LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Instructions: This screening must be completed for all persons applying for admission to a Medicaid certified nursing facility regardless of payment source. Fax the completed, signed form to 225-389-8198 or 225-389-8197. The Level of Care Eligibility Tool (LOCET) must also be called in to 877-456-1146 in order for the Office of Aging and Adult Services to process admission requests.

Illegible or incomplete forms will be rejected.

Section I: Referral Source Information		
Name of Hospital/ Nursing Facility/ Other Source Completing Level I Screen:		
Date:	Fax:	Phone:
Printed Name, Title and Credentials* of Preparer:	Preparer Signature:	
Preparer's Email:		
Email for Receipt of 142 if different:		

SECTION II: Applicant Information				
Applicant Name	First and Middle			
	Last			
Applicant Address (Partial)	Town/ City:			State:
Social Security #:	Date of Birth:	Medicaid # (If Applicable):		
Will the individual be admitted to the nursing facility using their Medicare Skilled Nursing Facility benefit?	☐ Yes ☐ No			
Is there a Legally Authorized Representative/ Guardian? Limit to curator, tutor, guardian or agent under a health care power of attorney.	☐ Not applicable. Applicant does not have a known legal representative of the type listed.			
	Name			
	Street			
	City		State	
	Zip	Phone		
	E-mail			

*Note: The list of individuals deemed to have the proper credentials to complete the Level I Screen are listed in the ***Instructions for Completing the PASRR Level I Screen*** (located on the OAAS website).

SECTION III: Mental Illness		
1.	Do you suspect the applicant has, or has the applicant ever been diagnosed as having a mental illness? Include mental disorders that may lead to chronic disability. **If yes, please check the diagnosis below.**	☐ Yes ☐ No
	☐ 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? (Do not include symptoms that are caused only 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 ☐ 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 MENTAL ILLNESS**? If yes, please provide as much of the information below as is known to you.	☐ Yes ☐ No ☐ Unknown
	☐ Inpatient psychiatric treatment. Date(s):	
	☐ Partial hospitalization / day treatment. Date(s):	
	☐ Law enforcement intervention. Date(s):	

SECTION IV: Intellectual Disability, Developmental Disability and Related Conditions		
4.	Does the applicant have a diagnosis of an intellectual disability (formerly referred to as mental retardation)?	☐Yes ☐No
5.	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):_____	
6.	Does the applicant have presenting evidence of intellectual disability, developmental disability or a related condition that has not been diagnosed?	☐Yes ☐No
7.	If "yes was marked for questions 4, 5, and/or 6, is there any information available to the preparer that this condition began before age 22? Age at which the condition began? _____	☐Yes ☐No ☐NA
8.	If "yes" was marked for questions 4, 5, and/or 6, are there substantial functional limitations attributable to the suspected intellectual disability, developmental disability or a related condition that are not attributable to a medical condition, dementia or mental illness? If yes, please specify all that apply:	☐Yes ☐No ☐NA
	☐ 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, ever in the past received services, or been referred 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:	

FOR RESEARCH PURPOSES: Information provided here does not affect the determination of need for a Level II review.

In the past 12 months, has the applicant had to stay in a place not meant for human habitation (such as the streets, a car, an abandoned building); stay in a homeless shelter; or live doubled up with family or friends **because he/she didn't have housing**?	☐Yes ☐No ☐Unknown
Has the applicant been diagnosed with a substance use or addictive disorder? If yes, please specify type(s):	☐Yes ☐No ☐Unknown

SECTION V. Hospital Exemption and Categorical Determinations

Complete this section if any item was checked "yes" in the Sections III or IV **AND** the applicant meets the criteria for one of the conditions described below. **If any item is selected, this page must be signed by the attending physician and supporting documentation must be attached.**

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

		SELECT ONE
10.	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 inpatient care in a hospital; • **AND** the individual needs nursing facility services for the condition for which the individual was admitted to 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 a current H&P will not be processed.**	☐
11.	The applicant cannot be assessed because of **DELIRIUM**.	☐
12.	The applicant requires **RESPITE** care for up to 30 calendar days.	☐
13.	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.	☐
14.	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?**	☐
15.	The applicant needs **CONVALESCENT CARE** for no more than 100 days 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, and how long will the applicant need convalescent care?**	☐
16.	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?** **NOTE: Applications without records supporting this diagnosis will not be processed.**	☐

Physician Name: MD only. (Please print.)	Physician Signature: