

**West Virginia Department of Health and Human Resources
PRE-ADMISSION SCREENING**

PAS Level 0

Facility/Agency/Person making referral FROM		Contact Person First Name	Contact Person Last Name
<input type="text"/>		<input type="text"/>	<input type="text"/>
Address:	City:	State:	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fax Number:	Fax Extension:	Phone Number:	Extension:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Facility/Agency/Person making referral TO		Contact Person First Name	Contact Person Last Name
<input type="text"/>		<input type="text"/>	<input type="text"/>
Address:	City:	State:	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fax Number:	Fax Extension:	Phone Number:	Extension:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Reason for Screening (check only ONE)

Nursing Home Only Initial

Nursing Home Only Transfer

Nursing Home Waiting Waiver - Yes

Other Explain

1. Demographic Information

1a. First Name	1b. Middle Name	1c. Last Name	1d. Suffix	2. Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
3. Medicaid Number:		Medicare Number:		
<input type="text"/>		<input type="text"/>		
5a. Address:	5b. City:	5c. State:	5d. Zip:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
6. Private Insurance/Private Pay				
<input type="checkbox"/> Yes If yes, specify <input type="text"/>				
<input type="checkbox"/> No				
7. County (WV Only)	8. Social Security Number:	9. Date of Birth	10. Age	11. Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12a. Spouse First Name:	12b. Spouse Middle Name:	12c. Spouse Last Name:	12d. Spouse Suffix:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
13a. Spouse Address (if different from above):	13b. City:	13c. State:	13d. Zip:	13e. County:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
14. Current living arrangements, including formal and informal support (i.e., family, friends, other services):				
<input type="text"/>				

15. Name and Address of Provider, if applicable:

15a. Provider First Name:	15b. Provider Last Name:			
<input type="text"/>	<input type="text"/>			
15c. Provider Address:	15d. Provider City:	15e. Provider State:	15f. Provider Zip:	15g. County
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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16. Medicaid Waiver Recipient:

- Yes, If Yes - MR/DD Waiver Aged and Disable Waiver
 No

17. Has the option of Medicaid Waiver been explained to the applicant?

- Yes
 No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.

SIGNATURE - Applicant or Person acting for Applicant Relationship Date:

- Checking this box certifies that the person indicated above has signed the completed PAS and a copy of this document containing the above-named applicant's signature (or person signing for the applicant) is on file in the applicant's record.
 If a verbal consent was received from the applicant, then checking this box certifies that this PAS has been signed by two witnesses and is on file in the applicant's record

19. Check if applicant has any of the following:

- a. Guardian c. Medical Power of Attorney e. Durable Power of Attorney g. Other
 b. Committee d. Power of Attorney f. Living Will

Name of Representative Address Phone Number

 City State Zip

II. Medical Assessment

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available.)

- Checking this box certifies that the attached document(s) contains the most recent health assessment data available for this member and that the most recent hospital discharge summary and physical has been attached, if applicable.

21. Normal Vital Signs for the Individual:

a. Height (inches or cm) b. Weight (pounds or kg) c. Blood Pressure (mmHg) d. Temperature (°F or °C) e. Pulse f. Resp. Rate

22. Check if abnormal:

- a. Eyes g. Breasts m. Extremities s. Musculo Skeletal
 b. Ears h. Lungs n. Abdomen t. Skin
 c. Nose i. Heart o. Hernias u. Nervous System
 d. Throat j. Arteries p. Genitalia Male v. Allergies
 e. Mouth k. Veins q. Gynecological
 f. Neck l. Lymph System r. Ano-Rectal
 Specify:

Describe abnormalities and treatment:

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23. Medical conditions/symptoms (Grade as following: 0 - None, 1 - Mild, 2 - Moderate, 3 - Severe)

a. Angina - Rest	Grade []	e. Paralysis	Grade []	i. Diabetes	Grade []
b. Angina - Exertion	[]	f. Dysphagia	[]	j. Contracture(s)	[]
c. Dyspnea	[]	g. Aphasia	[]	k. Mental Disorder(s)	[]
d. Significant Arthritis	[]	h. Pain	[]	l. Other (Specify):	[]
					[]

24. Does applicant have a decubitus?

Yes - If yes please fill out the following → Location [] e.g. (left - arm, leg, hip, buttock; right - arm, leg, hip, buttock; other)

No Stage [] 1, 2, 3, or 4

Size []

Treatment []

Developed at [] home, hospital, or facility

25. In the event of an emergency, the individual can vacate the building (select one):

Independently

With Supervision

Mentally Unable

Physically Unable

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a. [] Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b. [] Bathing	Self/Prompting	Physical Assistance	Total Care	
c. [] Dressing	Self/Prompting	Physical Assistance	Total Care	
d. [] Grooming	Self/Prompting	Physical Assistance	Total Care	
e. [] Continent/Bladder	Continent	Occasional Incontinent	Incontinent	Catheter
f. [] Continent/Bowel	Continent	Occasional Incontinent	Incontinent	Colostomy
g. [] Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h. [] Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
i. [] Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
j. [] Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (doors, etc.)	Total Assistance
k. [] Vision	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Blind
l. [] Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m. [] Communication	Not Impaired	Impaired/Understandable	Understandable with aids	Inappropriate/None

27. Professional and technical care needs (check all that apply):

<input type="checkbox"/> a. Physical Therapy	<input type="checkbox"/> f. Ostomy	<input type="checkbox"/> k. Parenteral Fluids
<input type="checkbox"/> b. Speech Therapy	<input type="checkbox"/> g. Suctioning	<input type="checkbox"/> l. Sterile Dressings
<input type="checkbox"/> c. Occupational Therapy	<input type="checkbox"/> h. Tracheostomy	<input type="checkbox"/> m. Irrigations
<input type="checkbox"/> d. Inhalation Therapy	<input type="checkbox"/> i. Ventilator	<input type="checkbox"/> n. Special Skin Care
<input type="checkbox"/> e. Continuous Oxygen	<input type="checkbox"/> j. Dialysis	<input type="checkbox"/> o. Other

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28. Individual is capable of administering his/her own medications:

- Yes
 With Prompting Supervision
 No

Comments

29. Current Medications

Is this Applicant on any Medications: Yes No If yes add medication in form below or attached medication list

Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted

III. MI/MR Assessment

30. Current Diagnosis (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> a. None | <input type="checkbox"/> h. Paranoid Disorder |
| <input type="checkbox"/> b. Mental Retardation | <input type="checkbox"/> i. Major Affective Disorder |
| <input type="checkbox"/> c. Autism | <input type="checkbox"/> j. Schizoaffective Disorder |
| <input type="checkbox"/> d. Seizure Disorder (Age at Onset): _____ | <input type="checkbox"/> k. Affective Bipolar Disorder |
| <input type="checkbox"/> e. Cerebral Palsy | <input type="checkbox"/> l. Tardive Dyskinesia |
| <input type="checkbox"/> f. Other developmental disabilities (Specify):
_____ | <input type="checkbox"/> m. Major Depression |
| <input type="checkbox"/> g. Schizophrenic Disorder | <input type="checkbox"/> n. Other related conditions (specify): _____ |

Date of last PASRR Level II Evaluation

31. Has an individual ever received services from an agency serving person with mental retardation/developmental disability and/or mental illness?

- Yes, specify Facility Address
 No Admission Date Discharge Date

32. Has the individual received any of the following medications on a regular basis within the last two years?

- Yes
 No
- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Chlorpromazine | <input type="checkbox"/> Perphenazine | <input type="checkbox"/> Haloperidol | <input type="checkbox"/> Promazine | <input type="checkbox"/> Fluphenazine |
| <input type="checkbox"/> Trifupromazine | <input type="checkbox"/> Fluphenazine HCl | <input type="checkbox"/> Loxapine | <input type="checkbox"/> Thiothixene | <input type="checkbox"/> Trifluoperazine |
| <input type="checkbox"/> Mesoridazine | <input type="checkbox"/> Chlorprothixene | <input type="checkbox"/> Prochlorperazine | <input type="checkbox"/> Actiphenazine | <input type="checkbox"/> Thiothixene |
| <input type="checkbox"/> Thorazine | <input type="checkbox"/> Trilafon | <input type="checkbox"/> Haldol | <input type="checkbox"/> Sparine | <input type="checkbox"/> Prolixin |
| <input type="checkbox"/> Vesprin | <input type="checkbox"/> Permitil | <input type="checkbox"/> Loxitane | <input type="checkbox"/> Mellaril | <input type="checkbox"/> Stelazine |
| <input type="checkbox"/> Serentil | <input type="checkbox"/> Taractan | <input type="checkbox"/> Molindone | <input type="checkbox"/> Tindal | <input type="checkbox"/> Navane |
| <input type="checkbox"/> Clozapine | <input type="checkbox"/> Compazine | <input type="checkbox"/> Moban | <input type="checkbox"/> Clozaril | |

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted

33. Was this medication used to treat a neurological disorder? Yes No

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34. Clinical and Psychological Data - Please check any of the following behaviors which the individual has exhibited in the past two years:

- | | |
|--|--|
| <input type="checkbox"/> a. Substance Abuse (Identify)
<input type="text"/> | <input type="checkbox"/> k. Seriously Impaired Judgment |
| <input type="checkbox"/> b. Combative | <input type="checkbox"/> l. Suicidal Thoughts, Ideations/Gestures |
| <input type="checkbox"/> c. Withdrawn Depressed | <input type="checkbox"/> m. Cannot Communicate Basic Needs |
| <input type="checkbox"/> d. Hallucinations | <input type="checkbox"/> n. Talks About His/Her Worthlessness |
| <input type="checkbox"/> e. Delusional | <input type="checkbox"/> o. Unable to Understand Simple Commands |
| <input type="checkbox"/> f. Disoriented | <input type="checkbox"/> p. Physically Dangerous to Self and Others, If Unsupervised |
| <input type="checkbox"/> g. Bizarre Behavior | <input type="checkbox"/> q. Verbally Abusive |
| <input type="checkbox"/> h. Bangs Head | <input type="checkbox"/> r. Demonstrates Severe Challenging Behaviors |
| <input type="checkbox"/> i. Sets Fire | <input type="checkbox"/> s. Specialized Training Needs |
| <input type="checkbox"/> j. Displays inappropriate social behavior | <input type="checkbox"/> t. Sexually Aggressive |

Does the individual have Alzheimer's, mult-infarct, senile dementia, or related condition? Yes No

Other (Specify):

IV. Physician Recommendation

35. Prognosis (check only one)

- Stable
- Improving
- Deteriorating
- Terminal
- Other:

36. Rehabilitative Potential (check only one)

- Good
- Limited
- Poor

37. Diagnosis Include ICD code and descriptor

- a. Primary:
- b. Secondary:
- c. Tertiary:
- d. Other medical conditions requiring services:

Explain:

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38. Physician Recommendations:

A. FOR NURSING FACILITY PLACEMENT ONLY

On the basis of present medical findings, the individual may eventually be able to return home or be discharged

Yes No

If yes, check one of the following:

a. Less than 3 months

Please specify estimated length of stay (in calendar days): _____

b. 3-6 months

c. More than 6 months

d. Terminal illness

B. I recommend that the services and care to meet these needs can provided at the level of care indicated.

A. Nursing Home

B. Nursing Home Waiting AD Waiver

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (MUST be signed by M.D. or D.O.)

Physician Signature

MD DO

Physician Credentials

Date Assessment Completed

- Checking this box certifies that the MD/DO Name typed into the 'Physician's Signature' field above is the Physician who completed this PAS form. Also checking this box certifies that #39 of this PAS form will be completed with the MD/DO signature for this applicant and is on file in the applicant's record.

Physician's Name and Address:

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.