**CARE LEVEL II RESIDENT REVIEW**

**FOR PERSONS WITH MENTAL ILLNESS**

*All questions must be answered completely*

Previous Assessment Date:

\*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 #16.

 **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 Question #5 and Sections V, VII, & VIII.**

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 Question #5 and Sections V, VII, & VIII.

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 Question #5 and Sections V, VII, & VIII.

5. Reason for Resident Review:

 [ ]  The review was requested by nursing facility due to significant change in the individual’s condition.

 [ ]  The diagnosis of SPMI was uncovered after admission to the nursing facility.

 [ ]  The individual with a serious mental illness was admitted prior to 1989 and has never been assessed as part of the Level II process.

 [ ]  The individual was approved for a temporary nursing facility rehabilitation stay, and the stay will exceed the time frame allowed in the determination letter.

 [ ]  The individual will exceed the temporary 30-day nursing facility stay.

 Please explain:

## SECTION III – SUMMARY OF TREATMENT SINCE LAST REVIEW

6. Please attach the most recent MEDICAL HISTORY and PHYSICAL from the clinical record. The review cannot be accepted without these documents and will be counted as an incomplete assessment.

7. Please describe any changes in living arrangements (including hospitalizations) that have occurred since the last review. State reasons and dates for these changes:

8. Please describe any changes in physical condition (positive or negative) and medical needs of this individual. Include any special needs, equipment, treatment or assistance this individual requires:

9. a) List all medications the individual currently takes including over the counter medication, and indicate whether

 the medication

 is: S = Stable *OR* A = Being Adjusted.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | FREQ | **ROUTE** | **S/A** |
|       |       |       |       |       |
|       |       |       |       |       |
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 b) Has there been a change in medication since the last review?

 If yes, please describe:

10. Have the recommendations listed in the PASRR Level II approval letter been addressed? *Please photocopy and attach a copy of the letter.*

 Please explain:

## SECTION IV – CURRENT LEVEL OF FUNCTIONING

11. *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** | **Change since last review** |
| 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** | **Change since last review** |
| Bathing | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Dress Appropriate | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Toileting | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Transfer | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Walking/Mobility | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Eating | [ ]  | [ ]  | [ ]  | [ ]  |  |

 Comments:

SECTION V – MENTAL STATUS EVALUATION

12. a) Complete a mental status exam. 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 #16.

**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:

##  b) List any changes since last review (include cognition, memory, orientation, behavior, sensorimotor, social and effect):

#### SECTION VI – CURRENT STATUS

13. Has there been a change since the last review regarding the individual’s preferred living arrangement (individual’s choice, not service provider’s recommendation.):

 If yes, please describe:

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

 If no, please explain:

15. a) Is there a date set for discharge?

 Proposed Date:

 If yes, where will the individual move upon discharge?

 b) Has CMHC case manager been assigned?

 If yes, indicate the CMHC, case manager’s name, and phone number:

 If no, please explain:

## SECTION VII – SUMMARY AND FINAL RECOMMENDATIONS

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

17. 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

18. 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.

19. 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:

20. Exact location of where the assessment took place:

**SECTION VIII – QMHP SIGNATURE**

21. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Is this Level II a courtesy assessment?

 Date Faxed to responsible CMHC:

 Contact Person at responsible CMHC:

23. Time Documentation Summary:

 Screen Time:       Hours       Minutes

 Travel Time:       Hours       Minutes

 Total Time:       Hours       Minutes

24. 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***