**CARE LEVEL II RESIDENT REVIEW**

**FOR PERSONS WITH MENTAL ILLNESS**

*All questions must be answered completely*

Previous Assessment Date:

\*Date Referral to KHS       Date Referred to Assessor

Date of Assessment       \*Tracking Number

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

# 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: (     )      -

**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: (     )      -

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 |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
|  | **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***