DEPARTMENT OF HEALTH

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Pilot Version 2 -- For use only in Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion Parishes

Instructions: This screening must be completed for all persons applying for admission to a Medicaid certified nursing facility regardless of payment source. The Level of Care Eligibility Tool (LOCET) must also be completed in order for the Office of Aging and Adult Services to process admission requests. Fax the completed, signed form to 225-389-8198 or 225-389-8197.

<table>
<tr><th colspan="6">Section I: Referral Source Information</th></tr>
<tr><td colspan="6">Name of Hospital/ Nursing Facility/ Other Source Completing Level I Screen:</td></tr>
<tr><td colspan="2">Date:</td><td colspan="2">Fax:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="6">Printed Name, Title and Credentials of Contact Person for Hospital/ Nursing Facility/ Other Source:</td></tr>
<tr><td colspan="6">Email:</td></tr>
<tr><td colspan="3">Physician Name: (Please print.)</td><td colspan="3">Physician Signature:</td></tr>
<tr><th colspan="6">SECTION II: Applicant Information</th></tr>
<tr><td rowspan="2">Applicant Name</td><td>First and Middle</td><td colspan="4"></td></tr>
<tr><td>Last</td><td colspan="4"></td></tr>
<tr><td colspan="3">Social Security #:</td><td colspan="3">Date of Birth:</td></tr>
<tr><td colspan="6">Medicaid # (If Applicable):</td></tr>
<tr><td rowspan="2">☐ Anticipated NF
☐ Current NF</td><td>Name</td><td colspan="4"></td></tr>
<tr><td>City</td><td colspan="4"></td></tr>
<tr><td rowspan="6">Legally Authorized Representative/ Guardian

Individual designated under State law to make decisions on the applicant's behalf, such as a curator, tutor, guardian or agent under a health care power of attorney.</td><td>Name</td><td colspan="4"></td></tr>
<tr><td>Street</td><td colspan="4"></td></tr>
<tr><td>City</td><td colspan="4"></td></tr>
<tr><td>State</td><td></td><td>Zip</td><td colspan="2"></td></tr>
<tr><td>Phone</td><td colspan="4"></td></tr>
<tr><td>E-mail</td><td colspan="4"></td></tr>
</table>

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Pilot Version 2 -- For use only in Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion Parishes

SECTION III: Mental Illness

1.	Has the applicant ever been diagnosed as having a serious mental illness? Include mental disorders that may lead to chronic disability. (Do not include dementia, acute illnesses related to medical conditions or episodic/situational conditions).	□ Yes □ No
	If yes to serious mental illness, please check the diagnosis below. ☐ Schizophrenia ☐ Schizoaffective disorder ☐ Delusional Disorder ☐ Other Psychotic Disorder ☐ Bipolar Disorder ☐ Major Depressive Disorder ☐ Obsessive Compulsive Disorder ☐ Panic Disorder ☐ Posttraumatic Stress Disorder ☐ Personality Disorder (specify): _____ ☐ Other mental health diagnosis/disorder that may lead to chronic disability (specify): _____	
2.	Has the applicant shown any of the following symptoms **DUE TO A SERIOUS MENTAL ILLNESS?** (Do not include symptoms that are caused by dementia or acute illnesses related to medical conditions or temporary situations.) **If yes, check all that apply:**	□ Yes □ No
	☐ Self-injurious or self-mutilating behaviors ☐ Danger to others, aggressive, assaultive ☐ Danger to self, suicidal ideation, threats, or attempts ☐ Serious loss of interest in things that used to be pleasurable ☐ Interpersonal functioning *(check all that apply)*: ☐ Serious difficulty interacting appropriately and communicating effectively ☐ History of altercations ☐ History of evictions ☐ History of job loss ☐ Fear of strangers ☐ Avoidance of interpersonal relationships/social isolation ☐ Concentration, persistence and pace *(check all that apply)*: ☐ Serious difficulty in sustaining focused attention ☐ Serious difficulty in maintaining concentration ☐ Inability to complete simple tasks ☐ Adaptation to change: ☐ Serious difficulty in adapting to changes (agitation, exacerbated symptomology, requires intervention) ☐ Other (specify): _____	
3.	Has the applicant had any of the following **DUE TO A SERIOUS MENTAL ILLNESS**? If yes, please provide as much of the information below as is known to you.	□ Yes □ Unknown □ No
	☐ Inpatient psychiatric treatment. Date(s):	
	☐ Partial hospitalization / day treatment. Date(s):	
	☐ Homelessness/ loss of housing / eviction. Date(s):	
	☐ Law enforcement intervention. Date(s):	
4.	Has the applicant been diagnosed with a substance use or addictive disorder? If yes, please specify type(s): _____	□ Yes □ Unknown □ No

Comments:

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Pilot Version 2 -- For use only in Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion Parishes

SECTION IV: Intellectual Disability, Developmental Disability and Related Conditions		
5.	Does the applicant have a diagnosis of an intellectual disability (formerly referred to as mental retardation)?	□ Yes □ No
	If yes, was there any information available to the screener that substantiates that this condition began prior to age 22?	□ Yes □ No
6.	Does the applicant have a diagnosis of a developmental disability or related condition other than an intellectual disability? • A developmental disability is a severe, chronic disability that is attributable to an intellectual or physical impairment (or combination), **occurs prior to age 22**, is likely to continue indefinitely, is not solely attributable to mental illness, and results in substantial functional limitations in major life areas (e.g., learning, language, mobility, self-care, independent living, etc.). • A related condition is a disability that **manifested prior to age 22**, is not solely attributable to mental illness, and impairs intellectual functioning or adaptive functioning and requires services normally delivered to individuals with intellectual disabilities. **If yes, please specify all that apply**:	□ Yes □ No
	☐Autism ☐ Genetic Syndrome Associated with Delay ☐ Cerebral Palsy ☐ Closed Head Injury/TBI ☐ Other (specify): _____	
	If yes, was there any information available to the screener that substantiates that this condition began prior to age 22?	□ Yes □ No
	Age at which the disability or condition began:	
7.	Does the applicant have presenting evidence of intellectual disability, developmental disability or a related condition that has not been diagnosed?	□ Yes □ No
8.	If "yes" was marked for questions 5, 6, and/or 7, are there substantial functional limitations attributable to the suspected intellectual disability, developmental disability or related condition that are not attributable to a medical condition, dementia or mental illness? If yes, please specify all that apply:	□ Yes □ No
	☐ Mobility ☐ Self-Direction ☐ Self-Care ☐ Learning ☐ Understanding/ Use of Language ☐ Capacity for Living Independently ☐ Economic Self-Sufficiency (If the applicant is 18 years or older)	
9.	Is the applicant currently receiving services from an agency that serves people with Intellectual and Developmental Disabilities?	□ Yes □ No
	If yes, please provide as much of the information below as is known to you:	
	Agency:	
	Dates:	
10.	Has the applicant received services in the past or been referred to an agency that serves people with Intellectual and Developmental Disabilities?	□ Yes □ No
	If yes, please provide as much of the information below as is known to you:	
	Agency:	
	Dates:	

SECTION V. Categorical Determinations

Complete this section if any item except #4 (substance use) was checked "yes" in the previous sections **AND** the applicant meets the criteria for one of the conditions described below.

NOTE: If the dementia category is selected, records supporting the diagnosis MUST accompany this form. For others, attaching records or submitting them directly to the Level II authority will expedite the process.

□ **Not applicable: No item was checked "yes" in previous sections.**

		SELECT ONE
11.	The applicant meets **all** of the following criteria for a **HOSPITAL EXEMPTION**. • The individual is being admitted directly to a nursing facility after receiving acute care in a hospital; • **AND** the individual needs nursing facility services for the condition for which he/ she received care in the hospital; • **AND** the attending physician certifies by signing this form that the individual will require 30 days or less of nursing facility services. What is the condition for which nursing facility care is needed? **NOTE: Applications without the condition indicated will not be processed.**	☐
12.	The applicant cannot be assessed because of **DELIRIUM**.	☐
13.	The applicant requires **RESPITE** care for up to 30 calendar days.	☐
14.	The applicant has a **TERMINAL ILLNESS** with a prognosis of a life expectancy of less than 6 months **AND** needs nursing care associated with the condition.	☐
15.	The applicant has a **PHYSICAL ILLNESS SO SEVERE** (*such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure*) that the individual would be unable to participate in a program of specialized services. What is the condition?	☐
16.	The applicant needs **CONVALESCENT CARE** for an acute physical illness that: • Required hospitalization for a serious illness and needs time to convalesce • **AND** does not meet all the criteria for an exempt hospital discharge. What is the condition that requires convalescent care? How long will the applicant need convalescent care? (Note: 90 days is the maximum that can be approved).	☐
17.	The applicant has a diagnosis of **DEMENTIA** or Alzheimer's disease that has progressed to the point that the individual would be unable to participate in a program of specialized services. How was the diagnosis determined? (For example, H&P, MRI, CT, Comprehensive Mental Status Exam) **NOTE: Applications without records supporting this diagnosis will not be processed.**	☐