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

Texas Health and Human Services

June 2023

TEXAS
Health and Human Services

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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 PE can be completed on the paper, but ultimately the information collected must be submitted on the LTC online portal.

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 (NF), 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 a related condition),
- the appropriateness of placement in the NF, and
- the individual's eligibility for specialized services.

If documentation entered on the PASRR Level 1 (PL1) Screening Form indicates suspicion of MI, ID and/or DD, a PE must be completed.

The PE is designed to validate the suspected diagnosis of MI, ID and/or a DD, indicated on the PL1 Screening Form.

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

The local authority (LA), which includes the local intellectual and developmental disability authority (LIDDA), local mental health authority (LMHA) and local behavioral health authority (LBHA), will meet in person with the individual or legally authorized representative (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 version of the PE.

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

When to Perform and Submit a PASRR Evaluation

The PE must be completed and submitted via the LTC Online Portal for every individual with a PL1 Screening Form 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 Online Portal within 7 days of notification.

The LA must travel to:

- the location of the individual as indicated by the referring entity (RE) to complete the PE in a Preadmission; or
- the NF to complete 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.

    a. In Expedited Admissions, the PL1 Screening Form is submitted by the NF on the date of admission of the individual. The PL1 Screening Form 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 Screening Form is submitted by the NF on the date of admission of the individual. The PL1 Screening Form 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.

3. **Preadmission**—The Preadmission Admission type occurs when a NF admission is coming from the community (such as from home, a group home, psychiatric hospital, jail, etc.).

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

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

4. **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 Minimum Data Set (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 interdisciplinary team (IDT) meeting within **14 calendar days** after the LTC Online Portal generated an automated notification to the LA to conduct a resident review.

How to Complete and Submit a PASRR Evaluation

The PE can only be completed and submitted on the LTC Online Portal by an LA. The LTC Online Portal can be accessed via www.tmhp.com. A log-on username 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 preadmission PL1 Screening Form notifications to submit the PL1 Screening Form.
- The LA must check the fax line daily to ensure all PL1 Screening Form notifications are acted on promptly.
- The individual/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 complete 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. The LA must ensure the individual/LAR receives a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy notice.
- The LA should use the medical information or documentation in the individual's medical record to determine whether the individual has a diagnosis for ID, DD, and/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 the Health and Human Services Commission (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 14 for program staff contact information.

If an individual or LAR refuses participation in the PE, the LA should request assistance from NF staff that have the greatest knowledge and rapport with the individual or LAR in explaining the process to the individual or LAR. If the individual or LAR continues to refuse, the LA will complete the PE solely from chart review and will document the individual's or LAR's refusal by using the "Add Note" function on the PE after submission.

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 LA within the seven-day timeframe.
2. The PE must include the address of the individual or LAR, or the address where the individual or LAR can be contacted.

Alzheimer's Disease and Dementia in PASRR

The PASRR definition of MI 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 MI. If the MI is primary, which is diagnosed before the dementia, then a PE must take place. Dementia can cause secondary symptomology such as psychosis, depression, anxiety; therefore, the MI must be diagnosed prior to dementia in order to be a true indication of MI.

If the individual has ID, DD 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 result will be a negative PE for MI and the rest of the PE still needs to be completed.

PASRR Evaluation Retention Period

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

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 or for a resident review, within 14 days after the LTC Online Portal generates a notification to the LA to complete a PE. The IDT is held to determine whether the individual is best served in a NF or community setting. The IDT is also used to identify which of the recommended specialized services the individual, or LAR on the individual'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 Online Portal.

The IDT consists of:

- the individual;
- the individual's LAR, if any;
- a registered nurse from the nursing facility with responsibility for the individual;
- a representative of the LIDDA, LMHA\LBHA, or both; and
- others as follows:
    - concerned persons whose inclusion is requested by the individual or LAR;
    - persons specified by the individual 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;
    - if the individual is school eligible, representatives of the appropriate school district as requested by the individual or LAR;
    - Managed Care Organization (MCO) Service Coordinator, if identified; and
    - Hospice provider if the individual is receiving hospice services.

As a required member of the IDT, a representative of the LIDDA or LMHA/LBHA 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.

Coding Conventions

The following coding conventions should be used when completing the PE on the LTC Online Portal:

- 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 "6. Other" is selected for 'Type of Setting' (A2100).
- 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 7/6/2018 (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.
- When completing the paper version of the PE to be used for data entry, capital letters may be easiest to read. Print legibly.

Form Assistance

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

- General Inquiries
- PE Form Status
- Claim Forms
- Claim Submissions

Contact **HHSC IDD PASRR Unit** by emailing PASRR.Support@hhsc.state.tx.us for:

- Assistance with locating information to complete the PE
- Assistance with or cooperation from an RE, LA or NF
- Assistance with locating a blank copy of the PE form, LAs, or additional training resources
- Policy guidance on PASRR processes and 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.

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 submitting the PE.

Steps for Assessment

- Fields A0100-A0500 will be disabled and auto populated with LA 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 No.—National Provider Identifier or Atypical Provider Identifier for the agency under which the submitter provides services.

A0400. Provider No.—Provider 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 completed. This field is auto populated based on the suspected diagnosis of the associated PL1 Screening Form. However, this field is enabled if you need to change the type of assessment.

Steps for Assessment

Field A0600 “Type of Evaluation(s)” will be auto populated with information from the linked PL1 Screening Form.

If the individual is dually diagnosed, the LIDDA will complete the IDD section of the PE, and the LMHA/LBHA will complete the MI section.

A0600 Type of Evaluation— 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. IDD only
2. MI only
3. IDD and MI

Section A.3: IDD Information

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

Steps for Assessment

Fields A0700-A0900 will be disabled and auto populated with LA identifying information documented in the PL1 Screening Form 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 Provider No. — LIDDA provider number under which the evaluator provides services.

A0800. LA-IDD Vendor No. — LIDDA vendor number under which the evaluator provides services.

A0900. LA-IDD NPI/API No.— LIDDA National Provider Identifier or Atypical Provider Identifier under which the evaluator provides services.

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

A1100A. First Name—Enter the first name of the evaluator completing the IDD Evaluation.

A1100B. Middle Initial—Enter the middle initial of the evaluator completing the IDD Evaluation. This is an optional field.

A1100C. Last Name—Enter the last name of the evaluator completing the IDD Evaluation.

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

A1100E. Phone Number—Enter the phone number of the evaluator completing the IDD Evaluation.

A1200. Evaluator Position/Title—Enter the position or title of the evaluator completing the IDD Evaluation.

A1300A. Type of Credential for IDD Evaluator—Select the type of credential for the evaluator completing the IDD Evaluation 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 Evaluation when "10. Other" was selected in A1300A.

Section A.4: MI Information

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

Steps for Assessment

Fields A1400 through A1600 will be disabled and auto populated with LMHA/LBHA identifying information documented in the PL1 Screening Form that is associated to this PE.

Fields A1700 through A2000 will be disabled if the type of evaluation is "1. IDD only" or blank.

A1400. LA-MI Provider No. —LMHA/LBHA provider number under which the evaluator provides services.

A1500. LA-MI Vendor No. —LMHA/LBHA vendor number under which the evaluator provides services.

A1600. LA-MI NPI/API No.—LMHA/LBHA National Provider Identifier or Atypical Provider Identifier under which the evaluator provides services.

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

A1800A. First Name—Enter the first name of the evaluator completing the MI Evaluation.

A1800B. Middle Initial—Enter the middle initial of the evaluator completing the MI Evaluation. This is an optional field.

A1800C. Last Name—Enter the last name of the evaluator completing the MI Evaluation.

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

A1800E. Phone Number—Enter the phone number of the evaluator completing the MI Evaluation.

A1900. Evaluator Position/Title—Enter the position or title of the evaluator completing the MI Evaluation.

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

1. Qualified Mental Health Professional-Community Services (QMHP-CS)
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 Evaluation when "9. Other" was selected in A2000A.

Section A.5: Location of Evaluation

INTENT: The purpose of this section is to document the type and address of the setting where the evaluation was completed. 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 and required if A2100 = "6. Other".

A2300A. Name—Enter the name of the evaluation setting.

A2300B. Street Address—Enter the current mailing address, including street address or P.O. Box, of the evaluation setting.

A2300C. City—Enter the city of the evaluation setting.

A2300D. State—Enter the state of the evaluation setting.

A2300E. ZIP Code—Enter the ZIP Code of the evaluation setting.

A2300F. County—Enter the county of the evaluation setting.

A2300G. Phone Number—Enter the ten-digit phone number of the evaluation setting.

Section A.6: Individual's Information

INTENT: The purpose of this section is to document the identifying and contact information for the individual for whom the evaluation is being completed. Most of these fields will be auto populated from the associated PL1 Screening Form. F Fields A2400 through A2900 will be disabled except for A2550, which will be enabled and optional for user input.

Steps for Assessment

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

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

A2400B. Middle Initial—The individual's middle initial and

suffix.

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

A2400D. Suffix—The individual's suffix.

A2500A. Social Security No.—The individual's nine-digit Social Security Number.

A2500B. Medicare No.—The individual's Medicare Number.

A2550. CARE ID—Enter the individual's Client Assignment and Registration (CARE) System ID, if available.

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

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

A2800. Age at Time of Evaluation—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 Screening Form with one of the following:

1. Male
2. Female

A3200A. Previous Residence Type—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 Previous Residence type— Enter the individual's previous residence/location type or program prior to current residence. This field is only available and required if "5. Other" is selected in A3200A.

A3200C. Street Address— Enter the street or P.O. Box of the previous residence/location type or program. This is a required field after a selection is made in A3200A.

A3200D. City— Enter the city of the previous residence/location type or program. This is a required field after a selection is made in A3200A.

A3200E. State— Select the state of the previous residence/location type or program via the drop-down list. This is a required field after a selection is made in A3200A.

A3200F. ZIP Code— Enter the ZIP Code of the previous residence/location type or program. This is a required field after a selection is made in A3200A.

A3200G. County of Residence—Select the county of the previous residence/location type or program via the drop-down list. This is a required field after a selection is made in A3200A.

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 is a required field.

0. No
1. Yes

Section A.7: Next of Kin

INTENT: The purpose of this section is to identify the individual's next of kin.

Steps for Assessment

1. The information requested in this section is optional until a selection is made in A3300A.

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

1. Legally Authorized Representative (Legal Guardian)
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. This field is required when "6. Other" is selected in A3300A.

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

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

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

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

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

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

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

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

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

Section A.8: Additional Contact Information- 1

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

Steps for Assessment

1. The information requested in this section is optional until a selection is made in A3400A.

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. This field is required when "5. Other" is selected in A3400A.

A3400C. First Name – Enter the first name of the person selected or entered in A3400A or A3400B.

A3400D. Middle Initial – Enter the middle initial of the person selected or entered in A3400A or A3400B.

A3400E. Last Name – Enter the last name of the person selected or entered in A3400A or A3400B.

A3400F. Suffix – Enter the suffix of the person selected or entered in A3400A or A3400B.

A3400G. Phone Number – Enter the ten-digit telephone number of the person selected or entered in A3400A or A3400B.

A3400H. Street Address – Enter the current mailing address, including street or P.O. Box, of the person selected or entered in A3400A for A3400B.

A3400I. City – Enter the city of the person selected or entered in A3400A or A3400B.

A3400J. State – Enter the state of the person selected or entered in A3400A or A3400B.

A3400K. ZIP Code– Enter the ZIP Code of the person selected or entered in A3400A or A3400B.

Section A.9: Additional Contact Information- 2

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

Steps for Assessment

1. The information requested in this section is optional until a selection is made in A3500A.

A3500A. 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

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. First Name – Enter the first name of the person selected or entered in A3500A or A3500B.

A3500D. Middle Initial – Enter the middle initial of the person selected or entered in A3500 or A3500B.

A3500E. Last Name – Enter the last name of the person selected or entered in A3500A or A3500B.

A3500F. Suffix – Enter the suffix of the person selected or entered in A3500A or A3500B.

A3500G. Phone Number – Enter the ten-digit telephone number of the person selected or entered in A3500A or A3500B.

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

A3500I. City – Enter the city of the person selected or entered in A3500A or A3500B.

A3500J. State – Select the state of the person selected or entered in A3500A or A3500B.

A3500K. ZIP Code– Enter the ZIP Code of the person selected or entered in A3500A or A3500B.

Section B.1: To Be Completed for Individuals Suspected of Having an Intellectual Disability or Developmental Disabilities

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 LIDDA.

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 to confirm 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—To your knowledge, does the individual have an Intellectual Disability which manifested before the age of 18? NOTE: The intellectual disability diagnoses must be listed in the medical record and documented in Field D0100A.

0. No
1. Yes

B0200. Developmental Disability—To your knowledge, does the individual have a developmental disability other than an intellectual disability that manifested before the age of 22? (e.g. autism spectrum disorder, cerebral palsy, spina bifida). NOTE: The DD diagnoses must be listed in the medical record and documented in Field D0100A.

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

0. No
1. Yes

Section B.3: Specialized Services Determination/Recommendations

INTENT: The purpose of this section is to determine what types of specialized services provided by the LIDDA or nursing facility this individual may benefit from receiving.

Steps for Assessment:

Check the corresponding box for each area of 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.

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 such as toileting, grooming, dressing and eating—Indicate whether the individual needs assistance to independently perform activities of daily living as stated in the field name.

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—Indicate whether the individual needs assistance with areas as stated in the field name.

B0400E. Social development to include social/recreational activities or relationships with others—Indicate whether the individual needs assistance with areas stated in the field name.

B0400F. Academic/educational development, including functional learning skills--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, emotions, making judgments, or making independent decisions—Indicate whether the individual needs assistance with areas stated in this field name.

B0400H. Independent living skills such as cleaning, shopping in the community, money management, laundry, accessibility within the community—Indicate whether the individual needs assistance with areas stated in this field name.

B0400I. Vocational development, including current vocational skills—Indicate whether the individual needs assistance pursuing employment assistance or supported employment.

B0400J. Additional adaptive medical equipment or adaptive aids to improve independent functioning—Indicate whether there is additional equipment needed by the individual as stated in this field name.

B0400K. Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal)—Indicate whether the individual needs assistance with areas stated in this field name.

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

B0400M. Other areas— This text box is only enabled and required if you checked "L. Other" in field B0400.

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 IDD Providers

Indicate the services that will be coordinated for delivery by the IDD providers.

Options 10 will be auto populated as the first recommended service provided by the LA. Other specialized services may also be checked by the system if they are associated to any of the areas you chose in the B0400 section.

1. Alternate Placement Services
2. Service Coordination (SC)
3. Employment Assistance
4. Supported Employment
5. Day Habilitation
6. Independent Living Skills Training
7. Behavioral Support
8. Habilitation Coordination

B0600. Recommended Services Provided/Coordinated by Nursing Facility- Indicate the services that will be coordinated for delivery by the NF. One or more specialized services may already be checked by the system if they are associated to any of the areas you chose in the B0400 section.

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)

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:	N/A
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
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: To Be Completed for 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 LMHA or LBHA.

C0050. I am completing the MI section—Check this box and continue completing this section to confirm 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 is disabled and will be auto populated based on the answers in fields C0100 through C0700.

C0100. Primary Diagnosis of Dementia—Does this individual have a PRIMARY diagnosis of dementia? NOTE: The diagnosis of dementia must be listed in the medical record as the primary diagnosis by the physician and documented in Field D0100A

0. No
1. Yes
2. Unknown

If the individual has ID, DD 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—Are the individual's dementia symptoms so severe that they cannot be expected to benefit from 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 checked 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. NOTE: The MI diagnoses must be documented in Field D0100A.

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 that may lead to a chronic disability diagnosable under the current DSM— 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, fingernails 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 NF.

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

Steps for Assessment

The answers to these questions could vary depending on whether the Qualified Mental Health Professional-Community Services (QMHP-CS) 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-CS performing this evaluation to understand that if the individual is already residing in a facility, the federal definition of mental illness must be viewed in light of that placement.

C0500. Intensive Psychiatric Treatment: Has this individual experienced intensive psychiatric treatment within the previous 2 years? —Indicate whether the individual has experienced any intensive psychiatric treatment such as, but not limited to: inpatient stay in a psychiatric hospital or partial psychiatric hospitalization (when an individual resides at

home, but commutes to a treatment center up to seven days a week). Select "2. Unknown" if there is no information in the medical record, statewide records, 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) within the previous 2 years due to mental illness? —Indicate whether the individual has required support services (residential or respite services) such as, but not limited to psychiatric home health nurse or the LMHA/LBHA provided in-home psychiatric services to assist the individual in staying in their own home, in the past two years. Select "2. Unknown" if there is no information in the medical record, statewide records, and the individual is unable to answer the question.

0. No
1. Yes
2. Unknown

C0700. Crisis Intervention: Has this individual experienced intervention by law enforcement, protective service agencies, housing officials or crisis services (i.e. evicted, arrested, charged or convicted of a crime) within the previous 2 years due to mental illness? —Indicate whether the individual has experienced any interventions as stated in this field name.

0. No
1. Yes
2. Unknown

C0800. Based on the QMHP assessment, does this individual meet the PASRR definition of mental illness? – This field is disabled and auto populated by the system based on your selections in fields C0100 through C0700.

0. No
1. Yes

Section C.4: Specialized Services Determination/ Recommendations

INTENT: The purpose of this section is to determine what types of specialized services provided by the LMHA/LBHA 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 medications— 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 ADLs 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, including current vocational skills— 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-assessment planning, facilitation of discharge (may only be delivered within 180 days or less, before planned discharge)— 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 'L. Other' in

field C0900. 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 Authority—Indicate the recommended services for this individual based on the evaluation.

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 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)
14. Cognitive Processing Therapy
15. Counseling Services (CBT- Individual or Group)
16. Peer Support
17. Pharmacological Management

Auto population of C1000 based on selections in C0900 are in the table below:

Field Name	Maps to Field Name
PE C0900. Does this individual need assistance in any of the following areas? Check all that apply:	N/A
B0900A. Self-monitoring of health status	PE C1000 13. Skills Training & Development
B0900B. Self-administering of medical treatment	PE C1000 7. Medication Training (Individual)

B0900C. Self-scheduling of medical treatment	PE C1000 7. Medication Training (Individual)
C0900D. Self-monitoring of medications	PE C1000 7. Medication Training (Individual)
C0900E. Self-monitoring of nutritional status.	PE C1000 13. Skills Training & Development
C0900F. Self-help with ADLs such as appropriate dressing and appropriate grooming.	PE C1000 13. Skills Training & Development
C0900G. Independent Living such as supported housing	PE C1000 2. Individual Skills Training
C0900H. Management of money	PE C1000 2. Individual Skills Training
C0900I. Vocational development, including current vocational skills	PE C1000 2. Individual Skills Training
C0900K. Discharge Planning- assessment, planning, facilitation of discharge (may only be delivered within 180 days or less, before planned discharge)	PE C1000 11. Routine Case Management

Section D: Nursing Facility Level of Care Assessment- Evaluation of History and Physical Information

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's 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.
3. Diagnoses listed in the D0100 fields should include any ID, DD or MI diagnoses along with any applicable medical diagnoses.

Diagnosis—Enter the following required and optional fields as appropriate. Click on the **"Add Diagnosis"** link to open another set of D0100 fields (D0100A through D0100D) to enter additional diagnoses.

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 by the system 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 the date using the date picker or manually using the following format: MM/DD/YYYY.

D0100D. Primary Diagnosis—Indicate if this is 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 button to remove the corresponding diagnosis.

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

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 open another set of D0200 fields (D0200A through D0200D) to enter additional medications.

D0200A. Current Medication—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 for this individual—Enter any known side effects for this individual.

D0200C. Is it an antipsychotic? —Select from this drop-down field to indicate whether this individual is on antipsychotic medications.

0. No
1. Yes

D0200D. Reason for antipsychotic—Manually enter the diagnosis or reason the individual is taking each antipsychotic medication. This is a required field if "1. Yes" is selected in D0200C. If a reason is not documented, manually enter "Unknown".

Delete Medication-Click this button to remove the corresponding medication.

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

D0600A. Is this individual a danger to himself/herself? —Select whether the individual is a danger to themselves 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

D0600B. If Yes, indicate reason why this individual is a danger to himself/herself. — This field is enabled and required if D0600A is marked "1. Yes". Manually enter the reasons why this individual is a danger to himself/herself at the time of the evaluation.

D0700A. 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

D0700B. If Yes, indicate reason why this individual is a danger to others. — This field is enabled and required if "1. Yes" is selected in D0700A. Manually enter the reasons why this individual is a danger to others at the time of the evaluation.

D0800. Is this individual known to demonstrate self-injurious behaviors? — 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 NF supervision and structure mitigate danger to self or others? —Select whether the NF 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

Terminal Illness/Hospice

D1000. 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. 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

D1150. If Yes, what date did the individual enter hospice? — Enter the date using the date picker or manually using the following format: MM/DD/YYYY. This field is enabled and optional when "1. Yes" is selected in D1100.

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

D1400A. Tracheostomy Care - 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 individual.

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

D1700A. Oxygen Therapy- 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

D2000A. Pressure Ulcers- 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).

D2100A. Other Ulcers, wounds, or skin issues -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

D2300A. Memory Loss -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

D2400A. Developmental Level -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

D2500A. Orientation -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 or bowel function? —The following questions refer to assistance needed for bladder and bowel functions. This is a required field.

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 Assessment-Evaluation of History and Physical Information

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.

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 tab out or click anywhere else in Section E to enable fields E0100B through E0100H,which will also be required.

Note: If "3" or more is entered in Field E0100A, Field B0600 1. Specialized Physical Therapy (PT) will be auto checked on the "Section B" tab.

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 (e.g., debris, slick or wet floors, lighting)— Enter the number of falls caused by environmental conditions including, but not limited to the conditions listed in this field name.

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

E0100E. Major Change in Medical Condition (e.g., Myocardial Infarction (Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting))—Enter the number of falls caused by major change in medical condition as indicated in this field name.

E0100F. Poor Balance/Weakness—Enter the number of falls caused by poor balance or weakness.

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

Note: If "2. Unclear speech- slurred or mumbled words" is selected in Field E0300, Field B0600 "3. Specialized Speech Therapy (ST)" will be auto checked on the "Section B" tab.

E0400. Which option best describes this individual's ability to express ideas and wants? Consider both verbal and non-verbal expressions —Indicate the individual's ability to express ideas and wants, as indicated in this field name, 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? Understanding verbal content, however able, with a hearing aid or device if applicable — Indicate the individual's ability to understand others, as indicated in this field name, 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 a 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

Note: If "1. Yes" is selected, Field B0500 "9. Behavioral Support" will be auto checked on the "Section B" tab.

E1000A. Pain Management -Is there an indication that the individual currently has issues with pain? —Indicate whether the individual currently has issues with pain 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, then this field becomes enabled and required. 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, then this field becomes enabled and required. 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

E1200A. Eating- 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 (Pureed food)? —Indicate whether this individual has a physician-ordered mechanically altered diet (e.g., pureed, liquid, soft) 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 (ADL)—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 or non-weight bearing.

If none of the above are met, code supervision.

1. ADL Self-Performance

   Code for individual's performance of ADLs – not including 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.

2. 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. Bed Mobility

How individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.

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

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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

2. ADL Support Provided—Indicate the individual's ability to be independent in bed.

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

8. 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. Walk in room

How individual walks between locations in his/her room.

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

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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

2. ADL Support Provided—Indicate the individual's ability to walk within his/her room.

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

E1400C. Walk in hallway

How individual walks in hallway on unit.

1. ADL Self-performance—Indicate the individual's ability to walk in the hallway.

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

2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided—Indicate the individual's ability to walk in the hallway.

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

E1400D. Locomotion On Unit Or In Room

How individual moves between locations in their room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

1. ADL 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.

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided—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.

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

E1400E. Locomotion Off Unit Or In Home

How individual moves to or returns from distant areas in the home (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how individual moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

1. ADL Self-performance—Indicate the individual's ability to move to or return from distant areas in his/her home (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how individual moves to and from distant areas on the floor. If in a wheelchair, identify self-sufficiency once in the chair.

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance Extensive assistance - resident involved in activity, staff provide weight- bearing support
3. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided—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.

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

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

E1400F. Dressing

How individual puts on, fastens and takes off all items of clothing, including donning and removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and house dresses.

1. ADL Self-performance—Indicate the individual's ability to put on, fasten and remove clothing.

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided—Indicate the individual's ability to put on, fasten and remove clothing.

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

E1400G. Eating

How individual eats and drinks, regardless of skill. Do not include eating or drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)

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

0. Independent - no help or staff oversight at any time

1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided — Indicate the individual's ability to eat and drink.

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

E1400H. Toilet Use

How individual uses the toilet room, commode, bedpan, or urinal; transfers on and off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal or bedside commode, catheter bag, or ostomy bag.

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

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided —Indicate the individual's level of independence in toileting skills.

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

E1400I. Medication Management

Level of assistance the individual needs to take prescribed medications.

1. ADL Self-performance —Indicate the individual's ability to take medications as prescribed.

0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement, or cueing
2. Limited assistance - resident highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance
3. Extensive assistance - resident involved in activity, staff provide weight- bearing support
4. 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 percent of the time for that activity over the entire 7-day period

2. ADL Support Provided —Indicate the individual's ability to take medications as prescribed.

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

E1400J. Transfer

How individual moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to or from the bath or toilet).

1. ADL Self-performance —Indicate the individual's ability to transfer and move between surfaces.

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

2. ADL Support Provided —Indicate the individual's ability to transfer and move between surfaces.

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

E1500A. Appropriate Placement- 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 a NF.

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 they are eligible for.
2. Inform the individual of all community support resources they are 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 the individual's diagnosis, for successful completion of the PE.

F0100. Did the individual or LAR participate in this evaluation 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

F0200A. Has this individual received information regarding the services and support alternatives to the nursing facility admission (for Preadmission Screening) or continuation of the NF stay (for Resident Review)? — Indicate whether the individual has received information on alternatives to the NF during the Preadmission Screening 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 PE.

0. No
1. Yes

F0200B. Does this individual, or LAR on the individual's behalf, expect to return to live in the community either following a short term stay in the NF or at some point in the future? —Indicate whether the individual, (or LAR on the individual's behalf) expects to return to the community by selecting one of the options from the drop-down list shown below.

0. No
1. Yes

Note: If "1. Yes" is selected in Field F0200B, Field B0500 option "1. Alternate Placement Services" will be auto checked on the "Section B" tab and Fields F1000A, F1000C and F1000D will become required on the "Section F" tab.

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. Community Programs- Did this individual receive services from a community program? 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 (AFC)

F0400B. Community Attendant Services (CAS)

F0400C. Community Living Assistance and Support Services (CLASS)

F0400D. Consumer Manages Personal Assistance Services (CMPAS) F0400E. Day Activity and Health Services (DAHS)

F0400F. Deaf Blind with Multiple Disabilities (DBMD) F0400G. Emergency Response Services (ERS)

F0400H. Family Support Services (FSS)

F0400I. Home & Community-based Services-Adult Mental Health (HCBS-AMH)

F0400J. Home and Community-based Services (HCS)

F0400K. Medically Dependent Children Program (MDCP)

F0400L. Primary Home Care (PHC)

F0400M. Program of All-Inclusive Care for the Elderly (PACE)

F0400N. STAR+PLUS

F0400O. Substance Use Treatment Services

F0400P. Texas Home Living (TxHmL)

F0400Q. Youth Empowerment Services (YES) Waiver

F0400R. Other

F0400S. Other Community Program

F0400T. None of the above

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 NF by selecting one of the options from the drop-down list shown below.

0. No
1. Yes
2. Unknown

Note: If "1. Yes" is selected in Field F0500, Fields F1000A, F1000C and F1000D will be required on the "Section F" tab.

F0600. Where would this individual 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 individual 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 Programs— Is this individual interested in enrolling in a community program?

0. No
1. Yes

Explain community 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 F0700A through F0700T will be enabled and required if you selected "1. Yes" in field F0700.

Check all that apply.

F0700A. Adult Foster Care (AFC)

F0700B. Community Attendant Services (CAS)

F0700C. Community Living Assistance and Support Services (CLASS)

F0700D. Consumer Manages Personal Assistance Services (CMPAS)

F0700E. Day Activity and Health Services (DAHS)

F0700F. Deaf Blind with Multiple Disabilities (DBMD)

F0700G. Emergency Response Services (ERS)

F0700H. Family Support Services (FSS)

F0700I. Home & Community-based Services-Adult Mental Health (HCBS-AMH)

F0700J. Home and Community-based Services (HCS)

F0700K. Medically Dependent Children Program (MDCP)

F0700L. Primary Home Care (PHC)

F0700M. Program of All-Inclusive Care for the Elderly (PACE)

F0700N. STAR+PLUS

F0700O. Substance Use Treatment Services F0700P. Texas Home Living (TxHmL)

F0700Q. Youth Empowerment Services (YES) Waiver

F0700R. Other

F0700S. Other Community Program—This field will be enabled and required if you select "Other" in field F0700R.

F0700T. None of the above

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: —Check all that apply. 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).

F0900A. An appropriate community setting

F0900B. List settings and supports required to enable community placement in the space below—This field will be enabled and required if you checked the "A. An appropriate community setting" box in field F0900.

F0900C. In an institutional setting

F0900D. Nursing Facility

F0900E. ICF/IID

F0900F. Other

F0900G. Other location—This field will be enabled and required if you checked the "F. Other" box in field F0900. List the other location not found in options F0900A through F0900E.

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 display another set of fields F1000A through F1000E to enter additional referrals. 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. Community Programs—Select an option from the drop-down list shown below. This is a required field.

1. Adult Foster Care (AFC)
2. Community Attendant Services (CAS)
3. Community Living Assistance and Support Services (CLASS)
4. Consumer Manages Personal Assistance Services (CMPAS)
5. Day Activity and Health Services (DAHS)
6. Deaf Blind with Multiple Disabilities (DBMD)
7. Emergency Response Services (ERS)
8. Family Support Services (FSS)
9. Home & Community-based Services-Adult Mental Health (HCBS-AMH)
10. Home and Community-based Services (HCS)
11. Medically Dependent Children Program (MDCP)
12. Primary Home Care (PHC)
13. Program of All-Inclusive Care for the Elderly (PACE)
14. STAR+PLUS
15. Substance Use Treatment Services
16. Texas Home Living (TxHmL)
17. Youth Empowerment Services (YES) Waiver
18. Other
19. None of the above

F1000B. Other Community Program—Enter the desired program here if it is not on the list in field F1000A. This is a required field if "18. Other" was selected 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.

Delete Referral—Click this button to remove the corresponding referral.

Add Referral—Click this button to enter an additional referral.

Authorization

INTENT: The purpose of this section is to display the status of the PASRR Transaction ID’s (PTID) and to perform some workflow actions. All fields in this section are disabled and blank while initiating a PE, and therefore no action is required.