DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
WASHINGTON STATE PASRR PROGRAM
PREADMISSION SCREEN AND RESIDENT REVIEW (PASRR)

Level II PASRR Invalidation Instructions

Dates

Date of Referral: Type in the date the Level I referral was made to contractor.
Date Hospital / SNF was Notified of Invalidation: Type the date the Hospital / SNF was notified that the Level I is invalidated.
Date Form Completed: Type in the date the forms was completed.
Date of Birth: Type in the date of birth of the individual.

Name

Type in the last name of the individual; check correct spelling.
Type in the first name of the individual; check correct spelling.
Type in the middle name / initial of the individual; check correct spelling.
If the individual does not have a middle name, leave it blank.

Preadmission

Check the Preadmission box if the individual has not yet been placed in a Nursing Facility. Inform discharge staff to include the Invalidation in the discharge packet of information sent to the nursing facility.

Nursing Facility Placement and Mailing Address

If the individual is currently in a nursing facility, check the "Current nursing facility resident" box. Provide the name, and complete address of the facility.

1. Categories for Invalidation

Check **at least one** category of invalidation that disqualifies the individual for a Level II Initial Psychiatric Evaluation. Invalidations **must be completed within 7 days** of the referral as required in CFR, and in **DSHS PASRR** contract.

Check box 1 if the individual:

- Has been discharged. This includes transfers to another facility, home or death of the individual.

Check box 2 if the individual:

- Has a severe medical illness as the primary diagnosis.
- The diagnosis results in a level of impairment so severe that he/she could not be expected to benefit from specialized behavioral health treatment.
- List severe medical diagnoses.

Check box 3 if the individual has a diagnosis of a major neurocognitive disorder. (for criteria see page 2)

Check box 4 if the individual APPEARS to exhibit symptoms of a major neurocognitive disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). (for symptom criteria see page 2)

Check box 5 if the individual **does not** have any of the diagnoses listed on the Invalidation form.

Check box 6 if the individual:

- Has been diagnosed with at least one serious mental illness **AND does not** have symptoms of serious mental illness as described in the **CRITERIA FOR SEVERITY OF SYMPTOMS** listed on page 2 of the form.
- List all DSM code and diagnoses using the most current DSM.

2. Evaluator Comments

Use the space provided to document related information to confirm individual's ineligibility for a Level II Evaluation. Include comments from the staff and family as appropriate.

3. Evaluator Information

Signature and Date: Sign and date the form.

Contractor's Name: If you are working for a contractor, write in the name of the contractor.

Print Name and **Title.**

County: Where the Invalidation was completed.

Distribution of this Document

- **Immediately send a copy to the hospital discharge staff or Nursing Facility**. The Invalidation must be included in the individual's clinical record.
- Original Invalidations are to remain with contractor / evaluator records.
- Submit copy to DBHR with a completed A19 Invoice, Worksheet and Level I for processing and payment.