2/13/24

To: James Peterson

From: Catherine M Clem RN

3154041237 - for questions

Packet on Phelan DOB 12/31/66

ASCEND
A MAXIMUS COMPANY

NEW YORK PASRR REFERRAL INTAKE FORM

Include this completed form as the first page of your Level II referral following the fax coversheet. All fields are required.

Required documents: Intake form, H&P, PRI, SCREEN

Return this content to Ascend, a MAXIMUS Company: ***877-431-9568.***

Print legibly to prevent delays. Outcomes will be **faxed 5 business days** from receipt of necessary information.

Individual's Full Legal Name: Phu (First) Le (Last) Date of Birth: 12/31/66

Individual's Mailing Address: 1206 Elm ST (Street) Utica (City) NY (State) 13502 (Zip)
Oneida (County)

Social Security Number: 098-80-6293 Marital Status: D Gender: F

Race: Vietnamese Primary Language: Vietnamese Translation Services Needed: ☑ Yes ☐ No Son Anthony will be present

Individual's Current Location: Home 1206 Elm ST. Utica Date of Admission: 0

Current Location Type: ☐ Community Setting ☐ Medical facility medical unit ☐ Medical facility ER/ED ☐ Medical facility psychiatric unit ☐ Psychiatric facility ☐ Nursing facility ☑ Other Home & family

Location Address: 1206 Elm ST Utica NY 13440 (Street / City / State / Zip)

Location Phone: 315 801 1500 Anthony son

Method of Payment: ☐ Self-Pay ☑ Medicare ☐ Medicaid ☐ Private Insurance ☐ Medicaid Pending
Medicare ID Number # CG026915
Medicaid ID Number # 4TI2EW4FY09

Legal Guardian: ☐ Yes ☑ No ***Legal Guardian is a court appointed representative. Do not include next of kin or POA.***

Legal Guardian Name: / Legal Guardian Phone Number:

Legal Guardian Address: *(required if applicable)* (Street / City / State / Zip)

Primary Care Physician: Thang Quac Le MD. ☐ N/A Physician Phone Number: 3158940071

Physician Address: *(required if applicable)* 1729 Burrstone Rd (Street) New Hartford (City) NY (State) 13413-1001 (Zip)

Referral Organization/Facility Name: NCitonic@gmail.com

Referral First and Last Name: Anthony Nguyen Referral Email: NCitonic@gmail.com

Referral Phone Number: 3158011500 Referral Fax Number: *Outcomes will be faxed to this number* 0

Review Type: ☐ Preadmission ☐ Status Change/Resident Review **Indicate reason below:**
☐ Psychiatric Hospitalization ☐ Increase in behavioral health symptoms
☐ Change in psychiatric diagnosis(es) ☐ Improvement in functional status
☐ Other (specify): Son is main care giver, works full time + Him mom needs more supervision + assistance than he can provide. She is not safe @ home c.c

NEW YORK STATE DEPARTMENT OF HEALTH
OHSM-Division of Quality and Surveillance for Nursing Homes and ICFs/MR

Hospital and Community Patient Review Instrument (HC-PRI)

NCitoNi@gmail.com

RUG II Group (print name) PA 3
RHCF Level of Care: ☑ HRF ☐ SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER (1-8) 6027-L001

2. SOCIAL SECURITY NUMBER (9-17) 098-80-6293

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW Nascentia

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY) Phu Le ~~C 225 Herkimer Rd Apt B34~~ 1206 Elm ST Utica NY 13502

4B. COUNTY OF RESIDENCE Oneida

5. DATE OF PRI COMPLETION (18-25) 2/13/24
MO DAY YEAR

6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34) 0

7. HOSPITAL ROOM NUMBER (35-39) 0

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING 0

9. DATE OF BIRTH (40-47) 12/31/66
MO DAY YEAR

10. SEX (48)
1=Male
2=Female (circled)

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT 0
(49-56) - -
MO DAY YEAR

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)
(57-64) - -
MO DAY YEAR

12. MEDICAID NUMBER (65-75) CG02691S

13. MEDICARE NUMBER (76-85) 4T12EW4FY09

14. PRIMARY PAYOR (86)
1=Medicaid (circled)
2=Medicare
3= Other

15. REASON FOR PRI COMPLETION (87)
1. RHCF Application from Hospital
2. RHCF Application from Community (circled)
3. Other (Specify:)

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. 0

17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS
1=YES
2=NO

A. Comatose	2
B. Dehydration	2
C. Internal Bleeding	2
D. Stasis Ulcer	2
E. Terminally Ill	2
F. Contractures	2
G. Diabetes Mellitus	2
H. Urinary Tract Infection	2
I. HIV Infection Symptomatic	2
J. Accident	2
K. Ventilator Dependent	2

18. MEDICAL TREATEMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.
1=YES
2=NO

A. Trachesotomy Care/Suctioning (Daily—Exclude self-care)	2
B. Suctioning-General (Daily)	2
C. Oxygen (Daily)	2
D. Respiratory Care (Daily)	2
E. Nasal Gastric Feeding	2
F. Parenteral Feeding	2
G. Wound Care	2
H. Chemotherapy	2
I. Transfusion	2
J. Dialysis	2
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS)	2
L. Catheter (Indwelling or External)	2
M. Physical Restraints (Daytime Only)	2

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) **19.** (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.

2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.

4=Totally fed by hand, patient does not manually participate

5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT **20.** (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.

2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3= Walks with *constant* one-to-one supervision and/or constant physical assistance.

4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). QRN may need assistance to stand from sitting **21.** (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.

2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.

4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.

5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. **22.** (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands). reminders for post toilet hygiene

3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).

4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.

5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. **23.** (117)

1=No known history

2=Known history or occurrences, but not during the past week (7 days)

3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH **INTENT FOR INJURY**. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) **24.** (118)

1=No known history.

2=Known history or occurrences, but not during the past week (7 days).

3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

E - 2-1
I - 1-1
T 2-1
T 3

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. **25.** (119)

1=No known history
2=Displays this behavior, but is not disruptive to others (for example, rocking in place).
3=Known history or occurrences, but not during the past week (7 days).
4=Occurences of this disruptive behavior at least once during the past week (7 days)
5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. **26.** (120)

1=Yes visits Mental Health Clinic **2**=No
Client monthly; has visual, Olfactory & Tactile hallucination
CL
3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level (121) /
P.T. Days (122) /
P.T. Time (123-126) 0 HOURS MIN/WEEK

B. Occupational Therapy (O.T.)

O.T. Level (127) /
O.T. Days (128) /
O.T. Time (129-132) 0 HOURS MIN/WEEK

LEVEL
1=Does not receive.
2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.
4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. **28.** (133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem drug induced Parkinson **29.** (135-139) -

If code cannot be located, print medical name here: AMS (altered mental status)

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is **attached** to this H/C-PRI.

30. DIAGNOSES AND PROGNOSES: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1. drug induced Parkinson disease

Secondary (Include Sensory Impairments)

1. Chronic hepatitis B
2. Hx urinary stones
3. Hx Chronic UTI
4. hydronephrosis
   microscopic hematuria

see attached

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION
see attached				

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY
0		

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

allergies - NKA → NO

diet - regular - soft foods due to missing teeth + Chewing is difficult

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP **34.**

1=White
2=White/Hispanic
3=Black
4=Black/Hispanic
5=Asian or Pacific Islander
6=Asian or Pacific Islander/Hispanic
7=American Indian or Alaskan Native
8=American Indian or Alaskan Native/Hispanic
9=Other Vietnamese

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

☑ YES ☐ NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

Catherine M Clem RN
SIGNATURE OF QUALIFIED ASSESSOR

IDENTIFICATION NO. 28636

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care – Division of Residential Services

SCREEN

A Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) must be completed before beginning the SCREEN form. Refer to the SCREEN Instructions (DOH-695i) when completing the SCREEN form.

IDENTIFICATION

1. Facility Operating Certificate Number: 6027L001 Nazareth
2. Patient/Resident/Person's Social Security Number: 098 | 80 | 6293
3. Name of Person(s) Completing SCREEN: Catherine M Clem RN
4. Patient/Resident/ Person's Name: Peter C
5. Date of HC-PRI or PRI Completion: 2/13/24
6a. Date of SCREEN Initiation: 2/13/24
6b. Date of SCREEN Completion:

DIRECT REFERRAL FACTOR FOR RESIDENTIAL HEALTH CARE FACILITY (RHCF)

	YES	NO	
7.	☑	☐	This person has a home in the community (owns or rents a home, lives in an Adult Care Facility or with family or friends) and that residence is still available OR appropriate community based living can be arranged OR this person is eligible for an Adult Care Facility.

Guideline: **If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT (items 8 -12). If item 7 is marked NO, explain on a separate sheet of paper and attach to this form; refer to RHCF. Proceed to REFERRAL RECOMMENDATION (item 21).**

DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT

Answer all items 8-12

	YES	NO	
8.	☐	☑	This person understands information given and opposes placement/continued stay in a Residential Health Care Facility.
9.	☐	☑	This person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility. Evaluator specifically described all necessary community services and described private resources (such as insurance coverage, savings, income or financial aid provided by a spouse, relative or friend) that may be available to pay for such services. Medicare and Medicaid should NOT be included as private financial resources.
10.	☐	☑	This person has an informal support system. Individuals in this system are willing and are physically and mentally capable of caring for this person, and providing for most of his/her specific needs.
11.	☑	☐	All ADL responses = 1 or 2 (see PRI or HC-PRI PART III, 19-22)
12.	☐	☑	This person was independent in ADLs prior to most recent acute episode and shows good rate of return of physical and mental functioning.

Guideline: **If any direct referral factor (items 8-12) is marked YES, refer to a Certified Home Health Agency (CHHA) for a community based assessment. Attach assessment to the SCREEN, then proceed to REFERRAL RECOMMENDATION (item 21). If all referral factors (items 8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS (Item 13).**

HOME AND CAREGIVING ARRANGEMENTS

13. a. Estimate the total number of hours per day that the informal support(s) system is willing and able to provide supervision or assistance to this person. a. _____

b. Estimate the total number of hours per day that this person can be alone. b. _____

c. Add **a** and **b** (**a+b=c**) ..... c. _____

YES	NO	
☐	☐	d. Does **c.** total 12 or more hours?

Guideline: **If item 13d. is marked YES, proceed to item 16.**
If item 13d. is marked NO, proceed to item 14.

YES NO

14. ☐ ☐ Can the number of hours that this person is attended by self or informal supports be expected to increase to 12 or more hours per day within six months?

Guideline: **If item 14 is marked YES, proceed to item 16.**
If item 14 is marked NO, proceed to item 15.

15. If the answer to item 14 is NO, enter reason(s) (a, b, and/or c): _____

a. This person's physical and/or mental condition is not expected to improve to a degree that would permit increased self care within six months.
b. Person has no informal supports.
c. Informal supports are unable or unwilling to provide additional assistance, or person does not want care from informal supports.

Guideline: **Proceed to item 16**

YES NO

16. ☐ ☐ Is there a need for restorative services documented by a physician or rehabilitation specialist?

Guideline: **If item 16 is marked YES, proceed to item 17.**
If item 16 is marked NO, proceed to item 19.

YES NO

17. ☐ ☐ Can this person receive restorative services at home, at adult day care, or as an outpatient?

Guideline: **If item 17 is marked YES, proceed to item 19.**
If item 17 is marked NO, proceed to item 18.

18. If the answer to item 17 is NO, enter reason(s) (a, b and/or c): _____

a. Restorative services are not available in this person's community.
b. Restorative services are too costly or not covered in this person's community.
c. This person cannot access restorative services in their community.

Guideline: **Proceed to item 19.**

YES NO

19. ☐ ☐ Does this person have any risk factors that could cause undue risk to self or others if placed in the community?

If YES, enter reason(s) (a, b, c and/or d):_____

a. This person has a history of unpredictable behaviors and may injure self or others. This condition is not temporary.
b. Comatose (PRI or H-C PRI Part II, 17 A) or all ADL responses = 4 or 5 (PRI or H-C PRI PART III, 19-22).
c. Requires constant monitoring due to health threatening medical conditions.
d. Skilled services are needed at least one time per day and cannot be delegated to nonprofessionals or informal supports.

Guideline: **Proceed to item 20.**

YES NO

20. ☐ ☐ Based on the answer to item 19, can this person be placed safely in the community without causing undue risk to self or others?

Guideline: **Proceed to item 21.**

REFERRAL RECOMMENDATION

21. **Based on the information obtained by the screener during the screen assessment, check the principal referral recommendation and reason. Explain as needed:**

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a. RHCF:

1. (✓) A community based assessment was done by a Certified Home Health Agency (CHHA), and it was determined that this person cannot be cared for in the community. This community assessment represents this person's current status.
2. ( ) This person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility, or cannot live with family or friends).
3. ( ) Appropriate community based living cannot be arranged because this person cannot be adequately cared for in the community and/or is a risk to self or others.
4. ( ) Both community based and RHCF care are being investigated. Recommendation is RHCF.

b. RHCF for Restorative Services:

1. ( ) This person cannot receive restorative services in their community.

c. Community:

1. ( ) A CHHA completed a community based assessment and determined that this person can be cared for in the community.

Guideline: **If RHCF (item 21 a) or RHCF for Restorative Services (item 21 b) is chosen, proceed to item 22. If Community (item 21 c) is chosen, proceed to item 36.**

DEMENTIA DIAGNOSIS

	YES	NO	
22.	☐	☑	Does this person have a dementia diagnosis (including Alzheimer's disease) documented in the medical record?

Guideline: **Proceed to item 23.**

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

	YES	NO	
23.	☑	☐	Does this person have a serious mental illness?

Guideline: **Proceed to LEVEL I Review for Possible Mental Retardation/Developmental Disability (items 24 -26)**

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer ALL items 24-26.

	YES	NO	
24.	☐	☑	Does this person have a diagnosis or documented history of mental retardation and/or a developmental disability, **and** did the mental retardation or developmental disability manifest itself **prior to age 22, and** is it likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of major life activity?
25.	☐	☑	Has this person ever been deemed eligible for and/or received MR/DD services, or has this person been referred by an agency that serves persons with MR/DD?

26. ☐ ☑ Does this person present with evidence of cognitive deficits and/or adaptive skill deficits that may indicate the presence of mental retardation or developmental disability?

Guideline: **If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30).**
If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).

CATEGORICAL DETERMINATIONS

Answer ALL items 27-30.

	YES	NO	
27.	☐	☑	Does this person qualify for convalescent care?
28.	☐	☑	Is this person seriously physically ill?
29.	☐	☑	Is this person terminally ill?
30.	☐	☑	Is this person to be admitted for a very brief and finite stay or a provisional emergency admission?

Guideline: **If any of the items 27-30 are marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 31).**
If all are marked NO, proceed to LEVEL II REFERRALS (item 33).

DANGER TO SELF OR OTHERS QUALIFIERS

	YES	NO	
31.	☑	☐	Based on your interview with this person (and/or available informants), and/or a review of this person's medical record, is there any evidence to suggest that this person is, or may have been, a danger to self or others during the past two years? per Interview & her care giver - evidence that she may not be safe @ times: 12 leaving stove on; trying to eat inedible objects; doesn't know to respond to smoke detector

Guideline: **If item 31 is marked YES, proceed to item 32.**
If item 31 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

	YES	NO	
32.	☐	☐	Has this person been deemed a danger to self or others based on a current psychiatric evaluation by a licensed mental health professional? I did not find a reference to this in her psych notes

Guideline: **If item 32 is marked YES, proceed to LEVEL II REFERRALS (item 33).**
If item 32 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

LEVEL II REFERRALS

33. Enter the Level II Referral(s): a, b, or c a

a. Level II mental illness evaluation by the designated mental health review entity
b. Level II evaluation by the Office of Mental Retardation and Developmental Disabilities
c. Both a and b

Guideline: **Proceed to item 34.**

	YES	NO	
34.	☐	☐	I, as the qualified screener, acknowledge that this Patient/Resident/Person and his/her legal representative* have received verbal and written notification that this Patient/Resident/Person is being referred for a Level II Evaluation.

Guideline: **STOP ! Do not complete items 35 through 38 until you have obtained the Level II recommendations from the designated evaluator(s).**

*Legal representative means an individual whose appointment is made and regularly reviewed by a state court or agency empowered under state law to appoint and review such officers, and having the authority to consent to health/mental health care or treatment of an individual.

LEVEL II RECOMMENDATIONS

	YES	NO	
35.	☐	☐	Specialized services are recommended based on the Level II Evaluation(s).

Guideline: **Proceed to item 36.**

PATIENT/RESIDENT/PERSON DISPOSITION

36. **Enter one response (a,b,c,d,e,f,g,h,i,j.):** _____

a. Home
b. Home with home care services
c. Adult Care Facility
d. Inpatient Psychiatric Care
e. OMR/DD Residential Placement
f. Adult Care Facility with home care services
g. RHCF for restorative services
h. RHCF for other services
i. Person died
j. Other (specify) _____

Guideline: **Proceed to item 37**

PATIENT/RESIDENT/PERSON AND/OR LEGAL REPRESENTATIVE AND/OR HEALTH CARE AGENT ACKNOWLEDGEMENT

37. I have had the opportunity to participate in decisions regarding the arrangements for my continuing care, and I have received verbal and written information regarding the range of services in my community.

_____ _____
Date Signature of the patient/resident/person being assessed and/or legal representative and/or health care agent

Guideline: **Proceed to item 38.**

QUALIFIED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN and I certify that I am a trained and qualified SCREENER and the information contained herein is a true abstract of this person's current condition and circumstances.

_____ _____
Print date, name and title of qualified SCREENER SCREENER Identification Number (Assigned by NYSDOH)

_____
Signature of qualified SCREENER