West Virginia Department of Health and Human Resources
PRE-ADMISSION SCREENING

PAS Level 0

Facility/Agency/Person making referral FROM:	Contact Person First Name:	Contact Person Last Name:	
Address:	City:	State:	Zip:
Fax Number:	Fax Extension:	Phone Number:	Extension:

Facility/Agency/Person making referral TO:	Contact Person First Name:	Contact Person Last Name:	
Address:	City:	State:	Zip:
Fax Number:	Fax Extension:	Phone Number:	Extension:

Reason for Screening (check only ONE):

- ☐ Nursing Home Only Initial
- ☐ Nursing Home Only Transfer
- ☐ Nursing Home Waiting Waiver – Yes
- ☐ Other Explain:

I. DEMOGRAPHIC INFORMATION

1a. First Name:	1b. Middle Name:	1c. Last Name:	1d. Suffix:	2. Gender:
				☐ Male ☐ Female

3. Medicaid Number:	4. Medicare Number:

5a. Address:	5b. City:	5c. State:	5d. Zip:

6. Private Insurance/Private Pay:	☐ Yes ☐ No
If yes, specify:	

7. County (WV Only):	8. Social Security Number:	9. Date of Birth:	10. Age:	11. Phone Number:

12a. Spouse First Name:	12b. Spouse Middle Name:	12c. Spouse Last Name:	12d. Spouse Suffix:

13a. Spouse Address (if different from above):	13b. City:	13c. State:	13d. Zip:	13e. County:

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services):

15. Name and Address of Provider, if applicable:

15a. Provider First Name:	15b. Provider Last Name:

15c. Provider Address:	15d. Provider City:	15e. Provider State:	15f. Provider Zip:	15g. Provider County

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16. Medicaid Waiver Recipient:				
☐ Yes	If Yes: ☐ MR/DD Waiver	☐ Aged and Disabled Waiver	☐ TBI Waiver	
☐ No				
17. Has the option of Medicaid Waiver been explained to the applicant?	☐ Yes ☐ No			
18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.				
SIGNATURE – Applicant or Person Acting for Applicant:	Relationship:	Date:		
X				
☐ Checking this box certifies that the person indicated above has signed the completed PAS and a copy of this document containing the above-named applicant's signature (or person signing for the applicant) is on file in the applicant's record.				
☐ If a verbal consent was received from the applicant, then checking this box certifies that this PAS has been signed by two witnesses and is on file in the applicant's record.				
19. Check if applicant has any of the following:				
☐ a. Guardian ☐ b. Committee ☐ c. Medical Power of Attorney ☐ d. Power of Attorney ☐ e. Durable Power of Attorney ☐ f. Living Will ☐ g. Other - Specify:				
Name of Representative:	Address:		Phone Number:	
City:	State:	Zip:		

II. MEDICAL ASSESSMENT

20. Health Assessment – Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates – date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available.)

☐ Checking this box certifies that the attached document(s) contains the most recent health assessment data available for this member and that the most recent hospital discharge summary and physical has been attached, if applicable.

21. Normal Vital Signs for the Individual:

a. Height (inches or cm):	b. Weight (pounds or kg):	c. Blood Pressure (mmHg):	d. Temperature (°F or °C):	e. Pulse:	f. Respiratory Rate:

22. Check if abnormal:

☐ a. Eyes	☐ g. Breasts	☐ m. Extremities	☐ s. Musculo Skeletal
☐ b. Ears	☐ h. Lungs	☐ n. Abdomen	☐ t. Skin
☐ c. Nose	☐ i. Heart	☐ o. Hernias	☐ u. Nervous System
☐ d. Throat	☐ j. Arteries	☐ p. Genitalia Male	☐ v. Allergies
☐ e. Mouth	☐ k. Veins	☐ q. Gynecological	**Specify:**
☐ f. Neck	☐ l. Lymph System	☐ r. Ano-Rectal	

Describe abnormalities and treatment:

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23. Medical conditions/symptoms (Grade as following: 0-None, 1-Mild, 2-Moderate, 3-Severe					
	Grade		Grade		Grade
a. Angina-Rest		e. Paralysis		i. Diabetes	
b. Angina-Exertion		f. Dysphagia		j. Contracture(s)	
c. Dyspnea		g. Aphasia		k. Mental Disorder(s)	
d. Significant Arthritis		h. Pain		l. Other	
				Other Specify:	

24. Does applicant have a decubitus? If Yes, please fill out the following:	☐ Yes ☐ No
Location (e.g. left – arm, leg, hip, buttock; right – arm, leg, hip, buttock; other):	
Stage (1,2,3, or 4):	
Size:	
Treatment:	
Developed at (home, hospital, or facility):	☐ Home ☐ Hospital ☐ Facility

25. In the event of an emergency, the individual can vacate the building (select one):
☐ Independently ☐ With Supervision ☐ Mentally Unable ☐ Physically Unable

26. Indicate individual's functional ability in the home for each item with the Level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

		Item	Level 1	Level 2	Level 3	Level 4
a.		Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.		Bathing	Self/Prompting	Physical Assistance	Total Care	
c.		Dressing	Self/Prompting	Physical Assistance	Total Care	
d.		Grooming	Self/Prompting	Physical Assistance	Total Care	
e.		Continent/Bladder	Continent	Occasional Incontinent	Incontinent	Catheter
f.		Continent/Bowel	Continent	Occasional Incontinent	Incontinent	Colostomy
g.		Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h.		Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
i.		Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
j.		Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (doors, etc.)	Total Assistance
k.		Vision	Not Impaired	Impaired/ Correctable	Impaired/Not Correctable	Blind
l.		Hearing	Not Impaired	Impaired/ Correctable	Impaired/Not Correctable	Deaf
m.		Communication	Not Impaired	Impaired/ Understandable	Understandable with Aids	Inappropriate/None

Describe functional ability in the home:

27. Professional and technical care needs (check all that apply):		
☐ a. Physical Therapy	☐ f. Ostomy	☐ k. Parenteral Fluids
☐ b. Speech Therapy	☐ g. Suctioning	☐ l. Sterile Dressings
☐ c. Occupational Therapy	☐ h. Tracheostomy	☐ m. Irrigations
☐ d. Inhalation Therapy	☐ i. Ventilator	☐ n. Special Skin Care
☐ e. Continuous Oxygen	☐ j. Dialysis	☐ o. Other

28. Individual is capable of administering his/her own medications:	☐ Yes ☐ With Prompting Supervision ☐ No
Comments:	

29. Current Medications- Is this Applicant on any Medications?	☐ Yes ☐ No	If yes, add medication in form below or attach medication list.

Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

☐ Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted.

III. MI/MR ASSESSMENT

30. Current Diagnosis (Check all that apply):

☐ a. None	☐ h. Paranoid Disorder
☐ b. Mental Retardation	☐ i. Major Affective Disorder
☐ c. Autism	☐ j. Schizoaffective Disorder
☐ d. Seizure Disorder (Age at Onset):_____	☐ k. Affective Bipolar Disorder
☐ e. Cerebral Palsy	☐ l. Tardive Dyskinesia
☐ f. Other developmental disabilities (Specify below):	☐ m. Major Depression
☐ g. Schizophrenic Disorder	☐ n. Other related conditions (Specify below):
Date of last PASRR Level II Evaluation:	

31. Has an individual ever received services from an agency service person with mental retardation/development disability and/or mental illness? If yes, specify below.			☐ Yes ☐ No
Facility:		Address:	
Admission Date:		Discharge Date:	

32. Has the individual received any of the following medications on a regular basis within the last two years? ☐ Yes ☐ No

☐ Chlorpromazine	☐ Perphenazine	☐ Haloperidol	☐ Promazine	☐ Fluphenazine
☐ Triflupromazine	☐ Fluphenazine HCl	☐ Loxapine	☐ Thioridazine	☐ Trifluoperazine
☐ Mesoridazine	☐ Chlorprothixene	☐ Prochlorperazine	☐ Actiphenazine	☐ Thiothixene
☐ Thorazine	☐ Trilafon	☐ Haldol	☐ Sparine	☐ Prolixin
☐ Vesprin	☐ Permitil	☐ Loxitane	☐ Mellaril	☐ Stelazine
☐ Serentil	☐ Taractan	☐ Molindone	☐ Tindal	☐ Navane
☐ Clozapine	☐ Compazine	☐ Moban	☐ Clozaril	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

☐ Checking this box certifies that a Medication List will be attached to this PAS form after the PAS form has been submitted.

33. Was this medication used to treat a neurological disorder? ☐ Yes ☐ No

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34. Clinical and Psychological Data – Please check any of the following behaviors which the individual has exhibited in the past two years:	
☐ a. Substance Abuse **(Identify below):**	☐ k. Seriously Impaired Judgment
	☐ l. Suicidal Thoughts, Ideations/Gestures
☐ b. Combative	☐ m. Cannot Communicate Basic Needs
☐ c. Withdrawn Depressed	☐ n. Talks About His/Her Worthlessness
☐ d. Hallucinations	☐ o. Unable to Understand Simple Commands
☐ e. Delusional	☐ p. Physically Dangerous to Self and Others, If Unsupervised
☐ f. Disoriented	☐ q. Verbally Abusive
☐ g. Bizarre Behavior	☐ r. Demonstrates Severe Challenging Behaviors
☐ h. Bangs Head	☐ s. Specialized Training Needs
☐ i. Sets Fire	☐ t. Sexually Aggressive
☐ j. Displays inappropriate social behavior	

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition?	☐ Yes ☐ No
Other (Specify):	

IV. PHYSICIAN RECOMMENDATION

35. Prognosis (Check only one)
☐ Stable
☐ Improving
☐ Deteriorating
☐ Terminal
☐ Other (Specify):

36. Rehabilitative Potential (Check only one)
☐ Good
☐ Limited
☐ Poor

37. Diagnosis – Include ICD code and descriptor	
a. Primary:	
b. Secondary:	
c. Tertiary:	
d. Other medical conditions requiring services:	
Explain:	

38. Physician Recommendations:	
A. FOR NURSING FACILITY PLACEMENT ONLY	B. I recommend that the services and care to meet these needs can be provide at the level of care indicated.
On the basis of present medical findings, the individual may eventually be able to return home or be discharged: ☐ Yes ☐ No	☐ A. Nursing Home ☐ B. Nursing Home Waiting AD Waiver
If yes, check one of the following:	
☐ a. Less than 3 months	
If less than 3 months, please specify estimated length of stay (in calendar days):	
☐ b. 3-6 months	
☐ c. More than 6 months	
☐ d. Terminal Illness	

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (MUST be signed by M.D. or D.O.).		
X	☐ MD ☐ DO	
Physician Signature	Physician Credentials	Date Assessment Completed

☐ Checking this box certifies that the MD/DO Name, typed into the "Physician's Signature" field is the Physician who completed this PAS form. Also checking this box certifies that #39 of this PAS form will be completed with the MD/DO signature for this applicant and is on file in the applicant's record.

Physician's Name and Address:	
PAS Overall Comments:	

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.
NOTE: Information gathered from this form may be utilized for statistical/data collection.

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WV Pre-Admission Screening Level I Supplemental Questions	
1. Major Mental Illness or suspected MI (check all that apply)	
☐	Major Depressive Disorder
☐	Dissociative Disorder
☐	Panic Disorder
☐	Personality Disorder
☐	Psychotic Disorder
☐	Schizoaffective Disorder
☐	Schizophrenia
☐	Other (Specify):
☐	None/NA
2. Intellectual Disability (ID) or suspected ID (check all that apply)	
☐	Current diagnosis of an ID, mild, moderate, severe or
☐	IQ or 70 or less, if available
☐	None/NA
3. Related Conditions (check all that apply)	
☐	Onset prior to 22 years of age (Age of onset):
☐	Autism
☐	Cerebral Palsy
☐	Down Syndrome
☐	Epilepsy
☐	Muscular Dystrophy
☐	Prader Willi
☐	Spina Bifida
☐	Traumatic Brain Injury
☐	Other (Specify):
4. Has/Is the individual: (check all that apply)	
☐	Held gainful employment
☐	Lived independently
☐	Able to make needs/wants known
☐	Able to complete own self care
☐	Able to choose activities or show preferences
☐	None/NA
5. Services (check all that apply)	
☐	Currently receiving services for MI
☐	Currently receiving services for ID
☐	Previously received services for MI
☐	Previously received services for ID
☐	Referred for MI services
☐	Referred for ID services
6. There is an indication that the induvial has received treatment for mental illness with an indication that the induvial has experienced either of the following:	
☐	Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization)

☐	Due to the mental illness, the individual has 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 by housing or law enforcement officials	
☐	N/A	
7. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others?		
☐	Yes	
☐	No	
8. The individual has a primary diagnosis of:		
☐	Dementia	
☐	Related Neurocognitive Disorder (including Alzheimer's disease)	
☐	N/A	
9. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?		
☐	Yes (confirm the items below are attached)	
	☐	Dementia work-up
	☐	Comprehensive mental status exam
	☐	Medical/functional history prior to onset
	☐	Other
☐	No	