LEVEL I SCREENING FOR NON-MEDICAID NURSING FACILITY APPLICANTS FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, OR RELATED CONDITIONS

Name: _____ **Date of Birth:** _____

Social Security No. _____ **If Applicable Medicaid No.** _____

1. **DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?**

   ☐ Yes ☐ No (If NO, the individual should not be admitted to a NF nor be referred for a Level II Screening.)

   Can a safe and appropriate plan of care be developed to meet all services and supports including medical/nursing/custodial care needs?

   a. ☐ Yes ☐ No

If the answer to #1 is "Yes", the remainder of this form MUST BE COMPLETED.

2. **DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?** ☐ Yes ☐ No

   (Check "Yes" only if each item below are all "Yes". If "No", do not refer for evaluation of active treatment needs for MI Diagnosis.)

   a. Is this major mental disorder diagnosable under DSM (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)?

      ☐ Yes ☐ No

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? ☐ Yes ☐ No

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ☐ Yes ☐ No

3. **DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD) WHICH WAS MANIFESTED BEFORE AGE 18?** ☐ Yes ☐ No

4. **DOES THE INDIVIDUAL HAVE A RELATED CONDITION (RC)?** ☐ Yes ☐ No

   (Check "Yes" only if each item below is checked "Yes". If "No", do not refer for evaluation of active treatment needs for related condition.)

   a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to ID because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of ID persons and requires treatment of services similar to those for these persons? ☐ Yes ☐ No

   b. Has the condition manifested before age 22? ☐ Yes ☐ No

   c. Is the condition likely to continue indefinitely? ☐ Yes ☐ No

   d. Has the condition resulted in substantial limitations in three (3) or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living?

      ☐ Yes (If yes, circle applicable areas) ☐ No

5. **RECOMMENDATION** (Either "a" or "b" must be checked.)

   a. ☐ Refer for Level II evaluation. **DATE LEVEL II REFERRAL MADE** _____

      (NF Placement = Level II refer to Ascend Maximus Management)

      ☐ MI (# 2 above is checked "Yes")

      ☐ ID or Related Condition (# 3 or # 4 is checked "Yes")

      ☐ Dual diagnosis (MI and IDD or Related Condition categories are checked)

** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded NF LTSS until the Level II evaluation has been completed.

   b. ☐ No referral for Level II evaluation for active treatment needs required because individual:

      ☐ Does not meet the applicable criteria for serious MI or ID or related condition

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of ID

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI

      ☐ Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stern level, or other conditions which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services.)

      ☐ Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: _____ **Date:** _____

Telephone #: _____ **Street Address:** _____

LEVEL I SCREENING
FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, OR RELATED CONDITIONS
INSTRUCTIONS FOR COMPLETION

NAME: Enter the Individual's Full Name **DATE OF BIRTH**: MM/DD/YYYY
SOCIAL SECURITY NUMBER: Enter the 9-digit number **IF APPLICABLE THE MEDICAID NUMBER**: Enter the 12-digit number

REQUEST RECEIVED: Enter the date that a request for a Level II evaluation was made

1. **Nursing Facility Level of Care**: Indicate whether the individual meets nursing facility level of care criteria. For reference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid portal.
   If "yes" is checked, complete the screening.
   If "no", is checked, the individual does NOT meet nursing facility level of care criteria, do not complete the Level I screening and do not refer for a Level II evaluation.

2. **Determination of Serious Mental Illness (MI**): Check "yes" (that the individual has a current diagnosis of serious MI) only if each item in 2- a, b and c is checked "yes". Indicate the diagnosis if "yes' is checked. If any answer to a, b or c is "no", then "no" is checked for the overall question and do not **refer for Level II evaluation** for mental illness.
   a. Check "yes' if the individual has a major mental disorder diagnosable under DSM (eg, schizophrenia (including disorganized, catatonic, and paranoid types), mood (including bipolar disorder (mixed depressed, seasonal, or NOS)). Major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder NOS, cyclothymia, dysthymia (primary/secondary or early/late onset). Paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder), panic or other severe anxiety disorder (including panic disorder with agoraphobia. agoraphobia with or without history of panic disorder, social anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder), somatoform disorder (includes somatization disorder, conversion disorder somatoform pain disorder, hypochondriasis. body dysmorphic disorder, undifferentiated somatotorm disorder, somatoform disorder NOS). Personality disorder (includes paranoid. schizoid. sehizotypal. histrionic, narcissistic, antisocial, borderline. avoidant, dependent. obsessive compulsive, passive aggressive, and NOS), other psychotic disorder (includes schizophreniform disorder. schizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical NOS or other mental disorder that may lead to a chronic disability).
   b. Check "yes" if the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning concentration, persistence, pace and adaptation to change
   c. Check "yes' if the individual's treatment history indicates that he or she has experienced (1) psychiatric treatment more intense than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder

3. **Determination of Intellectual Disability ID: Check "yes' if** the **individual** has a level of intellectual disability **(**mild, moderate, severe, or profound) described in the Classification in Mental Retardation: Chapter 3. American Association on Mental Deficiency (AAMD), 1983 that was manifested before **age 18.** Please note this reference is specifically cited in the Code of Federal Regulations but the AAMD is now known as the American Association on Intellectual and Developmental Disabilities (AAIDD) and the term Mental Retardation is no longer standardly used and has been replaced with Intellectual Disability.

4. **Determination of Related Conditions**: Check 'yes' for answer for 4, only if each item in 4, a-d is checked "yes". If any answer to a-d is "no", then "no" is checked for the overall question and do not **refer for Level II evaluation** for related conditions.
   a. Check 'yes' if the condition is attributable to any other condition (e g, cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to intellectual disability because this **condition** may result in impairment of general intellectual functioning or adaptive behavior similar to that of persons living with ID and requires treatment or services similar to those for persons living with ID.
   b. Check 'yes" if the condition has manifested before **age 22**
   c. Cheek "yes" if the condition is likely to continue indefinitely
   d**.** Check "yes' if the condition has resulted in substantial limitations in three (3) or more of the following areas of major life activity: self-care, understanding, use of language, learning, mobility, self-direction, and capacity for independent living. Circle the applicable areas.

5. **RECOMMENDATION** (Either 5a or b MUST be checked)
   a. Check this category if Question 2 is checked 'yes' AND/OR either Question 3 or 4 is checked "yes". Indicate whether referral is for MI, ID or RC, the date the package is referred to the appropriate Level II evaluator, and where and to whom the package is sent. An individual for whom 5a has been checked may NOT he admitted to a LTSS until the secondary evaluation is completed.

   b. Check this "no referral needed" category ONLY if there is documented evidence as follows
   - Does not meet the 'applicable criteria For MI, ID or a related condition.
   - Has a primary diagnosis of dementia (including Alzheimer's disease), If there is a diagnosis of ID this category does not apply.
   - Has a primary diagnosis of dementia (including Alzheimer's disease) AND a secondary diagnosis of MI.
   - Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other diagnoses, which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services. If the answer determines that an illness not listed here is so severe that the individual could not be expected to benefit from specialized services, documentation describing the severe illness must be attached for review).
   - Is terminally ill (note: a physician must document that individual's life expectancy is less than 6 months).

NOTE: WHEN A LEVEL I SCREENING HAS NOT BEEN PERFORMED PRIOR TO AN INDIVIDUAL'S ADMISSION TO A NF FEDERAL FINANCIAL PARTICIPATION (FFP) WILL NOT BE AVAILABLE UNTIL A SCREENING IS COMPLETE.

SCREENER INFORMATION

SIGNATURE: First Name, Middle initial, and Last Name
TITLE: Professional title of the screener
SCREENING ENTITY: Name of entity (organization) which performed the screening
DATE: Date screening was completed
TELEPHONE NUMBER: Telephone number, including area code
STREET ADDRESS: Complete Street address, including city-state and zip code