DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Care and Treatment Services
F-20378 (09/2016)

LEVEL II PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

ASSESSMENT FOR PERSONS WITH MENTAL ILLNESS

Name – Client

VALIDATION OF A SERIOUS MENTAL ILLNESS

Does the data about the person meet the criteria for the federal definition of a "serious mental illness"?

☐ Yes, all questions below are answered "yes"—Continue with the screening process.
☐ No, at least one question below was answered "no"—No further Level II screening is needed.

Also indicate the result of this determination on the first page of the facesheet (F-20853).

☐ Yes ☐ No Does the person have a major mental disorder meeting the diagnostic requirements in DSM III-R of *(check the applicable diagnosis)*: ☐ schizophrenia; ☐ mood, paranoid, panic or other severe anxiety disorder; ☐ somataform disorder; ☐ personality disorder; ☐ other psychotic disorder; or ☐ another mental disorder that may lead to a chronic disability. **Note: Dementia, as described in DSM III-R, is not considered a major mental disorder, even though it is a mental disorder that leads to a chronic disability.**

☐ Yes ☐ No Has the person's functioning, as a result of the mental disorder, been limited continuously or intermittently during the past 3 to 6 months in at least one of the following areas of major life activity *(check the applicable areas)*:

- ☐ Interpersonal functioning, including but not limited to: social isolation, altercations with others, difficulty interacting appropriately and communicating effectively with others;
- ☐ Concentration, persistence, and pace resulting in problems such as, difficulty completing common tasks found in a workplace, school, or home setting, difficulty in completing tasks on time, or making frequent errors; and
- ☐ Adaptation to change.

☐ Yes ☐ No Has the person **needed** during the past two years, as a result of the mental disorder: 1) Psychiatric treatment that is more intensive than outpatient care (e.g., partial or inpatient hospitalization) at least two times during the past two years; 2) Supportive services to maintain functioning in the community or in a residential treatment environment (e.g., group home, nursing facility, etc.); OR 3) Intervention by housing or law enforcement officials?

General Directions: The Level II Screen consists of the following five required assessment sections. The objective of each section is noted. Each assessment must be signed and dated.

I. Comprehensive Medical History and Physical (Primary Care) Exam Directions

- **The objective is to determine the basis medical conditions that are present, and to understand how they contribute to the need for nursing home placement**;
- Include medical history, review of body systems, review of neurological system, diagnoses and treatment plan;
- If a physician's assistant or nurse practitioner prepares the history and physical, it must be reviewed and signed by a physician. A previous hospital admission history and physical exam may be used if:
  - It is comprehensive and includes most of the points listed; **and**
  - It was done with in the last three (3) months; **and**
  - It is accompanied by an update that was done within the last ten days; **and**
  - It is accompanied by the previous records or referenced information.

Attach the history and physical.

II. Comprehensive Drug History (Current or Immediate Past Medications Used by the Person) Directions

- **The objective of the Drug History Assessment is to determine all current or immediate past medications that could mask or mimic mental illness symptoms**; and
- Include all medications prescribed during the last month and the use of PRNs and over-the-counter medications—include the dosage (e.g., 20 mg t.i.d.) and the diagnosis/indicators for usage.

The determination regarding the possible masking symptoms or mimicking mental illness in this person **must be completed by a psychiatrist.**

SIGNATURE - Psychiatrist	Date Signed

III. Psychosocial Evaluation Directions

- The object is to determine the individual's ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while in the community;
- The psychosocial evaluation requires the compilation of specific client information upon which the assessments in each category are based. The evaluation data ideally should cover a minimum of two (2) years. If the person has been institutionalized the past two years, provide information regarding functioning level prior to institutionalization;

- The following sections are provided to organize the information that can be compiled by staff trained to go through the person's records. **The assessment should be completed and signed off by a QMHP** and should include information pertinent to how the individual's mental illness has affected his/her functioning level. This section may be dictated and attached or inserted below.

A. **Living Situation**

Dates (approximate) or length of time in the living situation	Type of Provider (i.e., hospital; nursing home; CBRF; adult family home; RCAC; with relatives; independent, including room and board, or with home health services; or homeless). If known, include the name of the provider and location.

B. **Education**

Highest Grade/GED Completed	Year	List any Post-Secondary Education (place, credits, degrees, dates)
Special Education Classes		

C. **Employment**

Name of Employer	Position / Title	Dates/Duration

D. **Social History and Supports**

Marital Status (note dates and changes)	Names and Ages of Children

E. **Substance Abuse/Illegal Drug Use**
List the Types of Drugs Used and Indicate if Still Using or No Longer Using

F. **Current Financial Support**
List Sources of Funding

SIGNATURE – Qualified Mental Health Professional (QMHP)	Date Completed

IV. Functional Assessment

- **The objective is to determine the individual's ability to engage in activities of daily living**;
- Include the level of support which would be needed to assist the individual to perform these activities while living in the community and where that level of support can be provided;
- Data for this part of the assessment should be completed and signed off by any member of the team who meets the QMHP requirements.

Note: If the individual is dually diagnosed, completion of the Level II for Persons with Intellectual/Developmental Disabilities (F-20852) meets the requirements for this section.

	What level of support would this person need to assist him/her to perform this activity in the community?	Can this level of support be provided to the individual in an alternative community setting? If so, what setting?	Is this level of support such that nursing facility placement is required?
1. Self-monitoring of health status (including monitoring and supervising one's own health status, self-administering medication, and scheduling medical treatment).			Yes
2. Self-monitoring of nutritional status (eats balanced diet, appropriate snack foods, and fluids).			Yes
3. Handling money (does not do or has skills but does not have opportunity to do).			Yes
4. Dressing appropriately (on a daily basis; wears weather related clothing).			Yes
5. Grooming (personal hygiene, combs hair, brushes teeth).			Yes

SIGNATURE – Qualified Mental Health Professional (QMHP)	Date Completed

V. Comprehensive Psychiatric and Mental Status Evaluation Directions

- **The objective is to determine the individual's psychiatric status and to determine whether or not the individual needs specialized services for those conditions**;
- Include treatment history, recent and past psychiatric history, mental status exam, diagnoses and treatment recommendations;
- The data for this part of the assessment can be collected by staff trained to compile the past treatment information, but **the assessment must be either reviewed and countersigned or completed by a board certified or board eligible psychiatrist**.

Psychiatric and Mental Status Assessment

A. **Psychiatric Treatment History**

Inpatient/Outpatient Treatment History (start with most recent)	Name of Treatment Provider	Approximate Dates or Length of Time

B. **Recent Psychiatric History**

C. **Past Psychiatric History**

D. **Mental Status Exam** including 1) general appearance; 2) psychomotor; 3) thought content: current abilities, overt behavior, suicidal/homicidal ideation, reality testing, presence and content of delusions and hallucinations; 4) thought form; 5) perceptions; 6) affect and mood; 7) orientation; 8) cognitive functioning and intellect; 9) judgment; and 10) insight into his/her mental illness. **A previous hospital admission history and psychiatric assessment may be used if: 1) it is comprehensive and includes most of the points listed; 2) it was done within the last three (3) months; 3) it is accompanied by an update that was done within the last ten days; and 4) it is accompanied by the previous records or referenced information.**

E. **Summary of Findings, including review of current treatment plan.**

F. **Recommendations for treatment**

SIGNATURE – Psychiatrist	Date Completed