**CARE LEVEL II PRE-ADMISSION SCREEN**

**FOR PERSONS WITH MENTAL ILLNESS**

*All questions must be answered completely*

\*Date Referral to HIS       Date Referred to Assessor

Date of Assessment       \*Tracking Number

Date Faxed to HIS       *\*This information will be provided to you by HIS*

# SECTION I – IDENTIFICATION

**Name:**       Phone: (     )      -      DOB:

Residential Address:

     ,      

County:

SSN:      -     -      Gender:

Medicaid Number:       County of Responsibility:

**Current Location:**       Ward/Unit:

Current Address:

     ,

County:

Contact Person:       Admission Date:

Phone: (     )      -      Fax: (     )      -      Email

**Attending Physician:**       Phone: (     )      -

Physician’s Address:

     ,

County:

**Proposed Facility (if applicable):**

Contact Person:

Address:

     ,

County:

Phone: (     )      -      Fax: (     )      -

Proposed Date of Admission:

Please give the following information about any individuals serving as (**attach signature page of the court order**):

Guardian   DPOA  Other Legal or Medical Representative

**Name:**

Address:

     ,

County:

Home Phone: (     )      -      Work Phone: (     )      -      Email

Does the individual have another person involved in a significant way from whom we may be able to obtain additional information about the individual’s social, medical, emotional or environmental history and status?

If “yes,” please provide the following information:

**Name**:

Address:

     ,

County:

Home Phone: (     )      -      Work Phone: (     )      -

Relationship to individual:

## SECTION II – EXCLUSIONS

1. List all diagnoses according to the current DSM manual. Please list diagnosis code as well as descriptions. If QMHP disagrees with diagnosis of record please discuss in **Clinical Summary section**, Question #25, at this time.

**Diagnostic Code Description**

             
            

             
              
              
              
              
            

a) Does the individual have a major mental illness listed as defined by PASRR in Section II, pages 7 & 8 of the manual?

b) Does the individual have a primary diagnosis of dementia or a dementia-related disorder listed?

c) Does the individual have a non-primary diagnosis of dementia or a dementia-related disorder AND is the primary diagnosis something other than a major mental disorder?

**If the answer to (#1a is NO) or #1b or #1c is YES, the assessment is finished. Please provide documentation to support your answer and proceed to Sections VIII, IX, & X.**

2. Does the individual have a level of impairment resulting in functional limitations in major life activities, DUE TO HIS/HER MENTAL ILLNESS, within the past 3 to 6 months (interpersonal functioning, concentration, persistence, and pace, and adaptation to change)?

3. Does the recent treatment history indicate that the individual has experienced at least one of the following:

a) Psychiatric treatment more intensive than outpatient care more than one time in the past two years (e.g. partial hospitalization or inpatient hospitalization) **OR**

b) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention of housing or law enforcement officials.

If the answers to #2 or #3 is NO, the assessment is finished. Proceed to Sections VIII, IX, & X.

4. a) Does the individual have a clinical diagnosis of one or more of the following medical conditions? Check all that

apply. Supporting documentation must be attached to this assessment if any of these diagnoses apply. (If NONE is marked, proceed to #5)

NONE

PARKINSON’S DISEASE  HUNTINGTON’S DISEASE

AIDS  MULITPLE SCLEROSIS

BRAIN STEM INJURY  COPD

CHF  AMYOTROPHIC LATERAL SCLEROSIS (Lou Gehrig’s disease)

b) After interviewing the individual, legal guardian, family members, clinical staff, and reviewing the medical records, is it your professional clinical judgment that the medical condition indicated above is of a progressive degenerative or permanent nature?

(If No, proceed to #5)

c) If yes, is the individual being screened currently experiencing increasing levels of deterioration (due to the condition indicated above to the point that the medical condition listed above is the primary factor in determining the needs of the individual and the individual can no longer benefit from specialized services for persons with mental illness?

(If No, proceed to #5)

If #4b and #4c are both YES, the assessment is finished. Please provide supporting documentation and proceed to Sections VIII, IX & X.

## SECTION III – SERVICE/TREATMENT INFORMATION

5. Is there an active service/treatment plan in place?

*If this is a discharge from a state mental health hospital, a community mental health center liaison from the county of responsibility must be involved in the discharge plan.*

6. Is there a community mental health center involved in the service/treatment plan?

a) If yes, state the name of the CMHC:

b) Are there other mental health providers involved?

If **Yes**, list contact person and phone numbers of those involved and explain:

7. Name and phone number of service provider who is primarily responsible for the management of this individual’s mental health care needs in a community setting:

8. What is the proposed discharge/movement date from the current facility/location? The date or time frame must be given and must be writing the next 30 days.

9. If the individual is in a facility (i.e. state hospital, jail, rehabilitation or treatment center), what is the discharge planner’s name and phone number:

## SECTION IV – PRESENTING PROBLEM

10. Why is this individual being referred for nursing facility admission at this time?

a)  Needs medication management assistance.

Has difficulty remembering to take medications or is unable to take medications accurately.

Refuses to take prescribed medications.

Is unable to keep doctor appointments or obtain medications independently.

Uses non-prescription medications in a manner that interferes with prescription medication use.

Other

Please Explain:

b) Has the individual received case management assistance, medication assistance, medication reminders, medication drops, or other medication management assistance from a CMHC or other community agency in the past 6 months?

If not, explain why services were not provided, were discontinued or failed:

c) Needs assistance with Activities of Daily Living and Instrumental Activities of Daily Living:

*Check your response under the code* for EACH activity of IADL and ADL that indicates the average level of functioning for this individual during the course of the day in their present setting.

1. Independent

2. Supervision needed

3. Physical assistance needed

4. Unable or unwilling to perform

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **IADL’S** | | | |
|  | **1** | **2** | **3** | **4** |
| Meal Preparation |  |  |  |  |
| Shopping |  |  |  |  |
| Money Management |  |  |  |  |
| Transportation |  |  |  |  |
| Use of Telephone |  |  |  |  |
| Laundry/Housekeeping |  |  |  |  |
| Management of Medicine/Treatment |  |  |  |  |
| Keep Appointments |  |  |  |  |
| Seek Medical Help |  |  |  |  |
| Obtain Housing |  |  |  |  |
| Structuring Free Time |  |  |  |  |
| Weekdays |  |  |  |  |
| Evenings |  |  |  |  |
| Weekends |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **ADL’S** | | | |
|  | **1** | **2** | **3** | **4** |
| Bathing |  |  |  |  |
| Dress Appropriate |  |  |  |  |
| Toileting |  |  |  |  |
| Transfer |  |  |  |  |
| Walking/Mobility |  |  |  |  |
| Eating |  |  |  |  |

Comments:

d) Has the individual received case management assistance, attendant care service, skills teaching, or other daily living assistance from a CMHC or other community agency in the past 6 months?

If not, please explain why services were not provided, were discontinued or failed:

e) Currently has significant medical needs or need for special treatments requiring 24-hour nursing care. (Check all that apply.)

Incontinence

Monitoring of special diet (e.g. Diabetic)

Monitoring of fluid intake

IV medications or feeding tube

Mobility Assistance

Other

Please Explain:

f) Currently displays behaviors not tolerated by the community. (Check all that apply.)

Frequent / continuous yelling

Verbally Abusive or threatening

Damages / destroys property

Sexually aggressive / exposes self

Other

Please explain:

g) Has the individual received case management, attendant care service, counseling/therapy, or other behavior management assistance from a CMHC or other community agency in the past 6 months?

If not, please explain why services were not provided, were discontinued or failed:

h) Currently exhibits (within the past 6 months) dangerous behaviors. (Check all that apply.)

Injuries to self (Including suicide attempts)

Injuries to others

Wandering without regard to safety

Fire setting

Isolates self (refuses basic nutrition, refuses contact with service providers)

Other:

Please explain:

i) Did any of the behaviors indicated in the check boxes marked above result in intervention by the following? (Check all that apply.)

Adult Protective Services

Law Enforcement

Hospitalization

Incarceration

Other:

Please explain:

## SECTION V – MEDICAL HISTORY AND PHYSICAL

11. Please attach the most recent **MEDICAL HISTORY AND PHYSICAL**.

*THIS ASSESSMENT CAN NOT BE ACCEPTED WITHOUT THESE DOCUMENTS AND WILL BE COUNTED AS AN INCOMPLETE ASSESSMENT.*

12. List all medications the individual currently takes including over the counter medication, and indicate whether the medication is: S = Stable *OR* A = Being Adjusted.

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| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **FREQ** | **ROUTE** | **S/A** |
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13. List all medications the individual has taken during the last three months excluding those listed above unless there is a change in dosage.

| **MEDICATION** | **DOSAGE** | **FREQ** | **ROUTE** | **S/A** |
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## SECTION VI – PSYCHIATRIC TREATMENT HISTORY

***This must include detailed information for the assessment to be considered complete.***

14. a) Past Diagnosis(es):

b) Psychiatric Hospitalizations (specify locations, admit/discharge dates, and reasons for admission

for the **past two years**):

c) History of suicidal or homicidal attempt or ideation:

d) Outpatient Psychiatric Treatment (specify service providers and dates of service):

15. Have the following intensive mental health community support services been provided in the past two years? (Check all that apply.)

Intensive Case Management

Attendant Care Service

Respite / Crisis stabilization service

Medication assistance (med. drops, med. boxes, education, etc)

Residential services (supervised group home, nursing facility, family home)

In-home skills teaching and psychosocial rehabilitation

Home-Health care services

Other

16. Explain why community support services have not been provided or why those services marked above have failed

17. Substance Abuse Treatment (specify service providers and dates of service for the past 2 years):

**SECTION VII – LIVING ARRANGEMENT AND SUPPORT NETWORK**

18. Indicate the individual’s preferred living arrangement (individual’s choice, not service provider’s recommendation):

19. If there is a legal guardian, do they agree with the individual’s choice of living arrangement?

If no, please explain:

20. The individual currently has a residence available?

Please describe:

21. Please check all boxes describing living situations in which the individual has resided since age 18, and indicate the approximate length of time resided and reason individual is not returning to/remaining in living situation.

Lived Alone in Own Apartment/House/Etc.

Lived with Relatives/Friends

Lived in Homeless Shelter and/or Place(s) Not Meant for Human Habitation

Lived in Group Home/Transitional Living Center/Treatment Center Assisted Living Facility/Boarding Home

Lived in Nursing Facility/Nursing Facility for Mental Health

Other:

Please explain:

22. Individual’s Support Network includes: Check available supports and provide specific information (names, phone numbers, availability, etc. ) in space provided.

Family Members – Identify:

Case Manager -- Identify:

Guardian or Payee – Identify:

Others – Identify: :

23. Community Support Services and Resources Needed: Check all that apply. Indicate whether they would be available, not available or unknown.

| **NEEDED** | **AVAILABLE** |  | **NOT**  **AVAILABLE** |  | **UNKNOWN** |
| --- | --- | --- | --- | --- | --- |
| Affordable housing or housing subsidy |  |  |  |  |  |
| Attendant care services (estimated hrs per day or week      ) |  |  |  |  |  |
| Case management service to assist with goal planning, mobilizing community supports, problem solving, assisting the individual to learn to use available resources and crisis intervention |  |  |  |  |  |
| Crisis stabilization/Respite Program available as needed |  |  |  |  |  |
| Housekeeping services |  |  |  |  |  |
| In-home medication services (Med drops, prompts to take meds, etc) |  |  |  |  |  |
| Psychiatric services and medication management |  |  |  |  |  |
| Meals on Wheels or other nutritional program |  |  |  |  |  |
| Money management assistance or Conservator or Payee |  |  |  |  |  |
| Natural supports: such as family, roommates, friends, church, etc) |  |  |  |  |  |
| Psychosocial rehabilitation (including in-home skills teaching) |  |  |  |  |  |
| Recreational activities |  |  |  |  |  |
| Social Support Activities (or Consumer-Run Drop-In Center0 |  |  |  |  |  |
| Transportation assistance |  |  |  |  |  |
| Vocation assistance |  |  |  |  |  |
| **Medical Assistance** |  |  |  |  |  |
| Assistive devices |  |  |  |  |  |
| Personal care services (assistance with hygiene, eating, etc) |  |  |  |  |  |
| Nursing care (Visiting nurses in community) |  |  |  |  |  |
| **Substance Abuse Services** |  |  |  |  |  |
| AA/NA programs appropriate for persons with dual-diagnosis |  |  |  |  |  |
| Out-patient chemical dependency treatment |  |  |  |  |  |
| **Other services (*please list* below)** |  |  |  |  |  |
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***Please list agency responsible for providing these services in #23***

Please Explain:

SECTION VIII – MENTAL STATUS EVALUATION

24. Mental status evaluation is the psychological counterpart of a physical examination that provides specific, accurate information about current behavior and mental capabilities. A review of the individual’s current record or chart should assist in the completion of the evaluation. The individual being assessed must be interviewed. Any difficulties with this portion should be discussed in clinical summary section, question #25.

**General Appearance**

Appropriate hygiene/dress

Poor personal hygiene

Overweight  Underweight

Eccentric  Seductive

## Sensory/Physical Limitations

No limitations noted

Hearing  Visual

Physical  Speech

**Mood**

Cooperative  Calm

Cheerful  Anxious

Depressed  Fearful

Suspicious  Labile

Tearful  Pessimistic

Euphoric  Irritable

Guilty  Hostile

Dramatized  Apathetic

Elevated mood

Marked mood shifts

Affect

Primarily appropriate

Primarily inappropriate

Restricted  Blunted

Flat  Detached

**Speech**

**Unable to assess**

Logical/Coherent  Loud

Delayed responses  Tangential

Rambling  Slurred

Rapid/Pressured

Incoherent/loose associations

Soft/Mumbled/Inaudible

**Thought Content/Perceptions**

***Unable to assess***  Delusions

No disorder noted  Grandiose

Paranoid  Racing

Circumstantial  Obsessive

Disorganized  Flight of ideas

Bizarre  Blocking

Auditory Hallucinations

Visual Hallucinations

Other hallucinatory activity

Ideas of reference

Illusions/Perceptual distortions

Depersonalization or derealization

**Memory**

***Unable to assess***

No impairment noted

Impaired remote

Impaired recent

**Insight (Age Appropriate)**

***Unable to assess***

Good  Fair

Poor  Lacking

**Orientation**

***Unable to assess***  Impaired time

Oriented X4  Impaired person

Impaired place

Impaired situation

**Cognition/Attention**

***Unable to assess***

No impairment noted

Distractibility/Poor concentration

Impaired abstract thinking

Impaired judgment

Indecisiveness

**Behavior/Motor Activity**

***Unable to assess***

Normal/Alert  Poor eye contact

Self-Destructive  Uncoordinated

Lethargic  Catatonic

Repetitious  Tense

Agitated  Withdrawn

Tremors/Tics

Aggression/Rage

Restless/Overactive

Peculiar mannerisms

Bizarre behavior

Impulsiveness

Compulsive

Indiscriminate socializing

Disorganized behavior

Feigning of symptoms

Avoidance behavior

Increase in social, occup., sexual activity

Decrease in energy, fatigue

Loss of interest in activities

**Eating/Sleep Disturbance**

***Unable to assess***

No disturbance noted

Decreased/Increased appetite

Binge eating

Self-induced vomiting

Weight gain/loss (lbs/time     )

Hypersomnia/Insomnia

Bed-wetting

Nightmares/Night Terrors

**Anxiety Symptoms**

***Unable to assess***

Within normal limits

Generalized anxiety

Fear of social situations

Panic attacks

Obsessions/Compulsions

Hyper-vigilance

Reliving traumatic events

## Conduct Disturbance

***Unable to assess***

Conduct appropriate

Stealing  Lying

Projects blame  Fire setting

Short-tempered

Defiant/Uncooperative

Violent behavior

Cruelty to animals/people

Running away  Truancy

Criminal activity  Vindictive

Argumentative

Antisocial behavior

Destructive to others or property

**Occupational & School Impairment**

***Unable to assess***

No impairment noted

Impairment grossly in excess than expected in physical finding

Impairment in occupational functioning

Impairment in academic functioning

Not attending school/work

**Interpersonal/Social Characteristics**

***Unable to assess***

No significant trait noted

Chooses relationships that lead to disappointment

Expects to be exploited or harmed

by others

Indifferent to feelings of others

Interpersonal exploitiveness

No close friends or confidants

Unstable and intense relationships

Excessive devotion to work

Inability to sustain consistent work behavior

Perfectionistic  Grandiose

Procrastinates  Entitlement

Persistent emptiness & boredom

Constantly seeking praise or admiration

Excessively self-centered

Avoids significant interpersonal contacts

Manipulative/Charming/Cunning

NOTES:

## SECTION IX – SUMMARY AND FINAL RECOMMENDATIONS

25. **Clinical Summary**: (If additional space is needed please attach another page. If another page is attached, please sign and date the attached page).

26. Mark the appropriate placement/service recommendation:

Nursing facility or NFMH level of care **is** needed/Specialized mental health services **are not** needed in an acute care psychiatric hospital

Nursing facility or NFMH level of care **is not** needed/Specialized mental health care services **are** needed in an acute care psychiatric hospital

Nursing facility or NFMH level of care **is not** needed/Specialized mental health services **are not** needed in an acute care psychiatric hospital

27. Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. Please give additional service recommendations that would be beneficial for this individual’s needs (regardless of above recommendations). What additional services, resources, or referrals would benefit this individual, please be specific. Note: The CMHC liaison must be given a copy of these recommendations/referrals.

28. What resources were utilized to gather information for this assessment? ***Include names of individual and title.*** If family member or guardian is not involved in the assessment, please explain why in the remarks section of this question.

Date of interview with individual (face to face):

***Guardian should be included in the assessment!***

Guardian:       Date Interviewed:

(indicate if interview was by phone)

Family Members:

Health Care Professionals (Must be interviewed and listed):

Clinical Records:

Minimum Data Set (MDS) Version 2.0:        
Remarks:      

29. Exact location of where the assessment took place:

**SECTION X – QMHP SIGNATURE**

30. Assessor’s Name:        
*Print your full name (first, middle initial, last) and title*

Assessor’s phone number(s):

Date:

Assessor’s license type and number:

Assessor’s Email address:

Assessor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. Is this Level II a courtesy assessment?

Date Faxed to responsible CMHC:

Contact Person at responsible CMHC:

32. Time Documentation Summary:

Screen Time:       Hours       Minutes

Travel Time:       Hours       Minutes

Total Time:       Hours       Minutes

33.The individual’s financial resources include:

SSI/SSDI eligibility

Other income

Section 8 or other housing assistance, i.e. Alternate Care

Food Stamps

LIEAP

Veterans Benefits

CMHC Flex Funds

Others benefits/formal supports

Please explain:

***PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO MAKE SURE ALL NECESSARY REFERRALS ARE MADE***