is to document the individual’s previous residence/location type or program prior to current residence.

Steps for Assessment

1. The information requested in this section is required, unless otherwise indicated.

A3200A. Previous Residence—Select the individual’s previous residence/location type or program prior to current residence. This is a required field.

1. Private Home
2. ICF/IID
3. Waiver Setting
4. Nursing Facility
5. Other

A3200B. Other Residence type—Enter the individual’s previous residence/location type or program prior to current residence. This field is only available is if “A3200A is 5. Other”.

A3200C. Street Address—Enter the street or P.O. Box of the previous residence/location type or program if this field is enabled.

A3200D. City—Enter the city of the previous residence/location type or program if this field is enabled.

A3200E. State—Enter the state of the previous residence/location type or program via the drop-down list if this field is enabled.

State List

A3200F. ZIP Code— Enter the ZIP Code of the previous residence/location type or program if this field is enabled.

A3200G. County of Residence—Enter the county of the previous residence/location type or program via the drop-down list if this field is enabled.
County List

A3200H. Did the individual live with others—Select “1. Yes”, if the individual lived with others, or “0. No”, if the individual did not live with others. This field is always required.

- 0. No
- 1. Yes

Section A.8: Next of Kin

INTENT: The purpose of this section is to identify the individual’s next of kin and is optional

Steps for Assessment

1. The information requested in this section is optional, unless otherwise indicated.

A3300A. Relationship to Individual— Select the appropriate relationship of the next of kin to the **individual**.

- 1. Legally Authorized Representative
- 2. Spouse
- 3. Child
- 4. Parent
- 5. Sibling
- 6. Other

A3300B. Other Relationship to Individual— Enter another type of relationship to the individual if not shown in the drop-down list in field A3300A.

A3300C. Next of Kin First name – Enter the first name of person or LAR entered in A3300A or A3300B.

A3300D. Next of Kin Middle initial – Enter the middle initial of the person or LAR entered in A3300A or A3300B.

A3300E. Next of Kin Last name – Enter the last name of the person or LAR entered in A3300A or A3300B.

A3300F. Next of Kin Suffix – Enter the suffix of the person or LAR entered in A3300A or A3300B.

A3300G. Next of Kin Phone Number – Enter the ten-digit telephone number of the person or LAR entered in A3300A or A3300B.

A3300H. Next of Kin Street Address – Enter the current mailing address (street or P.O. Box) of the person or LAR entered in A3300A or A3300B.

A3300I. Next of Kin City – Enter the city of the person or LAR entered in A3300A or A3300B.

A3300J. Next of Kin State – Enter the state of the person or LAR entered in A3300A or A3300B.

A3300K. Next of Kin ZIP Code– Enter the ZIP Code of the person or LAR entered in A3300A or A3300B.

Section A.9: Additional Contact Information

INTENT: The purpose of this section is to identify the first additional contact person next on the list after next of kin and is optional.

Steps for Assessment

1. The information requested in this section is optional, unless otherwise indicated.

A3400A Relationship to Individual— Select the appropriate relationship of the additional contact person to the individual.

1. Spouse
2. Child
3. Parent
4. Sibling
5. Other

A3400B. Other Relationship to Individual— Enter another type of relationship to the individual if not shown in the drop-down list in field A3400A.

A3400C. Additional Contact #1 First name – Enter the first name of the person entered in A3400A or A3400B.

A3400D. Additional Contact #1 Middle initial – Enter the middle initial of the person entered in A3400A or A3400B.

A3400E. Additional Contact #1 Last name – Enter the last name of the person entered in A3400A or A3400B.

A3400F. Additional Contact #1 Suffix – Enter the suffix of the person entered in A3400A or A3400B.

A3300G. Additional Contact #1 Phone Number – Enter the ten-digit telephone number of the person entered in A3400A or A3400B.

A3400H. Additional Contact #1 Street Address – Enter the current mailing address, including street or P.O. Box, of the person entered in A3400A.

A3400I. Additional Contact #1 City – Enter the city of the person entered in A3400A or A3400B.

A3400J. Additional Contact #1 State – Enter the state of the person entered in A3400A or A3400B.

A3400K. Additional Contact #1 ZIP Code– Enter the ZIP Code of the person entered in A3400A or A3400B.

A3500 Additional Contact Information #2— The purpose of this section is to identify the second additional contact person next on the list after next of kin and is optional.

A3500A Enter the relationship to the individual:

1. Spouse
2. Child
3. Parent
4. Sibling
5. Other

A3500B. Other Relationship to Individual— Enter another type of relationship to the individual if not shown in the drop-down list of field A3500A.

A3500C. Additional Contact #2 First name – Enter the first name of the person entered in A3500A or A3500B.

A3500D. Additional Contact #2 Middle initial – Enter the middle initial of the person entered in A3500 or A3500B.

A3500E. Additional Contact #2 Last name – Enter the last name of the person entered in A3500A or A3500B.

A3500F. Additional Contact #2 Suffix – Enter the suffix of the person entered in A3500A or A3500B.

A3500G. Additional Contact #2 Phone Number – Enter the ten-digit telephone number of the person entered in A3500A or A3500B.

A3500H. Additional Contact #2 Street Address – Enter the current mailing address, including street or P.O. Box, of the person entered in A3500A or A3500B.

A3500I. Additional Contact #2 City – Enter the city of the person entered in A3500A or A3500B.

A3500J. Additional Contact #2 State – Enter the state of the person entered in A3500A or A3500B.

A3500K. Additional Contact #2 ZIP Code– Enter the ZIP Code of the person entered in A3500A or A3500B.

Section B.1: Individuals suspected of having Intellectual Disability or Developmental Disability

INTENT: The purpose of this section is to document the type of IDD evaluation as well as identifying and recommending specialized services. This section will only be enabled for the IDD LA.

Steps for Assessment

1. The information requested in this section is required, unless otherwise indicated.

B0050. I am completing the IDD section—Check this box and continue completing this section if the individual is suspected of having an Intellectual and/or Developmental Disability.

Section B.2: Determination for PASRR Eligibility (IDD)

INTENT: The purpose of this section is to determine if this individual meets PASRR IDD eligibility.

Steps for Assessment

1. The information requested in this section is required, unless otherwise indicated.

B0100. Intellectual Disability—Indicate whether the individual has a diagnosis of an Intellectual Disability (mental retardation) that manifested during the developmental period prior to age 18.

- 0. No
- 1. Yes

B0200. Developmental Disability—Indicate whether the individual has a related condition that is a severe and chronic disability that manifested prior to age 22. Refer to HHSC Approved Diagnostic Codes for Persons with Related Conditions for a complete list of conditions which may qualify an individual as having a related condition as described in federal and state law.

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/icd10-codes.pdf>

- 0. No
- 1. Yes

B0300. Intervention by law enforcement—Indicate whether the individual has experienced intervention by law enforcement, protective services agencies or other housing officials in the last two years (i.e. evicted, arrested, charged or convicted of a crime).

- 0. No
- 1. Yes
- 2. Unknown

Section B.3: Specialized Services Determination/Recommendations

INTENT: The purpose of this section is to determine what types of specialized services provided by the IDD Local Authority this individual may benefit from receiving.

Steps for Assessment

Check the corresponding box for each area of additional support the individual may need.

Check all boxes that apply.

Checking certain boxes in this section may automatically display associated specialized services in the B0500 and/or B0600 sections. See the table at the end of "Section B".

B0400. Does the individual need assistance in any of the following areas? —
Check all boxes that apply.

B0400A. Self-monitoring of nutritional support—Indicate if the individual needs assistance to independently monitor and maintain their dietary needs.

B0400B. Self-monitoring and coordinating medical treatments—Indicate whether the individual needs assistance to independently monitor and coordinate their medical appointments and self- medicate as needed.

B0400C. Self-help with ADL's—Indicate whether the individual needs assistance to independently perform activities of daily living such as toileting, grooming, dressing and eating.

B0400D. Sensorimotor Development—Indicate whether the individual needs assistance to independently perform ambulation, transferring, positioning or hand eye coordination to the extent that a prosthetic, orthotic, or an assistive device could improve independent functioning.

B0400E. Social Development—Indicate whether the individual needs assistance to independently engage in social/recreational activities and relationships with others.

B0400F. Academic/Educational Development--Indicate whether the individual needs assistance in using or applying functional learning skills including, but not limited to: reading, writing and basic comprehension.

B0400G. Expressing Interests—Indicate whether the individual needs assistance to express their interests, emotions, making judgments or independent decision making.

B0400H. Independent Living Skills—Indicate whether the individual needs assistance with independent living skills including, but not limited to: cleaning, shopping in the community, money management, laundry and accessibility within the community.

B0400I. Vocational Development—Indicate whether the individual needs assistance pursuing Employment assistance or supported employment.

B0400J. Adaptive Medical Equipment—Indicate whether there is additional adaptive medical equipment or adaptive aids needed to improve the independent functioning for the individual.

B0400K. Speech and Language—Indicate whether the individual needs assistance with their communication development; both verbal and non-verbal expressive and receptive.

B0400L. Other—Indicate whether there are any other areas the individual needs assistance in that are not listed above.

B0400M. Other Areas— This box is only enabled and required if you checked “Other” in field B0400L.

Provide information on the other areas of assistance that the individual requires.

B0400N. None of the above apply—Check this box if the individual does not need assistance in any of the categories listed above.

B0500. Recommended Services Provided/Coordinated by Local Authority- Indicate the services that will be coordinated for delivery by the Local Authority. Options 1 and 4 will be auto populated as the first recommended services provided by the LA. Other specialized services may also be displayed if they are associated to any of the areas you chose in the B0400 section. You will need to click on the **“Add Recommended Specialized Service”** link, which will bring up a new box with a drop-down list, to be able to select options 5 through 9 if they are not already displayed.

1. Alternate Placement Services— (this will be auto populated by default)
2. Service Coordination (SC)— (this will be auto populated by default)
3. Employment Assistance
4. Supported Employment
5. Day Habilitation
6. Independent Living Skills Training
7. Behavioral Support

B0600. Recommended Services Provided/Coordinated by Nursing Facility- Indicate the services that will be coordinated for delivery by the Nursing Facility. One or more specialized services may already be displayed if they are associated to any of the areas you chose in the B0400 section. You must click on the **“Add Recommended Specialized Service”** link, which will bring up a new box with a drop-down list, to be able to select any of the following options if they are not already displayed.

1. Specialized Physical Therapy (PT)
2. Specialized Occupational Therapy (OT)
3. Specialized Speech Therapy (ST)
4. Customized Manual Wheelchair (CMWC)
5. Durable Medical Equipment (DME)

Delete Recommended Specialized Service —To remove any specialized services displayed in the B0500 or B0600 sections, you must uncheck the associated area in the B0400 section. See the table below for the associations from the B0400 section to the B0500 and B0600 sections. Manually deleting Recommended Specializes Services became unavailable June 23, 2016.

Note: You may manually re-add a specialized service by clicking on the **“Add Recommended Specialized Service”** link.

Auto population of B0500 and B0600 based on selections in B0400 are in the table below:

Field Name	Maps to Field Name
PE B0400. Does this individual need assistance in any of the following areas? Check all that apply:	
B0400A. Self-monitoring of nutritional support	PE B0500 8. Independent Living Skills Training
B0400B. Self-monitoring and coordinating medical treatments	PE B0500 8. Independent Living Skills Training
B0400C. Self-help with ADLs such as toileting, grooming, dressing and eating	PE B0600 2. Specialized Occupational Therapy (OT)
B0400D. Sensorimotor development with ambulation, positioning, transferring, or hand eye coordination to the extent that a prosthetic, orthotic, corrective or mechanical support devices could improve independent functioning	PE B0600 1. Specialized Physical Therapy (PT) PE B0600 2. Specialized Occupational Therapy (OT) PE B0600 5. Durable Medical Equipment (DME)
B0400E. Social development to include social/recreational activities or relationships with others	PE B0500 8. Independent Living Skills Training PE B0500 9. Behavioral Support
B0400F. Academic/educational development, including functional learning skills	PE B0500 8. Independent Living Skills Training
B0400G. Expressing interests, emotions, making judgments, or making independent decisions	PE B0500 8. Independent Living Skills Training

Field Name	Maps to Field Name
B0400H. Independent living skills such as cleaning, shopping in the community, money management, laundry, accessibility within the community	PE B0500 8. Independent Living Skills Training
B0400I. Vocational development, including current vocational skills	PE B0500 5. Employment Assistance PE B0500 6. Supported Employment PE B0500 7. Day Habilitation
B0400J. Additional adaptive medical equipment or adaptive aids to improve independent functioning	PE B0600 5. Durable Medical Equipment (DME)
B0400K. Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal)	PE B0600 3. Specialized Speech Therapy (ST)

Section C.1: Individuals suspected of having Mental Illness

INTENT: The purpose of this section is to document the type of MI evaluation as well as identifying and recommending specialized services. This section will only be enabled for the MI LA.

C0050 I am completing the MI section—Check this box and continue completing this section if the **individual** is suspected of having Mental Illness.

Section C.2: Determination for PASRR Eligibility (MI)

INTENT: The purpose of this section is to determine if this individual meets PASRR MI eligibility. C0800 will be auto populated based on the answers in fields C0100 through C0700, and then disabled.

C0100. Primary Diagnosis of Dementia—Indicate whether the individual has a PRIMARY diagnosis of Dementia. NOTE: The diagnosis of Dementia must be listed in the medical record as the primary diagnosis by the physician.

0. No
1. Yes
2. Unknown

If the individual has IDD and/or MI and dementia, a PE is still required. In the case of MI only if the individual has a primary of dementia as noted in C0100, the rest of the PE still needs to be completed.

C0200. Severe Dementia Symptoms—Indicate whether the Individual's dementia symptoms are too severe for PASRR Specialized Services. This determination must be based on the documentation from the physician in the medical record. The documentation in the medical record must validate the individual's symptoms resulting from the dementia based on current functional status. The evaluator may also take into consideration how the individual is able to participate in the evaluation, if applicable.

0. No
1. Yes

C0300. Mental Illness—Indicate each diagnosis or diagnostic category that is applicable for the **individual**. Each diagnosis or diagnostic category selected must be documented in the medical record by a physician. The diagnosis may be documented by the admitting, attending or consulting physician. This instruction is applicable for C0300A through C0300J.

C0300A. Schizophrenia—Refer to instructions in C0300 (Mental Illness).

C0300B. Mood Disorder— Bipolar Disorder, Major Depression or Other Mood Disorder. Refer to instructions in C0300 (Mental Illness).

C0300C. Paranoid Disorder— Refer to instructions in C0300 (Mental Illness).

C0300D. Somatoform Disorder— Refer to instructions in C0300 (Mental Illness).

C0300E. Other Psychotic Disorder— Refer to instructions in C0300 (Mental Illness).

C0300F. Schizoaffective Disorder— Refer to instructions in C0300 (Mental Illness).

C0300G. Panic or Other Severe Anxiety Disorder Refer to instructions in C0300 (Mental Illness).

C0300H. Personality Disorder— Refer to instructions in C0300 (Mental Illness).

C0300I. Any other Disorder— This is any other disorder that may lead to chronic disability diagnosable under the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Refer to instructions in C0300 (Mental Illness).

C0300J. None of the above apply—Check this box if the individual has none of the above Mental Illnesses.

C0400. Functional Limitation—Check all that apply.

C0400A. Appetite Disturbance—Examples of appetite disturbance could be any of the following: weight loss, weight gain, loss of appetite, increase in appetite, nausea, vomiting, food allergies or any other factors that may affect the intake of nutrition.

C0400B. Sleep Disturbance—Examples of sleep disturbance could be any of the following: insomnia, sleep apnea, inability to easily wake, tiredness upon waking and sleeping too much.

C0400C. Personal Hygiene—Examples of a lack of personal hygiene could be any of the following: unkempt general appearance, unkempt hair, skin, finger nails and mouth; as well as possible dental problems.

C0400D. Impaired Social Interaction—Examples of impaired social interaction could be any of the following: lack of eye contact when interacting with others, inappropriate response to others when interacting, inability or no desire to socialize with others, isolates self, withdrawn and unwilling to communicate with others.

C0400E. Threatening or Aggressive Behavior— Examples of threatening or aggressive behaviors could be any of the following: individual attacks others, causes injury to self or others, prone to frequent outbursts, inability to control anger for prolonged periods and others fear for their safety when around this individual.

C0400F. Danger to Self or Others—Examples of behaviors an individual may exhibit that could be a sign of danger to self or others are the following: verbalizing the intent to harm self or others, verbalizing or has a written plan to harm self or others, recent attempt to harm self or others, expresses a sense of hopelessness, socially withdrawn and isolated, and giving away personal possessions.

C0400G. Employment Difficulties—Examples of employment difficulties could be any of the following: inability to maintain employment, inability to obtain employment due to functional limitations, and inability to perform adequately at jobs due to functional limitations.

C0400H. Housing Difficulties—Examples of housing difficulties could be any of the following: inability to obtain housing, inability to maintain housing, and history of homelessness prior to admission to the Nursing Facility.

C0400I. Co-occurring Substance Abuse—Indicate whether the individual has a mental illness and a substance abuse, drugs or alcohol, problem. This information can be obtained from the individual or documented by the admitting, attending or consulting physician.

C0400J. Criminal Justice Involvement—Criminal justice involvement could be any of the following:

arrests, jail time sentenced or served, or any other criminal acts in which law enforcement was involved.

This information may be obtained from the medical record or the individual.

C0400K. None of the above apply—Check this box if the individual has none of the above functional limitations

Section C.3: Recent Occurrences

INTENT: Fields C0500, C0600 and C0700 are now part of this new subheading.

Steps for Assessment

The answers to these questions could vary depending on whether the Qualified Mental Health Professional (QMHP) is evaluating a new individual to be admitted into an NF, or a current resident who might have had a change in condition after admission into an NF.

It is important for the QMHP performing this evaluation to understand that if the person is already residing in a facility, the federal definition of Mental Illness must be viewed in light of that placement.

C0500. Inpatient Psychiatric Treatment: Has this individual experienced a psychiatric treatment more intensive than outpatient care more than once in the past 2 years? —Indicate whether the individual has experienced any inpatient observations or stays. Select “2. Unknown” if there is no information in the medical record and the individual is unable to answer the question.

0. No
1. Yes
2. Unknown

C0600. Disruption to normal living situation: Has this individual experienced a significant disruption to their normal living situation requiring supportive services (e.g. residential or respite services) in the last two years due to mental illness? —Indicate whether the individual has required support services (residential or respite services) in the past two years. Select “2. Unknown” if there is no information in the medical record and the individual is unable to answer the question.

0. No
1. Yes
2. Unknown

C0700. Intervention by law enforcement: Has this individual experienced intervention by law enforcement, protective services agencies or other

housing officials in the last two years due to mental illness? —Indicate whether the individual has any evictions, arrests, charges or convictions of crime. Select “2. Unknown” if there is no information in the medical record and the individual is unable to answer the question.

- 0. No
- 1. Yes
- 2. Unknown

C0800. Based on the QMHP assessment, does this individual meet the PASRR definition of Mental Illness?

- 0. No
- 1. Yes

Section C.4: Specialized Services and Recommendations

INTENT: The purpose of this section is to determine what types of specialized services provided by the Local Mental Health Authority this individual may benefit from receiving.

Steps for Assessment

1. Check the corresponding box for each area of additional support the individual may need.

C0900. Does the individual need assistance in any of the following areas? — Check all boxes that apply.

C0900A. Self-monitoring of health status—Check this box if the individual needs assistance to understand current diagnosis and required treatment(s).

C0900B. Self-administering of medical treatment— Check this box if the individual needs assistance to understand treatment regimen and maintain compliance with prescribed medication(s).

C0900C. Self-scheduling of medical treatment— Check this box if the individual needs assistance to understand and independently coordinate medical appointments.

C0900D. Self-monitoring of medication— Check this box if the individual needs assistance in this area.

C0900E. Self-monitoring of nutritional status— Check this box if the individual needs assistance to independently monitor and maintain dietary needs.

C0900F. Self-help with ADL's such as appropriate dressing and grooming— Check this box if the **individual** needs assistance to independently perform activities of daily living such as toileting, grooming, dressing and eating.

C0900G. Independent Living such as supported housing— Check this box if the individual needs assistance with independent living skills including, but not limited to: cleaning, shopping in the community, laundry and accessibility within the community.

C0900H. Management of Money— Check this box if the individual needs assistance to manage finances, budget, pay bills and utilize banking services.

C0900I. Vocational Development— Check this box if the individual needs assistance pursuing vocational skills.

C0900J. Psychological Evaluation— Check this box if the individual needs assistance pursuing psychology or counseling services.

C0900K. Discharge Planning— Check this box if the individual needs assistance with discharge planning.

C0900L. Other— Check this box if the individual needs assistance in an area not listed above.

C0900M. Other Areas—This box is enabled and required if you checked 'Other' in C0900L. Provide information on the other areas of assistance the individual requires.

C0900N. None of the above apply—Check this box if the individual does not need assistance in any of the areas listed.

C1000. Recommended Services Provided/Coordinated by Local Mental Health Authority—Indicate the recommended services for this individual based on the evaluation by clicking on the **"Add Recommended Specialized Service"** link.

1. Group Skills Training
2. Individual Skills Training
3. Intensive Case Management (This service is also subject to the <180 day stay requirement)
4. Medication Training & Support Services (Group)
5. Medication Training & Support Services (Individual)

6. Medication Training Group
7. Medication Training Individual
8. Psychiatric Diagnostic Interview Examination
9. Psychosocial Rehabilitative Services (Group)
10. Psychosocial Rehabilitative Services (Individual)
11. Routine Case Management (This service is also subject to the <180 day stay requirement)
12. Skills Training & Development (Group)
13. Skills Training & Development (Individual)

Section D: Nursing Facility Level of Care Medical Assessment

INTENT: The purpose of this section is to document the individual's diagnosis, medical history and medical needs.

Steps for Assessment

1. This section is always required, regardless of the individual diagnosis, for successful completion of the PE.
2. Information recorded in this section should come directly from medical chart review or verbal conversation with the individual, LAR or other knowledgeable medical staff directly involved in this individual's plan of care.

D0100. Diagnosis—Enter the following required and optional fields as appropriate. Click on the **"Add Diagnosis"** link to show fields D0100A through D0100D.

D0100A. Physical/ Mental Diagnosis Code— Enter the physical/mental diagnosis code as documented in the medical record by the physician. The diagnosis codes will be based on the current version of International Classification of Diseases (ICD), or the Diagnostic and Statistical Manual of Mental Disorders (DSM). Enter the diagnosis code and click on the magnifying glass to auto populate the diagnosis description.

D0100B. Physical/ Mental Diagnosis Description—This field will be disabled and prepopulated based on the selection in D0100A.

D0100C. Date of Onset, if known—This information will be located in the annual history and physical report or the nursing admission assessment. Enter date using the date picker or manually using the following format: MM/DD/YYYY. Do not leave blank or partially completed especially for DD individuals.

D0100D. Primary Diagnosis—Indicate the individual’s primary diagnosis, which is defined as the condition that was the most serious and/or resource intensive during most recent hospitalization.

Delete Diagnosis—Click this link to remove the corresponding diagnosis.

Add Diagnosis—Click this link to enter an additional diagnosis.

D0200. Medications—This information can be obtained from the history and physical in the medical record, the individual or nursing staff. Click on the **“Add Medication”** link to show fields D0200A through D0200D.

D0200A. Current Medications—Manually enter all medications the individual is currently taking. If the **individual** is not taking any medications, manually enter “None”.

D0200B. Any known side effects—Enter any known side effects for this individual.

D0200C. Check if Antipsychotic—Select this box to indicate that this individual is on antipsychotic medications.

D0200D. Reason for Antipsychotic—Manually enter the diagnosis or reason the individual is taking each antipsychotic medication. This is a required field if D0200C is selected. If a reason is not documented, manually enter “Unknown”.

Delete Medication—Click this link to remove corresponding medication.

Add Medication—Click this link to enter additional medications.

D0300. Medication Allergies—Manually enter all allergies to medications. If the individual has no known medication allergies, enter "None".

D0400. Number of hospitalizations in the last 90 days—Enter a one- or two-digit number, which must be a numeric value from 0 to 90, to reflect the number of times the individual was admitted to a psychiatric or acute care hospital with an overnight stay in the last 90 days. Enter '0' if none.

D0500. Number of emergency room visits in the last 90 days—Enter the number of times, which must be a numeric value from 0 to 90, that the individual visited an ER without an overnight stay in last 90 days. This should include all emergency room visits. Enter '0' if none.

D0600. Is this individual a danger to him or herself? —Select whether the individual is a danger to himself/herself by selecting one of the options from the drop-down list shown below. This information can be obtained by speaking with the Individual, in physician progress notes, in nursing notes or by asking the nursing staff.

- 0. No
- 1. Yes

D0700. Is this individual a danger to others? —Select whether the individual is a danger to others by selecting one of the options from the dropdown list shown below. This information can be obtained by speaking with the **individual**, in physician progress notes, in nursing notes or by asking the nursing staff.

- 0. No
- 1. Yes

D0800. Is this individual known to demonstrate self-injurious behavior? — Select whether the **individual** has demonstrated self-injurious behavior by selecting one of the options from the drop-down list shown below. This information can be obtained by speaking with the individual, in physician progress notes, in nursing notes or by asking the nursing staff.

- 0. No
- 1. Yes

D0900. Does the nursing facility supervision and structure mitigate danger to self or others? —Select whether the nursing facility level of supervision mitigates danger to self or others by selecting one of the options from the drop-down list shown below. This information can be evaluated by

documentation in nurse's or physician's notes for increased supervision of this resident, determining the distance between staff and the individual's room, or immediate staff availability. This field is disabled if fields D0600, D0700 and D0800 are "0. No".

- 0. No
- 1. Yes
- 2. Unknown

D1000. Terminal Illness: Is there a physician certification that the individual is expected to live less than 6 months in the individual's chart? —

Select whether the physician has certified that the **individual** has a life expectancy of less than 6 months by selecting one of the options from the drop-down list shown below. This will be in the physician section of the medical record.

- 0. No
- 1. Yes

D1100. Hospice: Is this individual on hospice? —Select whether the individual is on hospice by selecting one of the options from the drop-down list shown below. This will be in the medical record or can be obtained by asking the nursing staff. This field is optional.

- 0. No
- 1. Yes

D1200. Does this individual require pacemaker monitoring? —Select whether the individual requires pacemaker monitoring by selecting one of the options from the drop-down list shown below. This information may be found in the medical record, annual history and physical report or nursing admission assessment or by the individual.

- 0. No
- 1. Yes
- 2. Unknown

D1300. Does this individual have an internal defibrillator? —Select whether the individual has an internal defibrillator by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual’s history, last physical exam, annual history and physical report, nursing admission assessment) or by the individual.

- 0. No
- 1. Yes
- 2. Unknown

D1400. Tracheostomy Care—The following questions refer to the individual’s tracheostomy needs.

D1400A. Does this individual have a tracheostomy? —Select whether the individual has a tracheostomy by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g.

individual's history, last physical exam, annual history and physical report, nursing notes) or by the person.

- 0. No
- 1. Yes

D1400B. If Yes, do they require care for their tracheostomy at least one time every day? —This field is enabled and required if you selected "1. Yes" in field D1400A. Select whether the individual requires care at least once daily by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, history and physical, nursing notes) or by the individual.

- 0. No
- 1. Yes

D1500. Does this individual require a ventilator or respirator on a continuous basis to breathe? — Select whether the individual requires continuous ventilator/respirator care by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, history and physical, nursing notes) or by the individual.

- 0. No
- 1. Yes

D1600. Does this individual require a ventilator or respirator to breathe at least one time every day? Select whether the individual requires ventilator/respirator care at least once daily by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report, nursing notes) or by the individual.

- 0. No
- 1. Yes

D1700. Oxygen Therapy—The following questions refer to the individual's oxygen therapy needs.

D1700A. Does this individual require Oxygen Therapy? —Select whether the individual requires oxygen therapy by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g.

individual's history, last physical exam, annual history and physical report, nursing notes) or by the individual.

- 0. No
- 1. Yes

D1700B. If yes, how often? —This field is enabled and required if you selected "1. Yes" in field D1700A. Select the frequency of oxygen therapy by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam annual history and physical report, nursing notes or in the respiratory therapy section of the medical record).

- 1. Less than once a week
- 2. 1 to 6 times a week
- 3. Once a day
- 4. Twice a day
- 5. 3 - 11 times a day
- 6. 6 - 23 hours
- 7. 24-hour continuous

D1800. Does this individual have any Special Ports/Central Lines/PICC? — Select whether the individual has a device for intravenous access by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report or nursing notes).

- 0. No
- 1. Yes
- 2. Unknown

D1900. Does this individual receive any treatments by injection? —Select whether the individual receives any treatments by injection by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, on the medication administration record, annual history and physical report or nursing notes).

- 0. No
- 1. Yes
- 2. Unknown

D2000. Pressure Ulcers—The following questions refer to the presence and treatment of any pressure ulcers.

D2000A. Does this individual have a pressure ulcer (bed sore or decubitus ulcer)? —Select whether the **individual** has a pressure ulcer by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual’s history, last physical exam, annual history and physical report, physician progress notes, nursing notes or physical therapy wound care notes).

0. No
1. Yes
2. Unknown

D2000B. If Yes, is it staged as—This field is enabled and required if you selected “1. Yes” in field D2000A. Select the pressure ulcer stage by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual’s history, last physical exam, annual history and physical report, physician progress notes, nursing notes or physical therapy - wound care notes).

1. Stage 1
2. Stage 2
3. Stage 3
4. Stage 4
5. Unstageable
6. SDTI (suspected deep tissue injury)

D2000C. Number of Ulcers— This field is enabled and required if you selected “1. Yes” in field D2000A. Manually enter the number of ulcers found. This information may be found in the medical record e.g. individual’s history, last physical exam, annual history and physical report, physician progress notes, nursing notes or physical therapy - wound care notes.

D2100. Other Ulcers, wounds or skin issues—The following questions refer to skin care needs.

D2100A. Does this individual have any other ulcers, wounds or skin issues-- Select whether the individual has any other ulcers, wounds, or skin issues by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual’s history, last physical exam,

annual history and physical report, physician progress notes, nurse notes or physical therapy - wound care notes).

- 0. No
- 1. Yes
- 2. Unknown

D2100B. If yes, is it staged as — This field is enabled and required if you selected "1. Yes" in field D2100A. Select the stage by selecting one of the options from the drop-down list shown below. This information may be found in the medical record e.g. individual's history, last physical exam, annual history and physical report, physician progress notes, nursing notes or physical therapy wound care notes.

- 1. Stage 1
- 2. Stage 2
- 3. Stage 3
- 4. Stage 4
- 5. Unstageable
- 6. SDTI (suspected deep tissue injury)

D2200. Is this individual in a coma (persistent vegetative state or no discernible consciousness)? — Select whether the individual is comatose by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report, physician progress notes or nursing notes).

- 0. No
- 1. Yes

D2300. Memory Loss—The following questions refer to the individual's memory loss issues.

D2300A. Does this individual experience memory loss? —Indicate whether this individual experiences memory loss by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report, physician progress notes or nursing notes).

- 0. No
- 1. Yes

D2300B. If Yes, indicate the appropriate answer for type of memory loss—

This field is enabled and required if you selected "1. Yes" in D2300A. Indicate the type of memory loss by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report, physician progress notes or nursing notes).

1. Short Term
2. Long Term
3. Unspecified

D2400. Developmental Level—The following questions refer to the individual's development functioning level.

D2400A. Is the individual's developmental level normal for their chronological age? —Indicate whether the individual's developmental level is normal by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report or physician progress notes).

0. No
1. Yes

D2400B. If No, at what developmental level is the individual functioning—

This field is enabled and required if you selected "0. No" in field D2400A. Indicate the developmental level at which the individual is functioning by selecting one of the options from the drop-down list shown below. This information may be found in the medical record (e.g. individual's history, last physical exam, annual history and physical report or physician progress notes).

1. < 1 Infant
2. 1 - 2 Toddler
3. 3 - 5 Pre-School
4. 6 - 10 School age
5. 11 - 15 Young Adolescence
6. 16 - 20 Older Adolescence
7. Unknown or unable to assess

D2500. Orientation—The following questions refer to the individual's current orientation.

D2500A. Is the individual oriented to person? —Indicate whether the individual is oriented to person (e.g. Does the individual know their own name?) by selecting one of the options from the drop-down list shown below. The information may also be in the medical record in the physician progress notes or nursing notes.

- 0. No
- 1. Yes
- 2. Unknown

D2500B. Is the individual oriented to place? —Indicate whether the individual is oriented to place (e.g. Does the individual know where they are located, city, state or facility?) by selecting one of the options from the drop-down list shown below. The information may also be in the medical record in the physician progress notes or nursing notes.

- 0. No
- 1. Yes
- 2. Unknown

D2500C. Is the individual oriented to time? —Indicate whether the individual is oriented to time (e.g. Does the individual know the year, month or time of day?) by selecting one of the options from the drop-down list shown below. The information may also be in the medical record in the physician progress notes or nursing notes.

- 0. No
- 1. Yes
- 2. Unknown

D2600. Is there any documentation that indicates the individual has an appliance assisting with bladder function? —The following questions refer to assistance needed for urination.

D2600A. Indwelling catheter—Indicate whether there is any documentation that indicates that the individual has an internal catheter assisting with bladder or bowel function. This information will be found in the medical record in the nursing notes or the intake and output documentation. The information may also be obtained by asking the nurse. NOTE: The catheter may be referred to by a brand name.

D2600B. External catheter—Indicate whether there is any documentation that indicates that the individual has an external catheter assisting with bladder or bowel function (e.g. condom catheter). This information will be found in the medical record in the nursing notes or the intake and output documentation. The information may

also be obtained by asking the nurse. NOTE: The catheter may be referred to by a brand name.

D2600C. Ostomy—Indicate whether there is any documentation that indicates that the individual has an appliance assisting with bladder or bowel function (e.g. colostomy, ileostomy). This information will be found in the medical record in the nurses notes or the intake and output documentation. There may be documentation by an ostomy nurse. The information may also be obtained by asking the nurse.

D2600D. Intermittent catheterization—Indicate whether there is any documentation that indicates that the individual has a scheduled or as needed catheter assisting with bladder or bowel function. This information will be found in the medical record in the nursing notes or the intake and output documentation. The information may also be obtained by asking the nurse.

D2600E. None of the above—Select this option if the individual does not require any of the appliances listed above.

D2600F. Unknown—Select this option if you are unable to determine if the individual has an appliance assisting with bladder or bowel function.

Section E: Nursing Facility Level of Care Functionality Assessment

INTENT: The purpose of this section is to document the individual's level of functioning and ability to perform activities of daily living.

Steps for Assessment

The information requested in this section is required, regardless of individual diagnosis, for successful completion of the PE.

Information recorded in this section should come directly from medical chart review or verbal conversation with the individual, LAR, or other knowledgeable medical staff directly involved in this individual's plan of care.

E0100. Fall History—The following questions refer to the individual's fall history. For all answers in section E0100, enter the number of times the individual has fallen in the last 90 days. The number can be any integer value between 000 and 999 (with or without leading zero's). Enter "0" if none.

E0100A. Enter the number of times this individual has fallen in the last 90 days— Record the number of times the resident has fallen in the last 90 days. Enter 0 (zero) if no falls. If you enter a number greater than “0”, then click anywhere else in Section E to enable fields E0100B through E0100H.

E0100B. In how many of the falls listed above was the individual physically restrained prior to the fall? —Enter the number of times the individual was physically restrained prior to the fall.

In the falls listed above, how many had the following contributing factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributing factor.)

E0100C. Environmental— Enter the number of falls caused by environmental conditions including, but not limited to: debris, slick or wet floors, or lighting.

E0100D. Medication(s) —Enter the number of falls caused by Medications.

E0100E. Major Change in Medical Condition—Enter the number of falls caused by major change in medical condition (e.g. Myocardial Infarction (MI/Heart attack), Cerebrovascular Accident (CVA/Stroke) or Syncope (Fainting)).

E0100F. Poor Balance/Weakness—Enter the number of falls caused by Poor Balance/Weakness.

E0100G. Confusion/Disorientation--Enter the number of falls caused by Confusion/Disorientation.

E0100H. Assault by Resident or staff—Enter the number of falls caused by Assault by Resident or Staff.

E0200. Does this individual have a history of medication error, non-compliance with medication regimen or drug seeking—Indicate whether the individual has a history of medication error, non-compliance with medication regimen, or drug seeking by selecting one of the options from the drop-down list shown below.

0. No
1. Yes
2. Unknown

E0300. Which option best describes this individual's speech pattern? —

Indicate whether the individual's speech pattern is clear, unclear or if there is no speech present by selecting one of the options from the drop-down list shown below.

1. Clear speech - distinct intelligible words
2. Unclear speech - slurred or mumbled words
3. No speech - absence of spoken words

E0400. Which option best describes this individual's ability to express ideas and wants? —

Indicate the individual's ability to express ideas and wants, considering both verbal and non-verbal expressions, by selecting one of the options from the drop-down list shown below.

1. Understood
2. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time
3. Sometimes understood - ability is limited to making concrete requests
4. Rarely/never understood

E0500. Which option best describes this individual's ability to understand others? —

Indicate the individual's ability to understand others, including their understanding of verbal content by either a hearing aid or other device if applicable, by selecting one of the options from the drop-down list shown below.

1. Understands - clear comprehension
2. Usually understands - misses some part/intent of message but comprehends most conversation
3. Sometimes understands - responds adequately to simple, direct communication only
4. Rarely/never understands

E0600. Does this individual have an impaired mental status? —

Indicate whether the individual has an impaired mental status by selecting one of the options from the drop-down list shown below.

0. No
1. Yes
2. Unknown

E0700. Does this individual have a hearing impairment? —Indicate whether the individual is hearing impaired by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes

E0800. Does this individual have vision impairment? —Indicate whether the individual is visually impaired by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes

E0900. Does the individual typically reject attempts at evaluations and assistance that are necessary to achieve goals for health and well-being? — Indicate if the individual typically rejects attempts at evaluations and assistance that are necessary to achieve goals for their health and well-being by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes
- 2. Unknown

E1000. Pain Management—The following questions refer to the individual’s pain management needs.

E1000A. Is there an indication that the individual currently has issues with pain? —Indicate whether the individual currently has issues with pain and/or pain management by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes

E1000B. If Yes, how severe is the pain? —If you selected “1. Yes” in field E1000A, indicate the severity of the pain by selecting one of the options from the drop-down list shown below.

- 1. Mild
- 2. Moderate
- 3. Severe
- 4. Very severe, horrible
- 5. Unable to answer

E1000C. If Yes, what frequency is the pain occurring? —If you selected “1. Yes” in field E1000A, indicate the frequency of the pain by selecting one of the options from the drop-down list shown below.

1. Almost constantly
2. Frequently
3. Occasionally
4. Rarely
5. Unable to answer

E1100. Does this individual require assistance with eating and drinking? — Indicate whether the individual requires assistance with eating and drinking by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

E1200. Eating—The following questions refer to the individual’s eating skills and needs.

E1200A. How does this individual eat? —Indicate how the individual eats food by selecting one of the options from the drop-down list shown below.

1. By mouth
2. By tube inserted in nose
3. By tube inserted into abdomen
4. By tube inserted into artery

E1200B. How much food is eaten by mouth? —Indicate the percentage of food the individual eats by mouth by selecting one of the options from the drop-down list shown below.

1. 75% or more
2. 50-74%
3. 49% or less

E1200C. Does this individual require a mechanically altered diet (e.g. pureed, liquid, soft)? —Indicate whether this individual has a physician-ordered mechanically altered diet by selecting one of the options from the drop-down list shown below.

0. No

1. Yes

E1200D. Is this individual on a therapeutic diet? —Indicate whether this individual has a physician-ordered therapeutic diet by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

E1300. Which option best describes the individual's functioning around urination? —Indicate the individual's continence or lack of continence in urinary functioning by selecting one of the options from the drop-down list shown below.

1. Always continent
2. Occasionally incontinent
3. Frequently incontinent
4. Always incontinent

E1400. Activities of Daily Living—The instructions below apply to questions E1400A - E1400J.

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
- When there is a combination of full caregiver performance, and extensive assistance, code extensive assistance.
- When there is a combination of full caregiver performance, weight bearing assistance and/or non-weight bearing assistance, code limited assistance (2).

If none of the above are met, code the level of supervision needed

ADL Self-Performance

Code for individual's performance of ADL's – do not include setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

ADL Support Provided

Code for most support provided; code regardless of individual's self-performance classification.

Note: In each of the following activities, code both the individual's ADL self-performance and the individual's support provided.

E1400A.1. Bed Mobility Self-performance—Indicate the individual's ability to be independent in bed.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400A.2. Bed Mobility Support—Indicate the individual's ability to be independent in bed.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person's physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400B.1. Walk in room Self-performance—Indicate the individual's ability to walk within his/her room.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing

3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care
8. 100% of the time for that activity over the entire 7-day period

E1400B.2. Walk in room Support—Indicate the individual’s ability to walk within his/her room.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400C.1. Walk in hallway Self-performance—Indicate the individual’s ability to walk in the hallway.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400C.2. Walk in hallway Support—Indicate the individual’s ability to walk in the hallway.

1. No setup or physical help from staff
2. Setup help only

3. One-person physical assist
4. Two+ person's physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400D.1. Locomotion on unit or in room Self-performance—Indicate the individual's ability to move between locations in his/her room and the adjacent corridor. If in a wheelchair, identify their self-sufficiency once in the chair.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400D.2. Locomotion on unit or in room Support—Indicate the individual's ability to move between locations in his/her room and the adjacent corridor. If in a wheelchair, identify their self-sufficiency once in the chair.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person's physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400E.1. Locomotion off unit or in home Self-performance—Indicate the individual's ability to move to or return from distant areas in his/her home. If in a wheelchair, identify self-sufficiency once in the chair.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance

4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400E.2. Locomotion off unit or in-home Support—Indicate the individual’s ability to move to or return from distant areas in his/her home. If in a wheelchair, identify self-sufficiency once in the chair.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400F.1. Dressing Self-performance—Indicate the individual’s ability to put on, fasten and remove clothing.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400F.2. Dressing Support—Indicate the individual’s ability to put on, fasten and remove clothing.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist

5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400G.1. Eating Self-performance — Indicate the individual's ability to eat and drink.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
7. Activity occurred only once or twice - activity did occur but only once or twice
8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400G.2. Eating Support — Indicate the individual's ability to eat and drink.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person's physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400H.1. Toilet Use Self-performance —Indicate the individual's level of independence in toileting skills.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
7. Activity occurred only once or twice - activity did occur but only once or twice
8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400H.2. Toilet Use Support —Indicate the individual’s level of independence in toileting skills.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400I.1. Medication Management Self-performance —Indicate the individual’s ability to take medications as prescribed.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400I.2. Medication Management Support —Indicate the individual’s ability to take medications as prescribed.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400J.1. Transfer Self-performance —Indicate the individual’s ability to transfer and move between surfaces.

1. Independent - no help or staff oversight at any time
2. Supervision - oversight, encouragement or cueing
3. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance

4. Extensive assistance - resident involved in activity, staff provide weight-bearing support
5. Total dependence - full staff performance every time during entire 7-day period
6. Activity occurred only once or twice - activity did occur but only once or twice
7. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1400J.2. Transfer Support —Indicate the individual’s ability to transfer and move between surfaces.

1. No setup or physical help from staff
2. Setup help only
3. One-person physical assist
4. Two+ person’s physical assist
5. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

E1500. Appropriate Placement—The following questions refer to the appropriateness of placement.

E1500A. Is placement in an NF appropriate for this individual at this time?

— Indicate whether placement in an NF is appropriate for the individual at this time by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

E1500B. Explanation of findings to support that the individual meets or does not meet a nursing facility level of care. Include any additional information to support why this individual does or does not require the level of care provided in a Nursing Facility—This is a required field and you must enter information to support or not to support the individual being placed in an NF LA/LMHA must list all known and documented medication side effects. This is particularly important for psychotropic medication.

Section F: Return to Community Living

INTENT: The purpose of this section is to document the individual’s previous community living experiences, alternate placement preferences, alternate placement

options, barriers to community living, supports needed for successful community living and referrals made for alternate placement.

Steps for Assessment

1. Inform the individual of all community options he/she is eligible for.
2. Inform the individual of all community support resources he/she is eligible for.
3. Inform the individual that they retain the right to change their mind or request alternate placement at any time.
4. This section is always required, regardless of individual diagnosis, for successful completion of the PE.

F0100. Did the individual or LAR participate in this assessment discussion?

—Indicate whether the individual or LAR participated in this section of the assessment by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

F0200. Information and Expectations—The following questions refer to the individual’s information and expectations for community living.

F0200A. Has this received information regarding the services and support alternatives to the nursing facility admission (for Preadmission process) or continuation of nursing facility stay (for Resident Review)? — Indicate whether the individual has received information on alternatives to the nursing facility during the Preadmission process or a Resident Review by selecting one of the options from the drop-down list shown below. Individuals should always be informed of alternative living options during a PASRR Evaluation.

0. No
1. Yes

F0200B. Does this individual/LAR expect to return to live in the community either following a short term stay in the nursing facility or at some point in the future? —Indicate whether the individual/LAR expects to return to the community by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

F0300. Employment

F0300A. Has this individual been employed in the past 12 months? —Indicate whether the individual has been employed in the past 6 months by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes
- 2. Unknown

F0300B. If Yes, what was the occupation? —This field is enabled and required if you selected "1. Yes" in F0300A.

F0400. Did this individual receive community-based services? Check all that apply—Select all of the community-based services that the individual has received in the past from the list shown below. If the individual has received services not listed, select 'Other' in field F0400T and manually enter in the service that was received in field F0400U.

F0400A. Adult Foster Care

F0400B. Community Attendant Services

F0400C. Community Based Alternative Program (CBA)

F0400D. Community Living Assistance and Support Services (CLASS)

F0400E. Consumer Manages Personal Assistance Services (CMPAS)

F0400F. Day Activity and Health Services (DAHS)

F0400G. Deaf Blind with Multiple Disabilities (DBMD)

F0400H. Emergency Response Services

F0400I. Home and Community Based Services (HCS)

F0400J. In Home and Family Support Services

F0400K. Medically Dependent Children's Program (MDCP)

F0400L. Primary Home Care

F0400M. Psychological Rehabilitation

F0400N. STAR Plus

F04000. Substance Use Treatment Services

F0400P. Texas Home Living (TxHmL)

F0400Q. Youth Empowerment Services (YES) Waiver

F0400R. None of the above

F0400S. Unknown

F0400T. Other

F0400U. Other community-based services

F0500. Would this individual like to live somewhere other than a nursing facility? —Indicate whether the individual would like to live somewhere other than a nursing facility by selecting one of the options from the drop-down list shown below.

- 0. No
- 1. Yes
- 2. Unknown

F0600. Where would the person like to live now? Check all that apply — Field F0600A through F0600E, and F0600G will be enabled and required if you selected "1. Yes" in field F0500. Select all of the settings that the individual states they would like to live. If the person states a setting that is not on the list, select 'Other' in field F0600E and manually enter the desired setting(s) stated by the individual in field F0600F.

F0600A. Live alone with support

F0600B. A place where there is 24-hour care

F0600C. A group home

F0600D. Family home

F0600E. Other

F0600F. Other location

F0600G. Unknown

F0700. Community-based Program— Explain community-based programs to the individual. If the individual indicates that they would like to enroll, select all programs of interest from the list shown below. Field F0700B through F0700U will be enabled and required if you selected “1. Yes” in field F0700A.

F0700A. Is this individual interested in enrolling in a community-based program?

- 0. No
- 1. Yes

Check all that apply.

F0700B. Adult Foster Care

F0700C. Community Attendant Services

F0700D. Community Based Alternative Program (CBA)

F0700E. Community Living Assistance and Support Services (CLASS)

F0700F. Consumer Manages Personal Assistance Services (CMPAS)

F0700G. Day Activity and Health Services (DAHS)

F0700H. Deaf Blind with Multiple Disabilities (DBMD)

F0700I. Emergency Response Services

F0700J. Home and Community Based Services (HCS)

F0700K. In Home and Family Support Services

F0700L. Medically Dependent Children’s Program (MDCP)

F0700M. Primary Home Care

F0700N. Psychological Rehabilitation

F0700O. STAR+Plus

F0700P. Substance Use Treatment Services

F0700Q. Texas Home Living (TxHmL)

F0700R. Youth Empowerment Services (YES) Waiver

F0700S. None of the above

F0700T. Unknown

F0700U. Other

F0700V. Other community-based services—This field will be enabled and required if you select “Other” in field F0700U.

F0800. What challenges or barriers has the individual indicated that could impede the opportunity to return to the community? Check all that apply—

These instructions apply for questions F0800A through F0800K. Discuss the challenges and barriers listed on the form with the individual. Select all challenges and barriers that the individual may encounter in order to return to community living.

F0800A. Care needs are likely greater than the support available in community

F0800B. Accessible housing limited

F0800C. Limited or no family/friend support available

F0800D. Limited income to support community living

F0800E. Guardian/family likely not to support community living

F0800F. Interest list slot not available at this time

F0800G. Lost house during NF stay

F0800H. Affordable housing limited

F0800I. Other

F0800J. Other challenges/barriers—This field will be enabled and required if you selected “Other” in field F0800I. List the additional challenges and barriers not found in options F0800A through F0800H.

F0800K. No challenges/barriers—Select this option if there are no known challenges or barriers.

Additional Information.

F0800L. Describe the individual’s strengths, available supports and barriers to living in the community. Provide a description of identified strengths and supports for this individual (e.g. communication skills, decision-making skills, family/friend support or knowledge of community resources).

F0900. This individual’s needs can be met in—Based on the assessment with the individual, select all applicable settings from the list (fields F0900A, and F0900C through F0900E). Field F0900B is required if you clicked on field F0900A. If there is a location that is not on the list, select “Other” (field F0900F) and enter the desired setting in “Other location” (field F0900G).

F1000. Referrals— If the individual expresses interest in an alternate setting other than a nursing facility, select the program of interest from the drop-down list in field F1000A (shown below). You must click on the “Add Referral” link to show field F1000A through F1000E. Once a referral is made, enter the referral’s phone number (field F1000C), date of referral (field F1000D) and any additional comments (field F1000E).

F1000A. Program—Choose an option from the drop-down list shown below. This is a required field.

1. Adult Foster Care
2. Community Attendant Services
3. Community Based Alternative Program (CBA)
4. Community Living Assistance and Support Services (CLASS)
5. Consumer Manages Personal Assistance Services (CMPAS)
6. Day Activity and Health Services (DAHS)
7. Deaf Blind with Multiple Disabilities (DBMD)
8. Emergency Response Services
9. Home and Community Based Services (HCS)
10. In Home and Family Support Services
11. Medically Dependent Children’s Program (MDCP)
12. Primary Home Care
13. Psychological Rehabilitation
14. Star+Plus
15. Substance Use Treatment Services
16. Texas Home Living (TxHmL)
17. Youth Empowerment Services (YES) Waiver
18. None of the above

19.Other

F1000B. Other Program—Enter the desired program here if it is not on the list in field F1000A. This is a required field if “19. Other” was chosen in field F1000A.

F1000C. Phone Number—Enter the ten-digit phone number. This is a required field.

F1000D. Date of Referral—Enter the date via the date picker icon, or enter it manually using the “mm/dd/yyyy” format. This is a required field.

F1000E. Referral Comments—Enter any additional comments regarding the referral.