

# **SCREEN Form:**

## **DOH-695 (2/2009)**

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**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:	4. Patient/Resident/ Person's Name:
2. Patient/Resident/Person's Social Security Number:	5. Date of HC-PRI or PRI Completion:
3. Name of Person(s) Completing SCREEN:	6a. Date of SCREEN Initiation:
	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:

**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?

**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?

**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. 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.



# NOTIFICATION OF NEED FOR LEVEL II EVALUATION

A Level I SCREEN has been completed for \_\_\_\_\_, on \_\_\_\_\_. This notice serves to inform \_\_\_\_\_ and his/her legal representative that a Level II Evaluation is required, due to suspected mental illness and/or mental retardation. The Level II Evaluation will be completed by the New York State Office of Mental Health and/or Office of Mental Retardation/Developmental Disability or designee.

\_\_\_\_\_  
Print date, name and title of qualified SCREENER

\_\_\_\_\_  
SCREENER Identification Number  
(Assigned by NYSDOH)

\_\_\_\_\_  
Signature of qualified SCREENER

RUG-II GROUP OF PATIENT:  
(please print name)

# PATIENT REVIEW INSTRUMENT (PRI)

Use with separate PRI Instructions and Training Manual

## I. ADMINISTRATIVE DATA

**1 OPERATING CERTIFICATE NUMBER**  
(1-8)

**2 SOCIAL SECURITY NUMBER**  
(9-17)

**3 RESIDENT IS LOCATED:**  
1 = Former HRF Area (18)   
2 = Former SNF Area

**11 DATE OF INITIAL ADMISSION:** to this facility (NF) (first admission, not most recent) (62-67) MO. DAY YEAR  1 9

**4 PATIENT NAME (PLEASE PRINT)**  
LAST F.I. M.I. (19-30)

**12 MEDICAID NUMBER**  
(68-78)

**5 DATE OF PRI COMPLETION**  
(31-36) MO. DAY YEAR  1 9

**13 MEDICARE NUMBER**  
(79-88)

**6 MEDICAL RECORD NUMBER**  
(37-45)

**14 PRIMARY PAYOR**  
1 = Medicaid 2 = Medicare 3 = Other (89)

**7 ROOM NUMBER**  
(46-50)

**15 A REASON FOR PRI COMPLETION:**  
1 = Biannual Full Facility Cycle (90)   
2 = Quarterly New Admission Cycle

**8 UNIT NUMBER (Assigned by RUG II Project)**  
(51-52)

**15 B Was a PRI submitted by your facility (NF) for this patient during a previous full facility or a new admit cycle?**  
1 = Yes 2 = No (91)

**9 DATE OF BIRTH**  
(53-60) MO. DAY YEAR

**10 SEX**  
1 = Male 2 = Female (61)

## II. MEDICAL EVENTS

**16 DECUBITUS LEVEL:** ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS (92)

**17 MEDICAL CONDITIONS:** DURING THE PAST FOUR WEEKS. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS. 1 = Yes 2 = No (93-103)

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

**18 MEDICAL TREATMENTS:** READ THE INSTRUCTIONS FOR QUALIFIERS. 1 = Yes 2 = No (104-116)

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

PATIENT NAME (please print) \_\_\_\_\_

**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   
(123)

- 1 = No infantile or socially inappropriate behavior, whether or not disruptive, during the past four weeks.
- 2 = Displays this behavior, but is not disruptive to others (for example, rocking in place).
- 3 = Disruptive behavior during the past four weeks, but *not* at least once per week.
- 4 = Disruptive behavior at least *once per week* during the past four weeks.
- 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 PER WEEK DURING THE PAST FOUR WEEKS. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.

- 1 = Yes
- 2 = No
- 3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

26   
(124)

**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) PER WEEK.

- A. Physical Therapy (P.T.).....
- B. Occupational Therapy (O.T.).....

**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 four or more consecutive weeks.
- 4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, restorative therapy given or to be given for only two weeks.)

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

P.T. Level  (125)

P.T. Days  (126)

P.T. Time     (127-130)  
HOURS MIN/WEEK

O.T. Level  (131)

O.T. Days  (132)

O.T. Time     (133-136)  
HOURS MIN/WEEK

**28 NUMBER OF PHYSICIAN VISITS:** ENTER ONLY THE NUMBER OF VISITS DURING THE PAST FOUR WEEKS THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. EXCLUDE VISITS BY PSYCHIATRISTS.

28    
(137-138)

**29 MEDICATIONS**

- A. Monthly average number of medications ordered.
- B. Monthly average number of psychoactive medications ordered.

29A   (139-140)

29B   (141-142)

**DIAGNOSIS**

**30 PRIMARY PROBLEM:** THE MEDICAL CONDITION (ICD-9 CODE) REQUIRING THE LARGEST AMOUNT OF NURSING TIME. THIS MAY NOT BE THE ADMISSION DIAGNOSIS BY THE PHYSICIAN.

ICD-9 Code of medical problem \_\_\_\_\_

30        
(143-147)

If code cannot be located, print medical name here: \_\_\_\_\_

**31 QUALIFIED ASSESSOR:** I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS PRI:

Yes  No

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

Signature of Qualified Assessor \_\_\_\_\_

Assessor Identification Number

31        
(148-152)