



# Pre-Admission Screening and Resident Review PASRR

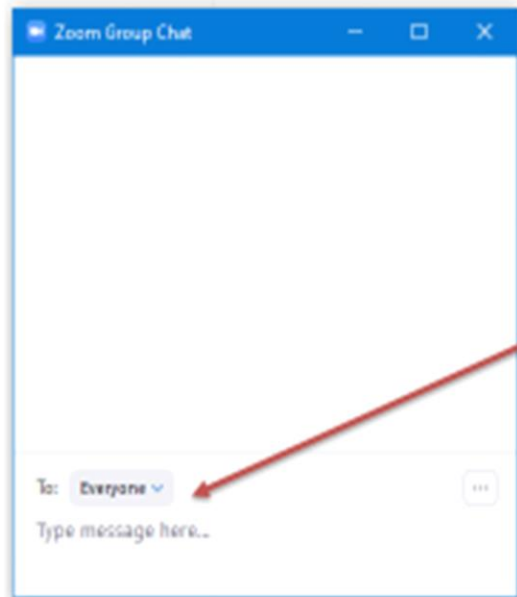
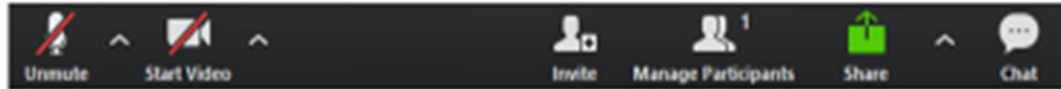
Information for hospitals, nursing facilities and medical offices  
2025

Presented by:

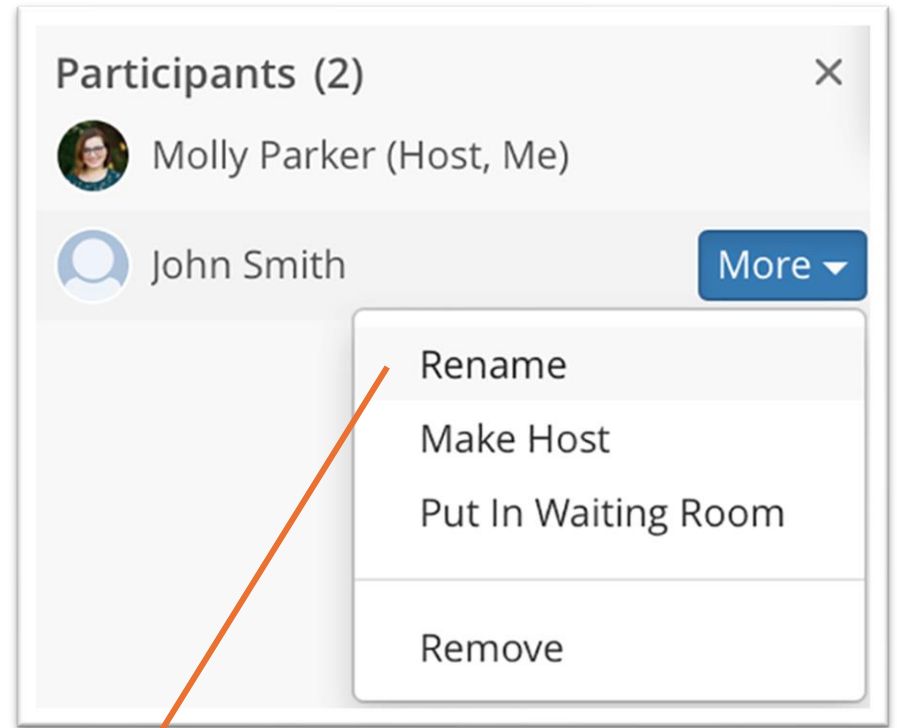
Beth Loska (HCA), Tiffany Meyers (RCS), Rebecca Kaiser (HCS),  
Heidi Johnston (DDCS), Yvonne Alexander (DDCS), Krystle Malo (RCS).

Please remember to keep your microphone and video off during the presentation!

zoom



If you have a question during the presentation, post it in the **“Chat”** section and make sure **“everyone”** is selected



To rename yourself, pull up the participants list, find your name, and right click.

# Introduction



## For Your Information ...

- We will focus on the unique roles of Washington hospitals, clinic and nursing facilities regarding federally mandated Pre-Admission Screening and Resident Review.
- PASRR helps our patients in their journey from hospital to skilled nursing facility, using person-centered practices and integrated care.

Purpose of PASRR is to:

- Transition resident to most supportive and least restrictive setting.
- Identify person-centered services critical to the success of the most vulnerable.
- Continuously improve quality and delivery across the state.

## Regulations Related to PASRR

Both the federal government and the State of Washington regulate PASRR.

- The federal rules related to PASRR can be found at: [42 C.F.R. 483.100 - 483.138](#) (Note: an annual PASRR is no longer required but Code of Federal Regulation has not been revised to reflect this change.)
- Washington Administrative Code addresses PASRR in two sections: [388-97-1910](#) through [388-97-2000](#) and Section [388-834](#).



Department of Social and Health Services

Health Care Authority  
Medicaid State Agency

Developmental Disabilities  
Community Services PASRR Program

Behavioral Health/Serious Mental  
Illness PASRR Program

We all use the same  
**Level 1**  
Pre-Admission and Resident Review form

# PASRR In Washington



**Level 1 Hospitals & Community**



**Level 2 State Administration**

**Nursing Facility**



**Significant Change**





## Hospitals and Community Partners

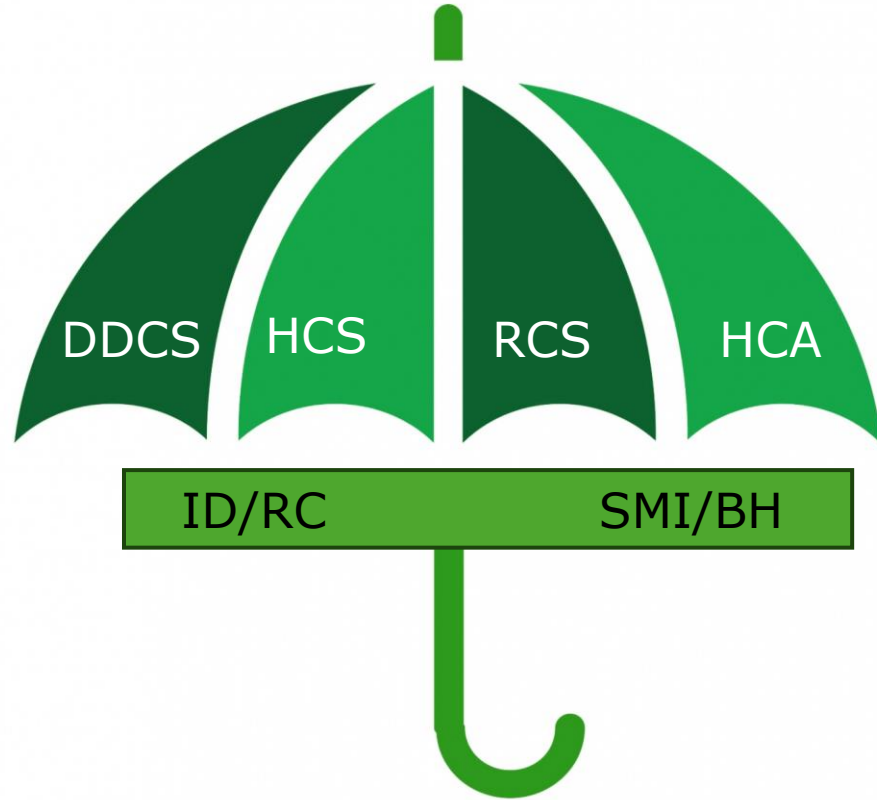
- Hospital admission is the ideal time to identify potential PASRR clients.
- Hospitals & clinics referring Level 1 PASRR forms are expected to adhere to state policies.
- Level 1 referrals may be initiated by specialty providers as well (Internal Medicines, etc.).
- “For a respite admission for those with SMI indicators, The PASRR Level 2 (either an invalidation or full evaluation) must still be completed prior to Hospital Discharge/NF admission.” Pg 5, Level 1 PASRR form.

## Important Notice – WA Level 1 Forms

- The WA Level 1 form was redesigned and published in Jun 2025.
- The DSHS Form 14-300, PASRR Level 1 form is considered a screening form, and should accurately document any known or suspected SMI, ID, or RC prior NF admission.
- Please fill out Level 1 forms with all relevant data.
  - Your signature on the Level I form is an attestation that you have properly screened the individual. This form is a federal requirement and should include all pertinent data.
  - The completed Level 1 is sent to the PASRR Evaluators/Assessors for determination.

**Do not leave the Level 1 blank!**

# Level 2's, Training & Enforcement



- A client does not have to be eligible for DDCS state services to qualify under PASRR.
  - PASRR Is more inclusive!
- Refer all clients with 'known or suspected' mental health concerns.
- Traumatic brain injuries and stroke are examples of related conditions if they occurred prior to age 22.



## Nursing Facilities

## Incorporate Level II into Care Plan

- Nursing Facilities should not admit clients without a complete Level 2 PASRR evaluation.
- Specialized service recommendations from PASRR should be reviewed by a multi-disciplinary team.
- These recommendations should be incorporated into the individual's care plan.
- Minimum Data Set review could indicate PASRR conditions or other changes in resident behavior would indicate the need for a significant change.

## DOH Complaint Criteria

- Hospitals and community medical clinics are primarily responsible for initiating the Level 1 PASRR for new admissions to CMS certified nursing facilities.
- Accurate PASRR referrals are part of a safe discharge practice.
- PASRR Screenings are federally required per 42 CFR § 483.102(a) prior to admission to CMS Certified NF, and per WAC 388-97-1915.
- Habitual errors or omissions could result in a complaint to the Department of Health.
- Possible violation of WAC 246-320-226; Patient Care Services re: discharge planning.
- <https://doh.wa.gov/sites/default/files/2024-12/346-172-ComplaintProcessHospitalsAndHospitalStaffing.pdf>

## What does PASRR do?

PASRR has three goals:

- To identify people referred to nursing facilities who have an intellectual disability or related condition or a serious mental illness.
- To determine that individuals are admitted appropriately.
- To make sure individuals receive the services they need for ID/RC or SMI.



## Why is PASRR important?

According to [Medicaid.gov](https://www.Medicaid.gov):

"PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning-long term care."

PASRR can enhance nursing facility care by providing additional disability-related services not included in the NF daily rate and by making recommendations to the NF.

Medicaid-Certified nursing facilities cannot admit prior to completion of PASRR process.



### Level 1 Pre-Admission Screening and Resident Review (PASRR)

**What is the purpose of this form?**

Federal regulations (42 CFR §483.100 – 138) require that all individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Have serious mental illness or an intellectual disability or related condition; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

This form documents the first level of screening. If serious mental illness or intellectual disability or a related condition is identified or credibly suspected, a Level II evaluation is required to confirm that identification, determine whether the individual requires nursing facility level of care, and determine whether specialized services are required.

See Page 5 for definitions and instructions.

|  |                               |  |   |                                   |
|--|-------------------------------|--|---|-----------------------------------|
| NAME: FIRST<br>[ ]                             | MIDDLE INITIAL<br>[ ]         | LAST<br>[ ]                                      | ADSA ID (IF AVAILABLE)<br>[ ]                     | DATE OF BIRTH (MM/DD/YYYY)<br>[ ] |
| LEGAL REPRESENTATIVE OR FAMILY MEMBER<br>[ ]   |                               |  | RECEIVING NURSING FACILITY (IF APPLICABLE)<br>[ ] |                                   |
| RELATIONSHIP<br>[ ]                            | PHONE (WITH AREA CODE)<br>[ ] | RECEIVING NURSING FACILITY ADDRESS LINE 1<br>[ ] |   |                                   |
| REPRESENTATIVE OR FAMILY MEMBER ADDRESS<br>[ ] |                               | RECEIVING NURSING FACILITY ADDRESS LINE 2<br>[ ] |   |                                   |

- New Nursing facility admission;  
Anticipated date of admission: [ ] \_\_\_\_\_
- Current nursing facility resident  
Date of admission (if current resident): \_\_\_\_\_
- Significant Change\*, indicate the date of the significant change: [ ] \_\_\_\_\_

\*See Page 5 for definitions and instructions.

For more information about significant change of condition, see the [Resident Assessment Instrument Manual](#) pages 2-24 through 2-29.

**The instructions related to “significant change of condition” have been updated to match CMS guidance.**

# Level 1: SMI

- Please note that the updated WA PASRR Level I – Section I has been modified.
- If any question in Section IA is marked “yes”, this is considered a (+) Positive PASRR for SMI.
- Level II is required if SNF stay is more than 30 days.

| Section I. Serious Mental Illness (SMI) / Intellectual Disability (ID) or Related Condition (RC) Determination  |   |  |  |
|---|---|--|--|
| <b>A. Serious Mental Illness Indicators</b>   |   |  |  |
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> 1. Does the individual have known or suspected indicators for serious mental illness? Check the appropriate box(s).   |   |  |  |
| <input type="checkbox"/>  | <input type="checkbox"/> PTSD (trauma or stressors related) | <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Schizophrenic Disorders and other Psychotic Disorder  |
| <input type="checkbox"/>  | <input type="checkbox"/> Mood Disorders                     | <input type="checkbox"/> Anxiety Disorders     | <input type="checkbox"/> Other (i.e., Credible suspicion of any behavioral health disorder, OCD, eating disorder, SUD, etc.) |
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> 2. Is there evidence the person exhibits functional limitations (described below) related to a known or suspected behavioral health disorder?   |   |  |  |
| Examples include, but are not limited to:   |   |  |  |
| <ul style="list-style-type: none"> <li>• Inappropriate behavior or communication (altercations, evictions, avoidance, social isolation)</li> <li>• Difficulty adapting to changing circumstances (work, school, family)</li> <li>• Agitation, withdrawal, or intervention by mental health and/or judicial system</li> <li>• Failure to thrive, refusal of treatment, SUD, homelessness</li> <li>• Psychiatric hospitalization</li> <li>• Inability to maintain function at home or in residential environment</li> </ul>   |   |  |  |
| <b>If the answer(s) to Section I.A. is “Yes”, forward this form to your SMI PASRR Contractor.</b>   |   |  |  |
| LEVEL 1 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)<br>DSHS 14-300 (REV. 06/2025)   |   |  | Page 1 of 6  |
| <ul style="list-style-type: none"> <li>• A referral for a PASRR Level 2 for SMI is required if:               <ol style="list-style-type: none"> <li>1. <u>Any</u> of the questions in Section I are marked YES, or there is known, suspected and/or credible suspicion of SMI; AND</li> <li>2. The requirements for Exempted Hospital Discharge do not apply (see Section II.A.).</li> </ol> </li> <li>• A referral for a PASRR Level 2 for SMI is not required if:               <ol style="list-style-type: none"> <li>1. <u>Both</u> of the questions in Section 1 are marked No or</li> </ol> </li> </ul> <p>There are indicators of SMI in Section 1, but the requirements for Exempted Hospital Discharge are met per Section II.A.<br/> <u>SMI Contact</u> information can be found at: <a href="http://www.hca.wa.gov/pasrr">www.hca.wa.gov/pasrr</a></p> <p><b>Continue to Section I.B.</b></p> |   |  |  |



- If an individual does NOT have indicators, but you believe the individual may have SMI, refer to PASRR.
- Any positive findings in Section 1.A.1., to include anxiety and/or depression, refer to SMI PASRR.
- The same criteria is used for a significant change.
- **For SMI only**, a referral for Level II is not required if all the criteria for Exempted Hospital Discharge are met and the stay is less than 30 days.

| Section I. Serious Mental Illness (SMI) / Intellectual Disability (ID) or Related Condition (RC) Determination  |   |  |  |
|---|---|--|--|
| <b>A. Serious Mental Illness Indicators</b>   |   |  |  |
| Yes No<br><input checked="" type="checkbox"/> <input type="checkbox"/> 1. Does the individual have known or suspected indicators for serious mental illness? Check the appropriate box(s).  |   |  |  |
|   | <input type="checkbox"/> PTSD (trauma or stressors related) | <input type="checkbox"/> Personality Disorders | <input checked="" type="checkbox"/> Schizophrenic Disorders and other Psychotic Disorder                                     |
|   | <input type="checkbox"/> Mood Disorders                     | <input type="checkbox"/> Anxiety Disorders     | <input type="checkbox"/> Other (i.e., Credible suspicion of any behavioral health disorder, OCD, eating disorder, SUD, etc.) |
| Yes No<br><input checked="" type="checkbox"/> <input type="checkbox"/> 2. Is there evidence the person exhibits functional limitations (described below) related to a known or suspected behavioral health disorder?  |   |  |  |
| Examples include, but are not limited to:   |   |  |  |
| <ul style="list-style-type: none"> <li>• Inappropriate behavior or communication (altercations, evictions, avoidance, social isolation)</li> <li>• Difficulty adapting to changing circumstances (work, school, family)</li> <li>• Agitation, withdrawal, or intervention by mental health and/or judicial system</li> <li>• Failure to thrive, refusal of treatment, SUD, homelessness</li> <li>• Psychiatric hospitalization</li> <li>• Inability to maintain function at home or in residential environment</li> </ul> |   |  |  |
| <b>If the answer(s) to Section I.A. is "Yes", forward this form to your SMI PASRR Contractor.</b>   |   |  |  |

# Determining ID/RC

A person can qualify in several ways:

- As a client of DDCS;
- As a person who meets the federal definition of a person with an intellectual disability;
- As a person who meets the federal definition of a person with a condition related to intellectual disability.

## B. Intellectual Disability / Related Conditional Indicators

Yes No

1. Has the person received services from the Developmental Disabilities Administration?  
*If the answer to B1 is yes, SKIP to question B11 and answer "Yes" to question B11.*
2. Does the individual have an IQ score of less than 70, as measured by a standardized, reliable test of intellectual functioning?
3. Does the person have impairments in adaptive functioning as described in the current DSM?  
According to the Diagnostic and Statistical Manual of Mental Disorders these impairments result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communications, social participation, and independent living, and across multiple environments, such as home, school, work, and recreation.
4. Did the condition causing the IQ and adaptive functioning impairments occur before age 18?
5. Is the condition expected to continue indefinitely?  
*If the answers to B2, B3, B4, and B5 are all yes, SKIP to question B11 and answer "Yes" to question B11.*
6. Does the individual have a severe, chronic disability, other than mental illness, that results in impairment of general intellectual functioning or adaptive functioning?
7. Did the onset of the disability occur before age 22?
8. Is the condition expected to continue indefinitely?
9. Does the condition result in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living?  
*If the answers to B6, B7, B8, and B9 are all yes, SKIP to question B11 and answer "Yes" to question B11.*
10. In the absence of a diagnosis of intellectual disability or related condition as described in B1 – B9, do you have reason to believe this individual has undiagnosed intellectual disability or related condition? If yes, please explain:  
\_\_\_\_\_
- If the answer to B10 is yes, SKIP to question B11 and answer "Yes" to question B11.*
11. Does this individual have an intellectual disability or related condition, or do you have reason to believe the individual may have an undiagnosed intellectual disability or related condition?  
*If the answer to B11 is "Yes", forward this form to your regional DDA ID/RC PASRR Team.*  
*Follow up by Developmental Disabilities Administration is required before this individual can be admitted to a nursing facility.*

12. Please share any additional comments regarding this individual related to a possible intellectual disability or related condition:  
\_\_\_\_\_

# Clarification about “Related Condition”

6. Does the individual have a severe, chronic disability, other than mental illness, that results in impairment of general intellectual functioning or adaptive functioning?
7. Did the onset of the disability occur before age 22?
8. Is the condition expected to continue indefinitely?
9. Does the condition result in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living?

*If the answers to B6, B7, B8, and B9 are all yes, answer “Yes” to question B11. A referral to the DDA PASRR Coordinator is required.*

- The form makes it clear that functional limitations alone *do not* necessitate a referral.
- Functional deficits must be attributable to a severe disability which occurred before age 22 and is expected to continue indefinitely.
- This includes TBI, stroke, etc. If in doubt, refer.

# Additional Relevant Information

A diagnosis of dementia does not exclude an individual from the PASRR process, and it is considered relevant information.

The PASRR process must be completed if the individual has a diagnosis of dementia.

| <ul style="list-style-type: none"> <li>A referral for a PASRR Level 2 for ID/RC is required if:<br/>If Section I.B.11. is marked "Yes".</li> <li>A PASRR Level 2 for ID/RC is not required if:<br/>If Section I.B.11. is marked "No".</li> </ul> <p><i>DDA ID/RC contact information can be found at: <a href="https://www.dshs.wa.gov/dda/PASRR">https://www.dshs.wa.gov/dda/PASRR</a></i></p>   |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
|---|-------------------------------------|--|----|--|-------------------------------------|--------------------------|---|--------------------------|-------------------------------------|---|-------------------------------------|--------------------------|--|--------------------------|-------------------------------------|---|-------------------------------------|--------------------------|--|
| <b>C. Additional Relevant Information</b><br><table border="1"> <thead> <tr> <th>Yes</th> <th>No</th> <th></th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1. (a) Does the individual have a diagnosis of dementia? Comment (if applicable):</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td>(b) Is dementia the primary diagnosis? Comment (if applicable):</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2. Does the individual have a substance use disorder? Comment (if applicable):</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td>3. Does the individual have a diagnosis of delirium? Comment (if applicable):</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4. Is the individual's primary language English? Comment (include primary language and any other considerations for adaption to culture, ethnic origin, or communication):</td> </tr> </tbody> </table> |                                     | Yes  | No |  | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 1. (a) Does the individual have a diagnosis of dementia? Comment (if applicable): | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (b) Is dementia the primary diagnosis? Comment (if applicable): | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 2. Does the individual have a substance use disorder? Comment (if applicable): | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Does the individual have a diagnosis of delirium? Comment (if applicable): | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 4. Is the individual's primary language English? Comment (include primary language and any other considerations for adaption to culture, ethnic origin, or communication): |
| Yes   | No                                  |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <input checked="" type="checkbox"/>   | <input type="checkbox"/>            | 1. (a) Does the individual have a diagnosis of dementia? Comment (if applicable):  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <input type="checkbox"/>  | <input checked="" type="checkbox"/> | (b) Is dementia the primary diagnosis? Comment (if applicable):  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <input checked="" type="checkbox"/>   | <input type="checkbox"/>            | 2. Does the individual have a substance use disorder? Comment (if applicable):   |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <input type="checkbox"/>  | <input checked="" type="checkbox"/> | 3. Does the individual have a diagnosis of delirium? Comment (if applicable):  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <input checked="" type="checkbox"/>   | <input type="checkbox"/>            | 4. Is the individual's primary language English? Comment (include primary language and any other considerations for adaption to culture, ethnic origin, or communication): |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <b>Section II.A. Exempted Hospital Discharge</b><br>CHECK ALL THAT APPLY<br><input type="checkbox"/> The individual with SMI or ID/RC will be admitted directly to a NF from a hospital after receiving acute inpatient care at the hospital.<br><input type="checkbox"/> The individual with SMI or ID/RC requires NF services for the condition for which they received care in the hospital.<br><input type="checkbox"/> The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services.<br><br>If all three boxes are marked, the individual meets the requirements for an exempted hospital discharge and can be referred to a NF without a PASRR Level II.<br><i>For individuals with ID/RC, the PASRR Level 1 must be forwarded to the DDA PASRR Coordinator prior to nursing facility admission.</i>   |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <b>Section II.B. Categorical Determination</b><br>CHECK ANY THAT APPLY (SEE INSTRUCTIONS)<br><input type="checkbox"/> Referral to NF for protective services of seven (7) days or less<br><input type="checkbox"/> Referral to NF for respite of 30 days or less<br><br><i>If one of these indicators applies, the individual meets the requirements for Categorical Determination. Check the "Categorical Determination" box in Section III. The referring party must sign section III.</i>  |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <b>Section III. Documentation of:</b><br><input type="checkbox"/> Exempted Hospital Discharge ("EHD" per Section II.A)<br><input type="checkbox"/> Categorical Determination ("CD" per Section II.B)<br><b>This section is only required if the individual meets the requirements for Exempted Hospital Discharge or Categorical Determination.</b>   |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| PERSON IDENTIFYING BASIS FOR EHD OR CD (SIGN BELOW)   | TITLE                               |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| LIST DATA USED FOR DETERMINATION  |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| WHAT EVIDENCE DID YOU USE TO CONCLUDE THE INDIVIDUAL MEETS THE CRITERIA FOR EHD OR CD?  |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| <b>By entering my name in the signature fields below, I indicate my intent to sign this record and agree that my electronic signature is the legally binding equivalent to my handwritten signature.</b>  |                                     |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |
| SIGNATURE (PHYSICIAN, ARNP, PHYSICIAN'S ASSISTANT OR REGIONAL AUTHORITY / DESIGNEE)   | DATE                                |  |    |  |                                     |                          |   |                          |                                     |   |                                     |                          |  |                          |                                     |   |                                     |                          |  |

What about people who are going to a NF for short-term rehab after hospital treatment?





# How is an EHD designated?

Complete Sections IIA and III in the PASRR Level 1 to show the EHD.

Please include:

- Data used for determination
- Evidence individual meets criteria for Exempted Hospital Discharge

All EHD's must be signed by a physician, PA or ARNP

|  |                      |
|--|----------------------|
| <b>Section II.A. Exempted Hospital Discharge</b>   |                      |
| CHECK ALL THAT APPLY   |                      |
| <input checked="" type="checkbox"/> The individual with SMI or ID/RC will be admitted directly to a NF from a hospital after receiving acute inpatient care at the hospital.   |                      |
| <input checked="" type="checkbox"/> The individual with SMI or ID/RC requires NF services for the condition for which they received care in the hospital.  |                      |
| <input checked="" type="checkbox"/> The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services.   |                      |
| If all three boxes are marked, the individual meets the requirements for an exempted hospital discharge and can be referred to a NF without a PASRR Level II.  |                      |
| <i>For individuals with ID/RC, the PASRR Level 1 must be forwarded to the DDA PASRR Coordinator prior to nursing facility admission.</i>   |                      |
| <b>Section II.B. Categorical Determination</b>   |                      |
| CHECK ANY THAT APPLY (SEE INSTRUCTIONS)  |                      |
| <input type="checkbox"/> Referral to NF for protective services of seven (7) days or less  |                      |
| <input checked="" type="checkbox"/> Referral to NF for respite of 30 days or less  |                      |
| <i>If one of these indicators applies, the individual meets the requirements for Categorical Determination. Check the "Categorical Determination" box in Section III. The referring party must sign section III.</i> |                      |
| <b>Section III. Documentation of:</b>  |                      |
| <input checked="" type="checkbox"/> Exempted Hospital Discharge ("EHD" per Section II.A)   |                      |
| <input type="checkbox"/> Categorical Determination ("CD" per Section II.B)   |                      |
| This section is only required if the individual meets the requirements for Exempted Hospital Discharge or Categorical Determination.   |                      |
| PERSON IDENTIFYING BASIS FOR EHD OR CD (SIGN BELOW)  | TITLE                |
| <input type="text"/>   | <input type="text"/> |
| LIST DATA USED FOR DETERMINATION   |                      |
| <input type="text"/>   |                      |
| WHAT EVIDENCE DID YOU USE TO CONCLUDE THE INDIVIDUAL MEETS THE CRITERIA FOR EHD OR CD?   |                      |
| <input type="text"/>   |                      |
| By entering my name in the signature fields below, I indicate my intent to sign this record and agree that my electronic signature is the legally binding equivalent to my handwritten signature.                    |                      |
| SIGNATURE (PHYSICIAN, ARNP, PHYSICIAN'S ASSISTANT OR REGIONAL AUTHORITY / DESIGNEE)  | DATE                 |
| <input type="text"/>   | <input type="text"/> |



**What happens if a person entered the facility on an EHD, but their stay extends beyond 30 days and the person does not meet PASRR Level 2 criteria?**

**Section IIA. Exempted Hospital Discharge**

CHECK ALL THAT APPLY

- The individual with SMI or ID/RC will be admitted directly to a NF from a hospital after receiving acute inpatient care at the hospital.
- The individual with SMI or ID/RC requires NF services for the condition for which he or she received care in the hospital.
- The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services.

If all three boxes are marked, the individual meets the requirements for an exempted hospital discharge and can be referred to a NF without a PASRR Level II. If all three boxes are marked, check the "Exempted Hospital Discharge" box in Section III. A physician, ARNP or physician's assistant must sign section III. *For individuals with ID/RC, the PASRR Level I must be forwarded to the DDA PASRR Coordinator upon nursing facility admission.*

## What about people who admit to the NF for a respite stay?

- For individuals with ID/RC, the DDCCS PASRR assessor typically completes the Level 1.
- Contact the regional PASRR coordinator if you wish to refer someone to a NF for respite. A Regional DDCCS authority or designee will sign section III.
- Respite admissions must be 30 days or less (allowed: 30 total days over the course of one calendar year).





# How is a Categorical Determination designated?

Complete Sections IIB and III in the PASRR Level 1 to show CD.

CD's are typically signed by a Regional DSHS Authority or Designee.

|  |                      |
|--|----------------------|
| <b>Section II.B. Categorical Determination</b>   |                      |
| CHECK ANY THAT APPLY (SEE INSTRUCTIONS)  |                      |
| <input type="checkbox"/> Referral to NF for protective services of seven (7) days or less  |                      |
| <input checked="" type="checkbox"/> Referral to NF for respite of 30 days or less  |                      |
| <i>If one of these indicators applies, the individual meets the requirements for Categorical Determination. Check the "Categorical Determination" box in Section III. The referring party must sign section III.</i> |                      |
| <b>Section III. Documentation of:</b>  |                      |
| <input type="checkbox"/> Exempted Hospital Discharge ("EHD" per Section II.A)  |                      |
| <input checked="" type="checkbox"/> Categorical Determination ("CD" per Section II.B)  |                      |
| This section is only required if the individual meets the requirements for Exempted Hospital Discharge or Categorical Determination.   |                      |
| PERSON IDENTIFYING BASIS FOR EHD OR CD (SIGN BELOW)  | TITLE                |
| <input type="text"/>   | <input type="text"/> |
| LIST DATA USED FOR DETERMINATION   |                      |
| <input type="text"/>   |                      |
| WHAT EVIDENCE DID YOU USE TO CONCLUDE THE INDIVIDUAL MEETS THE CRITERIA FOR EHD OR CD?   |                      |
| <input type="text"/>   |                      |
| By entering my name in the signature fields below, I indicate my intent to sign this record and agree that my electronic signature is the legally binding equivalent to my handwritten signature.                    |                      |
| SIGNATURE (PHYSICIAN, ARNP, PHYSICIAN'S ASSISTANT OR REGIONAL AUTHORITY / DESIGNEE)  | DATE                 |
| <input type="text"/>   | <input type="text"/> |

Referral resources are listed on page 4

If there is credible suspicion of SMI or ID/RC, but no diagnosis, you must complete the Additional Comments section!

| Section IV. Service Needs and Assessor Data  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> <b>No Level II evaluation indicated:</b> Person does not show indicators of SMI or ID/RC.<br><input type="checkbox"/> <b>Level II evaluation referral required for SMI:</b> Person shows indicators of SMI per Section 1.A.<br><input type="checkbox"/> <b>Level II evaluation referral required for ID/RC:</b> Person shows indicators of ID or RC per Section 1.B.<br><input type="checkbox"/> <b>Level II evaluation referrals required for SMI <u>and</u> ID/RC:</b> Person shows indicators of both SMI and ID/RC per Sections 1. A and B.<br><br><input type="checkbox"/> <b>Level II evaluation referral required for significant change.</b><br><input type="checkbox"/> <b>No Level II evaluation indicated <u>at this time</u> due to exempted hospital discharge:</b> Level II <u>must</u> be completed if scheduled discharge does not occur.<br><input type="checkbox"/> <b>No Level II evaluation indicated <u>at this time</u> due to categorical determination identified by DDA or BHA:</b> Level II <u>must</u> be completed if scheduled discharge does not occur. |                                      |
| <b>NOTE:</b> If Level II evaluation is required for SMI, forward this document to the BHA PASRR contractor immediately. If an indicator of ID/RC is identified, forward this document to the DDA PASRR Coordinator immediately. See link below.  |                                      |
| <b><u>PASRR CONTACT INFORMATION IS AVAILABLE AT:</u></b><br>For SMI - <a href="http://www.hca.wa.gov/pasrr">www.hca.wa.gov/pasrr</a><br>For ID/RC - <a href="https://www.dshs.wa.gov/dda/PASRR">https://www.dshs.wa.gov/dda/PASRR</a>  |                                      |
| NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT)   | NAME OF FACILITY OR AGENCY           |
| TITLE  | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| ADDRESS  | CITY STATE ZIP CODE                  |
| <b>By entering my name in the signature fields below, I indicate my intent to sign this record and agree that my electronic signature is the legally binding equivalent to my handwritten signature.</b>   |                                      |
| SIGNATURE OF PERSON COMPLETING THIS FORM   | DATE                                 |
| ADDITIONAL COMMENTS (REQUIRED IF REFERRING DUE TO CREDIBLE SUSPICION OF SMI, ID, OR RC) <div style="border: 2px solid red; border-radius: 50%; height: 100px; width: 100%; margin-top: 5px;"></div>  |                                      |



The last two  
pages  
contain  
additional  
information.

Many of your  
questions  
are  
answered  
here.

## Level 1 Pre-Admission Screening and Resident Review (PASRR) Instructions

### What is the purpose of this form?

This screening form applies to all persons being considered for admission to a Medicaid-Certified Nursing Facility (NF). The nursing facility is responsible for ensuring that the form is complete and accurate before admission. After admission, the NF must retain the Level 1 form as part of the resident record. In the event the resident experiences a significant change\* in condition, or if an inaccuracy in the current Level I is discovered, the NF must complete a new PASRR Level 1 and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected.

Any professional who is referring an individual for admission to a nursing facility may complete this form. The form may also be completed by designated HCS or DDA staff who are facilitating the referral. If an exempted hospital discharge is identified under Section II, a physician, ARNP, or physician's assistant must complete and sign Section III. In the case of a respite stay for an individual with an intellectual disability or related condition (ID/RC), the DDA regional administrator or designee must complete and sign Section III.

### Readmissions and Transfers

**Readmission:** when an individual discharges from a hospital to the same facility they resided in prior to the hospital stay, a new PASRR screen is not required unless there has been a significant change in condition.

**Interfacility Transfer:** when an individual transfers from one NF to another with or without an intervening hospital stay, a new PASRR screen is not required unless there has been a significant change in condition.

**Significant change in physical or mental condition** for PASRR purposes means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.

### Section I. Serious Mental Illness / Intellectual Disability or Related Condition (RC) Determination

**Credible suspicion of SMI:** The person exhibits or is reliably reported to exhibit one or more of the functional limitations described in A2 of Section I and, although none of the diagnoses in A1 can be confirmed, there is some evidence that a serious mental illness may exist. Explain the factors that led you to the conclusion the person may have a SMI in the Additional Comments box in Section IV.

**Credible suspicion of ID / RC:** Although a diagnosis of intellectual disability or related condition cannot be confirmed, the person exhibits significant limitations in either intellectual functioning (reasoning, learning, problem solving) or in adaptive behavior (everyday social and practical skills). Records or verbal accounts indicate that these limitations began before age 18 (for ID) or 22 (for related condition) and are expected to be life-long.

### Sections II and III. Exempted Hospital Discharge or Categorical Determination for Individual with SMI or ID / RC

**Exempted Hospital Discharge:** Per 42 C.F.R. §483.104, a person may be admitted to a NF without a PASRR Level II when he or she admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital; the NF admission is to treat the condition for which the person was hospitalized; and the person's attending physician, ARNP, or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services. For individuals with ID/RC, the Level 1 must be forwarded to the DDA PASRR Coordinator upon NF admission.

**Categorical Determination:** For a respite admission for those with ID/RC, the DDA Regional Authority or designee sign Section III. **The PASRR Level II determinations must still be completed prior to NF admission**, but an abbreviated version may be allowed.

For a respite admission for those with SMI indicators, the referring party must complete the Level 1 screening form and contact the MH Contractor for his/her county prior to admission to the SNF. The PASRR Level 2 (either an invalidation or full evaluation) must still be completed prior to NF admission.

## **Back to Basics: PASRRs must be completed before admission**

The nursing home bears the responsibility to track admissions and obtain a Level 1 and Level 2, if indicated.

A facility could be cited for failing to obtain a PASRR Level 1 and a Level 2 before admission.

# **DDCS PASRR can help people with intellectual disabilities or related conditions by providing specialized services:**

- Assistive Technology
- Community Engagement
- Person Centered Planning
- Therapeutic Supplies.

# **Communication with the PASRR team is highly important for the resident, the PASRR Team and the nursing facility!**

Let PASRR know as soon as possible if a PASRR resident:

- Has a significant change in condition.
- Is hospitalized.
- Experiences behavior challenges.
- Requests supports in addition to regular NF care.
- Passes away.



# Behavioral Health Support Team (BHST)

**Krystle Malo**

Behavioral Health Provider Training  
Specialist

[krystle.malo@dshs.wa.gov](mailto:krystle.malo@dshs.wa.gov)

**BHST Inbox:**

[RCSBHST@dshs.wa.gov](mailto:RCSBHST@dshs.wa.gov)

**BHST Training Inbox:**

[ALTSABHSTTraining@dshs.wa.gov](mailto:ALTSABHSTTraining@dshs.wa.gov)

# Facilities Served by the BHST

Facilities served by the BHST include:

- Adult Family Homes (AFH)
- Assisted Living Facilities (ALF)
- Nursing Homes (NH)
- Certified Community Residential Services & Supports (CCRSS)
- Supportive Living Facilities (SL)
- State Operated Living Alternative (SOLA)

Services are always **voluntary** & always **free** to the LTC Facility

Please note, the BHST client is the **LTC Staff** and **Provider's** - this is **not** a counseling service for Residents



# Provider Support Meeting

Provider Support Meetings Often Include:

- Information on the Requested Topic(s)
- Behavioral Health Interventions & Approaches
- Regulatory Expertise
- Community Resources
- ...And More!



# Provider Support Topics

- Aggressive Behaviors
- Care Transitions
- Crisis Response & De-Escalation
- Diagnosis Education (w/ Interventions)
- Exit Seeking and Wandering
- Grief, Loss and Adjustment
- Hoarding
- Trauma Informed Care
- Responding to Allegations
- Resistance to Care
- Substance Abuse
- Suicide and Self-Harm
- ....And so much more!!

## BHST PROVIDER SUPPORT TOPICS

- Activities and Quality of Life
- Aggressive Behavior
- Balancing Resident Rights and Safety
- Behaviors Related to a Developmental or Intellectual Disability (DD/ID)
- Behaviors Related to Dementia
- Behaviors Related to Traumatic Brain Injury (TBI)
- Care Planning and Documentation
- Care Refusal
- Communication
- Crisis Response and De-Escalation
- Education About a Specific Disorder
- Exit-Seeking, Wandering, and Eloping
- Facility Rules and Agreements
- Facility, Organizational, and Staff-Related Concerns
- Grief, Loss, and Adjustment
- Hallucinations and Delusions
- Hoarding
- Providing Trauma-Informed, Person-Centered Care
- Reporting Requirements
- Responding to Allegations and Complaints from Residents
- Setting and Maintaining Boundaries
- Sexual Expression and Consent
- Substance Use
- Suicide and Self-Harm
- Tracking Behavior to Understand Root Causes
- Transitions of Care and Admissions Challenges

[Click here](#) to submit a request for a provider support meeting.

## RCS Behavioral Health Support Team

# RCS BHST Provider Support What to Expect

“

I'm feeling hopeful I took three pages of notes.

I thought it was great training for my staff and found your stories especially helpful to illustrate your points.

”



### 1. Initial Info-Gathering Phone Call (15-30 Minutes)

Once a referral is received, a consultant will reach out to provide you more information about the supports offered.

In this initial call, we will also explore the topics you wish to learn more about and identify how we can best support you.

### 2. Meeting (1-3 hours)

Since all meetings are conveniently scheduled via Zoom or Teams, your consultant will email you relevant resources, suggestions, training topics, and/or regulatory guidance tailored to your area of requested support.

### 3. Follow-Up Phone Call (10-30 minutes)

Depending on facility needs, we will schedule a follow up to check in and answer questions you have about the content shared at the previous meeting or cover additional information. If no further support is needed, we will close the case.

### 4. Survey (5 minutes)

Included with your materials is a QR code to participate in our survey about your experience. Additionally a link will also be emailed.

We thank you for completing the survey. Your insights help us learn, grow, and provide more meaningful support tailored to your needs.



Please email [RCSBHST@dshs.wa.gov](mailto:RCSBHST@dshs.wa.gov) for more information.

# What to Expect

## Steps of our process:

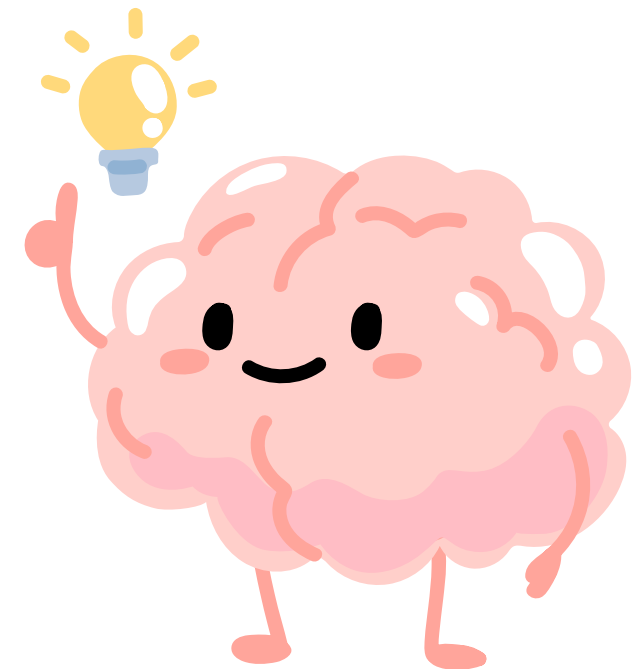
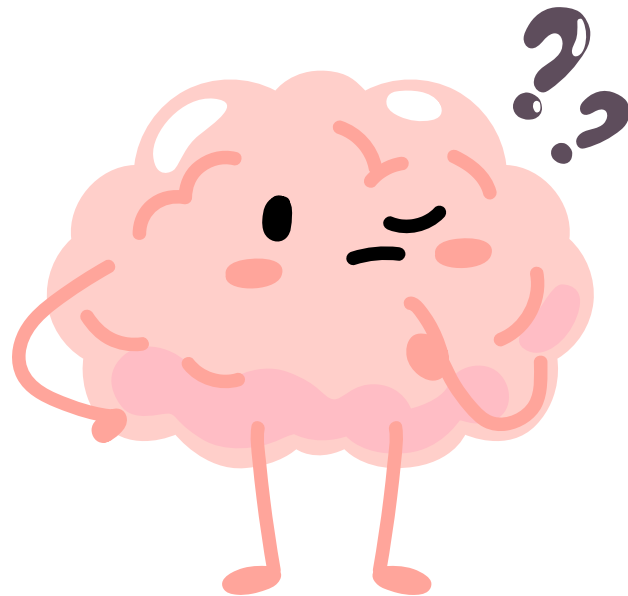
- Info gathering phone call with the provider
- Meeting via Zoom or Teams
- Follow up meetings or phone calls
- We ask the provider to partake in a survey



# RCS BHST Open Office Hours:

---

An Informal Q & A  
Opportunity





# RCS BHST Training

## BHST Provided Trainings are:

- **FREE!**
- Many have **Continuing Education credits** awarded for completion
- Generally, **1-2 hours** in length
- **To improve access** to the LTC Community Statewide all trainings are provided on a ZOOM platform

### Behavioral Health Support Team Training Schedule

| AUGUST 2024 |        |   |   |   |        |          |
|-------------|--------|---|---|---|--------|----------|
| Sunday      | Monday | Tuesday   | Wednesday   | Thursday  | Friday | Saturday |
| 28          | 29     | 30  | 31  | 1   | 2      | 3        |
| 4           | 5      | 6   | 7   | 8<br>Coping With Abuse Training - (2.5 CEU's)<br>10am-12:30pm<br><a href="#">Click HERE to register!</a>        | 9      | 10       |
| 11          | 12     | 13<br>Grief and Loss<br>1pm-2pm (1 CEU)<br><a href="#">Click HERE to register!</a>                        | 14  | 15<br>Improving Resident Quality of Life<br>(No CEU's)<br>1pm-2:30pm<br><a href="#">Click HERE to register!</a> | 16     | 17       |
| 18          | 19     | 20  | 21<br>Crisis Response & De-escalation training (No CEU's)<br>1pm-3pm<br><a href="#">Click HERE to register!</a> | 22  | 23     | 24       |
| 25          | 26     | 27<br>Coping With Abuse Training - (2.5 CEU's)<br>10am-12:30pm<br><a href="#">Click HERE to register!</a> | 28  | 29  | 30     | 31       |

All trainings are on Zoom. If you have any questions, please email [ALTSABHSTTraining@dshs.wa.gov](mailto:ALTSABHSTTraining@dshs.wa.gov). All scheduled trainings are open to providers and their staff, from different facilities, across the state. As a reminder, not all our trainings are certified for continuing education credits. Those trainings that offer continuing education credits are labeled as such.

# How to Submit a Referral

Use **Microsoft Forms** or **email!**

When you refer, we will ask for:

- Name of the Home/ Facility
- Contact Name/ Phone Number of a Person at the Facility
- Topics the provider hopes to cover.
- Facility Approval for the BHST referral



HELP

**Email:**  
**RCSBHST@dshs.wa.gov**



# Do you have questions?



Thank you for your  
Participation & Support!

Krystle Malo  
Behavioral Health Training Specialist  
[krystle.malo@dshs.wa.gov](mailto:krystle.malo@dshs.wa.gov)

**BHST Inbox:** [RCSBHST@dshs.wa.gov](mailto:RCSBHST@dshs.wa.gov)  
**BHST Training Inbox:**  
[ALTSABHSTTraining@dshs.wa.gov](mailto:ALTSABHSTTraining@dshs.wa.gov)

# Significant Change of Condition

Significant change definition is in the Resident Assessment Instrument, RAI, Manual, in Chapter 2.

## **Referrals to PASRR for significant change**

- Must be done promptly.
- Required for individuals who have been previously identified by PASRR as having mental illness, or intellectual disability or related condition.
- Required for those not previously identified.

# Referral to PASRR for significant change may not be necessary if...

The resident is expected to return to baseline function within two weeks, and any one of the following apply:

- The interdisciplinary team, IDT, can initiate corrective action to address the symptoms.
- A short-term illness is causing the symptoms.
- Cyclical signs and symptoms are associated with a previous diagnosis.

# Resident-Centered Care Planning





How do I incorporate PASRR recommendations from the Level II or follow-up into the care plan?



# Resident Care and PASRR



## Reinvestment Grants

- Washington state participates in the Civil Money Penalty Fund Grant Program.
- <https://www.dshs.wa.gov/altsa/civil-money-penalty-cmp-funds>



# A Final Thought

PASRR is a partnership between the resident, important people in the resident's life, the hospital, the NF and state agencies.

At its center, is our common desire to provide person-centered, high-quality services for each individual we serve.



# Where can I find more information?

**ID/RC PASRR website:** [www.dshs.wa.gov/dda/pasrr](http://www.dshs.wa.gov/dda/pasrr)

**SMI PASRR website:** [www.hca.wa.gov/pasrr](http://www.hca.wa.gov/pasrr)

**Contractor Map:** <https://www.hca.wa.gov/assets/billers-and-providers/82-0431-pasrr-contractor-contacts-map.pdf>

## **Behavioral Health Support for Providers:**

[www.dshs.wa.gov/altsa/residential-care-services/behavioral-health-support-providers](http://www.dshs.wa.gov/altsa/residential-care-services/behavioral-health-support-providers)

BHST Email: [rCSbhst@dshs.wa.gov](mailto:rCSbhst@dshs.wa.gov)

BHST Referral Message Line: 360-725-3445

# PASRR Contacts

## **Home and Community Living Administration RCS Behavioral Health Support Team**

Krystle Malo, Behavioral Health Provider Training Specialist,  
[krystle.malo@dshs.wa.gov](mailto:krystle.malo@dshs.wa.gov)

## **Home and Community Services**

Julie Cope, RCL and NFCM Policy Unit Manager, [julie.cope@dshs.wa.gov](mailto:julie.cope@dshs.wa.gov)  
Rebecca Kaiser, RCL Enrollment Specialist, [rebecca.kaiser@dshs.wa.gov](mailto:rebecca.kaiser@dshs.wa.gov)

## **Washington State Department of Health**

Liz Gordon, Clinical Care Supervisor, Investigation and Inspection  
[elizabeth.gordon@DOH.WA.GOV](mailto:elizabeth.gordon@DOH.WA.GOV)

DOH Hospital reporting:

<https://fortress.wa.gov/doh/providercredentialsearch/ComplaintIntakeForm.aspx>



# PASRR Contacts

## **DSHS Developmental Disabilities Community Services (ID/RC)**

Heidi Johnston, PASRR Program Manager, [heidi.johnston@dshs.wa.gov](mailto:heidi.johnston@dshs.wa.gov)

ID/RC PASRR regional contacts: [www.dshs.wa.gov/dda/pasrr](http://www.dshs.wa.gov/dda/pasrr)

## **Washington Health Care Authority (SMI)**

Beth Loska, LTC Coordination Manager/PASRR, [elizabeth.loska@hca.wa.gov](mailto:elizabeth.loska@hca.wa.gov)

Tabitha Craven, PASRR Program Manager, [tabitha.craven@dshs.wa.gov](mailto:tabitha.craven@dshs.wa.gov)

BH PASRR Evaluator map is located at [www.hca.wa.gov/pasrr](http://www.hca.wa.gov/pasrr)

## **DSHS Home and Community Living Administration Residential Care Services**

Tiffany Meyers, NH Policy Program Manager, [RCS Policy Inbox](#)

# DOH Hospital reporting:

## Department of Health Hospital reporting:

<https://fortress.wa.gov/doh/providercredentialsearch/ComplaintIntakeForm.aspx>

# PASRR Contacts

## **Region 1 North DDCS Office**

1611 West Indiana Avenue  
Spokane, WA 99205-4221

Phone: 509-329-2900

**Fax:** 509-568-3037

**Email:** [ddar1pasrrteam@dshs.wa.gov](mailto:ddar1pasrrteam@dshs.wa.gov)

Counties: Asotin, Davenport, Ferry, Lincoln, Pend Oreille, Spokane, Stevens, Whitman.



## **Region 1 South DDCS Office**

1002 North 16<sup>th</sup> Avenue  
Yakima, WA 98902

Phone: 509-225-7970

**Fax:** 509-575-2326

**Email:** [ddar1pasrrteam@dshs.wa.gov](mailto:ddar1pasrrteam@dshs.wa.gov)

Counties: Adams, Benton, Chelan, Columbia, Douglas, Franklin, Garfield, Grant, Kittitas, Klickitat, Okanagan, Yakima, Walla Walla

# PASRR Contacts

## **Region 2 North DDCS Office**

840 N. Broadway Building B, Suite 540  
Everett, WA 98201-1288

Phone: 206-379-0730

**Fax:** 206-720-3426

**Email:** [ddar2pasrrteam@dshs.wa.gov](mailto:ddar2pasrrteam@dshs.wa.gov)

Counties: San Juan, Skagit, Snohomish, Whatcom



## **Region 2 South DDCS Office**

1700 E. Cherry St. Suite 200  
Seattle, WA 98122-4695

Phone: 206-379-0730

**Fax:** 206-720-3426

**Email:** [ddar2pasrrteam@dshs.wa.gov](mailto:ddar2pasrrteam@dshs.wa.gov)

Counties: King

# PASRR Contacts

## **Region 3 North DDCS Office**

1305 Tacoma Avenue South, Suite 300  
Tacoma, WA 98402

Phone: 253-404-5500

**Fax:** 253-999-5476

**Email:** [ddar3pasrrteam@dshs.wa.gov](mailto:ddar3pasrrteam@dshs.wa.gov)

Counties: Clallam, Jefferson, Kitsap, Pierce



## **Region 3 South DDCS Office**

6860 Capital Blvd. SE  
Tumwater, WA 98501

Phone: 360-725-4250

**Fax:** 253-999-5476

**Email:** [ddar3pasrrteam@dshs.wa.gov](mailto:ddar3pasrrteam@dshs.wa.gov)

Counties: Clark, Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum

# Questions and Answers

