Greenwood House
SKILLED NURSING ASSISTED LIVING
HOMECARE SERVICES REHABILITATION
HOSPICE CARE KOSHER MEALS ON WHEELS
53 Walter Street | Ewing, NJ 08628

Dear Friend:

Thank you for your inquiry concerning the Robert and Natalie Marcus Home for the Jewish Aged. Enclosed please find an application form and a guide explaining our Home's role, responsibilities and relationships.

Only fully processed applicants secure a position on our waiting list. Please take note that sending us a completed application does not automatically place an applicant on the waiting list. The following steps have to be completed prior to placement on the waiting list:

a. Send completed application back to Greenwood House

b. Copies of all Medicare, Medicaid, and secondary Insurance Cards (front & back)

c. Family interview with Executive Director

d. Completion of all applicable Greenwood House Medical and Financial forms

e. Applicant assessment by Greenwood House Staff

Please send the completed application to our office and we will then be in contact with you to set up an appointment.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Richard Goldstein

Richard Goldstein
Executive Director

Greenwood House

SKILLED NURSING : ASSISTED LIVING
HOMECARE SERVICES : REHABILITATION
HOSPICE CARE : KOSHER MEALS ON WHEELS

FACILITY CHARGE LIST

ROOM AND BOARD	$366.00	Semi-Private Room
	$407.00	Private Room

THERAPIES

Physical	$ 92.50	Evaluation/per session
	$ 60.00	Rehab Treatment/per session
	$ 25.00	Maintenance Sessions
Speech	$250.00	Evaluation/per session
	$ 60.00	Rehab Treatment /per session
Occupational	$105.00	Evaluation/per session
	$ 60.00	Rehab Treatment/per session

Enteral Feeding & Other Specialty Items will be billed based on usage.

PHARMACY will be billed directly from PHARMCARE

Effective: 02/01/2021

Greenwood House

SKILLED NURSING · ASSISTED LIVING
HOMECARE SERVICES · REHABILITATION
HOSPICE CARE · KOSHER MEALS ON WHEELS

53 Walter Street, Ewing NJ 08628 Phone # 609 883-5391 Fax # 609 530-1635

1. Name: _____ Religion: _____ Rehab or Long term _____

2. Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Years at Present Address: _____

If Less Than 2 Years, Previous Address: _____

3. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

4. Date of Birth: _____ Age: _____ Birthplace: _____ Maiden Name: _____

5. Medicare # _____ Social Security # _____ Medicaid # _____

Health Insurance Co.: _____ ID # _____

6. With whom are you now living? _____ Relationship: _____

Address: _____ Phone # _____

7. Names & Addresses of Spouse, Children and/or Responsible Parties:

1) Name: _____ Address: _____

Home # _____ Cell # _____ Work# _____

Email: _____

2) Name: _____ Address: _____

Home # _____ Cell # _____ Work# _____

Email: _____

3) Name: _____ Address: _____

Home # _____ Cell # _____ Work# _____

Email: _____

4) Name: _____ Address: _____

Home # _____ Cell # _____ Work# _____

Email: _____

8. Do you receive any Pension, Private or Governmental payments, including Medicaid, Social Security?

☐ Yes ☐ No If yes, please itemize source & amount (Monthly):

Source _____ Amount _____ Source _____ Amount _____

Source _____ Amount _____ Source _____ Amount _____

9. Is your Life Insured? ☐ Yes ☐ No

Amount: _____ Company: _____

Beneficiary: _____ Policy # _____

11. What serious illnesses have you had in the past 5 years? _____

_____

_____

Name & Address of Physician who last attended you: _____

_____ Date of Last Visit: _____

Who is your family physician? _____

Have you been a resident of any other Home? ☐ Yes ☐ No

If yes, give name, address: _____

Date of Residency: _____

Have you ever filed an application to any other Home? ☐ Yes ☐ No

If rejected, please state reason: _____

13. Do you have burial benefits? ☐ Yes ☐ No

14. Do you have a Living Will? ☐ Yes ☐ No

15. Funeral Arrangements: _____

Please provide copies of all:

☐ Social Security ☐ Medicare ☐ Medicaid ☐ Medical & Prescription Insurance Cards

---

If admitted, I will abide by the rules of Greenwood House and apply for any governmental aid programs which may be necessary. I agree to complete any statements required for the admission process.

A non-refundable processing fee of $50.00 is required with the filing of this application.
If unable to pay fee, please consult with the Executive Director.

Applicant's Signature: _____ Date: _____

Co-Signer (Children or those responsible): _____ Date: _____

_____ Date: _____

State of New Jersey Department of Human Services Division of Medical Assistance and Health Services

Governor Thomas H. Kean signed a law on August 23,1985 which is important to persons seeking admission to a Medicaid Nursing Home. It prohibits nursing homes from denying admission to a Medicaid applicant if a bed is available and the home is below a specific occupancy level. The law also prohibits nursing homes from requiring any payment from a Medicaid eligible person or his/her family as a condition for admission or for a continued stay at a nursing home. The Medicaid District Office should be notified immediately if this law is not followed.

Greenwood House

SKILLED NURSING ASSISTED LIVING
HOMECARE SERVICES : REHABILITATION
HOSPICE CARE : KOSHER MEALS ON WHEELS

PERSONAL FINANCIAL STATEMENT (CONFIDENTIAL)

Name: _____ Date: _____ *Please do not leave any

Address: _____ questions unanswered

ASSETS		LIABILITIES	
Cash On Hand & In Bank(s)		Notes Payable to Bank(s)	
Total Bonds (next page)		Secured	
Cash Value of Life Insurance		Unsecured	
Total Stocks - Listed (next page)		Loans Against Cash Value of	
Total Stocks - Unlisted (next page)		Life Insurance	
Accounts & Notes Receivable		Notes Payable to Relatives	
Due from Relatives & Friends		Notes Payable to Others	
Accounts & Notes Receivable (good)		Accounts & Bills Due	
Accounts & Notes Receivable (doubtful)		Accrued Taxes & Interest	
Total Real Estate Owned (next page)		Other Unpaid Taxes	
Total Real Estate		Total Mortgages Payable on	
Morgages Owned (next page)		Real Estate (next page)	
Automobiles		Chattel Mortgages & Other Liens Payable	
Personal Property		Total Other Debts (Itemize below)	
Total Other Assets - (Itemize below)			
		Total Liabilities	
		Net Worth	
TOTAL ASSETS:		Total Liability & Net Worth	

SOURCE OF INCOME		CHANGE IN ASSETS
Salary/Bonus/Commission		Please explain changes over the last 5 years, include gifts, etc.:
Dividends		
Real Estate Income - Cash Flow		
Social Security-Pensions-Public Asst.		
Other Income		
Total		

CONTINGENT LIABILITIES		GENERAL INFORMATION
As Endorser or Co-maker		Are any Assets Pledged?
On Leases or Contracts		Are you a Defendant in any Legal Actions?
Legal Claims		Personal Checking Account(s):
Provision for Federal Income Taxes		Personal Savings Account(s):
Other Special Debt - Itemize below		Amount of Life Insurance Carried
		Cash Surrender Value
		Beneficiaries
		Have you ever declared Bankruptcy?

STOCKS: LISTED

# of Shares	Name of Company	Kind of Stock	Amount / Dividend Paid	Market	If Pledged as Security state Amount of Loan

STOCKS: UNLISTED

# of Shares	Name of Company	Kind of Stock	Amount / Dividend Paid	Market	If Pledged as Security state Amount of Loan

BONDS:

Par Values	Name of Company	Description	Market Values	If Pledged as Security state Amount of Loan

MORTGAGES OR TRUST NOTES OWNED:

Description of Property Covered	Date of Acquisition	Maturity	Original Amount	Present Balance

REAL ESTATE (Please give particulars on each parcel owned):

Description & Location of Property	Title in Name Of	Cost	Date Acquired	Mortgages	Insurance

I hereby certify that the above is a true and correct statement as of the date above stated. I understand that admission to Greenwood House is made upon the strength of the statements contained herein.

Signature _____ Date _____

Greenwood House

SKILLED NURSING · ASSISTED LIVING
HOMECARE SERVICES · REHABILITATION
HOSPICE CARE · KOSHER MEALS ON WHEELS

Resident Name: _____

Date: _____ Reason for Admission: _____

History of Present Illness(es)

Past Medical History:

Surgical Procedures:

Medications:

Allergies and Sensitivities:

Family History: ("non-contributory" not acceptable):

Social History

Review of systems: Check if negative. Highlight or circle issues - pull contributory labs, x-rays, etc.	
	☐ Appetite is normal ☐ Denies weight gain or loss ☐ Denies fever or chills.
Skin	Denies ☐ new lesions ☐ changes in hair or nails ☐ rash
Heme	Denies ☐ easy bruisability ☐ gland enlargement ☐ abnormal bleeding
Head	Denies ☐ headache ☐ recent trauma
Eyes	Denies ☐ double vision ☐ blind spots ☐ cataracts ☐ glaucoma ☐ macular degeneration Last saw eye doctor _____
Mouth	Last saw dentist _____. Denies ☐ bleeding ☐ lesions. Dentures? Y/N
Pharynx/Larynx	Denies ☐ sore throat ☐ hoarseness ☐ voice change ☐ difficulty swallowing
Breasts	Denies ☐ new bumps ☐ lumps ☐ discharge ☐ deferred. Examine own breasts monthly? Y/N
Respiratory	Denies ☐ cough ☐ sputum production ☐ hemoptysis ☐ chest pain ☐ TB exposure ☐ pleurisy ☐ night sweats
Cardiac	Denies ☐ chest pain ☐ shortness of breath ☐ palpitations ☐ ankle swelling ☐ fainting ☐ heart murmur ☐ valvular Heart disease ☐ history of angina/infarction ☐ circulatory problems
Gastrointestinal	Denies ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ history of hepatitis or yellow jaundice ☐ heartburn ☐ ulcers ☐ blood in stool ☐ throwing up blood. Denies ☐ recent change in bowel habits ☐ stool color ☐ rectal pain. Denies History of ☐ hemorrhoids ☐ hernia.
Urinary	Denies ☐ incontinence ☐ burning ☐ frequency ☐ urgency ☐ polyuria ☐ nocturia ☐ oliguria ☐ retention ☐ dribbling ☐ hesitancy ☐ poor stream. Denies ☐ blood in urine ☐ history of UTI ☐ stones.
Genital	Denies history of ☐ venereal disease. Men: Denies ☐ genital lesions ☐ pain ☐ discharge ☐ testicular pain. Women: Denies ☐ vaginal discharge ☐ bleeding. ☐ deferred
Endocrine	Denies ☐ fatigue ☐ goiter ☐ temperature intolerance ☐ change in features ☐ thyroid history
Musculoskeletal	Denies ☐ pain in muscles ☐ joints ☐ arthritis
Neuro	Denies ☐ numbness ☐ tingling ☐ weakness ☐ tremor ☐ forgetfulness ☐ history of stroke.
Misc	Denies ☐ recent falls in last six months. Denies ☐ difficulty walking. Denies ☐ difficulty sleeing. Denies ☐ Depressive symptoms ☐ tearfulness ☐ hopelessness ☐ suicidal/homicidal ideation
Misc. Notes:	

Physical Exam: Check if negative:

General	
Vital Signs	BP _____ P _____ T _____ RR _____ Weight _____
	Pain _____
Head	☐ normocephalic ☐ atraumatic
Hair	☐ normal texture
Skin	
Eyes	Pupils ☐ equal ☐ round ☐ reactive to light and accommodation; ☐ extra ocular movement intact.
Ears	☐ tympanic membranes intact ☐ canals clear
Nose and Throat	☐ unremarkable Oral mucosa: _____ Dentition: _____
Neck	Supple without ☐ jugular venous distention ☐ adenopathy ☐ thyromegaly
Back	☐ normal with kyphoscoliosis
Breasts	Without ☐ mass ☐ tenderness ☐ discharge
Lymphatics	Without ☐ cervical ☐ inguinal ☐ axillary adenopathy
Lungs	☐ clear to percussion and auscultation; ☐ air entry normal
Cardiac	Regular ☐ rhythm and rate; without ☐ murmurs ☐ rubs ☐ gallops.
Abdomen	☐ soft ☐ bowel sounds present; without ☐ mass ☐ tenderness ☐ organomegaly.
Genital	Men: Women: ☐ External vulvae nl, ☐ vaginal mucosa nl, ☐ deferred
Rectal	☐ normal sphincter tone ☐ normal stool color; without ☐ mass ☐ tenderness
Prostate	Prostate size: ☐ Smooth ☐ firm ☐ non-nodular ☐ non-tender ☐ deferred
Extremities	Without ☐ clubbing ☐ cyanosis ☐ edema; ☐ peripheral pulses intact.
Neurologic	☐ awake ☐ alert ☐ Cranial nerves II-XII grossly intact ☐ sensorimotor intact ☐ without focal signs
Mental State	St Louis Exam Mini-mental state exam score (if applicable).

Prognosis/Condition/Rehabilitation Potential: _____

_____

_____

Preventative Health

Vaccines:
- ☐ Pneumovax Date _____
- ☐ Flu Date _____
- ☐ D/T Tetanus Date _____
- ☐ Zostivax Date _____
- ☐ Other: _____

Advanced Directives:

Health Care Proxy/Living Will? ☐ Yes ☐ No _____

DNR: ☐ Yes ☐ No DNH ☐ Yes ☐ No

☐ Other care request _____

Functional Status:

Ambulation:	☐ independent	☐ assisted			
	☐ no assistive device	☐ cane	☐ walker	☐ wheelchair	☐ bedbound
Transfers:	☐ independent	☐ assisted			
Dressing:	☐ independent	☐ supervised	☐ assisted		
Feedings:	☐ independent	☐ assisted	☐ dependent	☐ enteral	
Toileting:	☐ independent	☐ assisted			

Continence (Bladder): ☐ continent ☐ incontinent

Continence (Bowel): ☐ continent ☐ incontinent

Labs (include dates): _____

_____

_____

_____

Assessment/Plan: _____

_____

_____

_____

_____

_____

_____

(if additional space is needed, use progress note)

M.D. Signature: _____ Date: _____

NJ Nursing Homes Require a PASRR Form for EVERY applicant

PRIOR TO DAY OF ADMISSION

per Federal Regulation 42 CFR 483.106

This requirement is for ALL admissions, both short-term and long-term. It is unrelated to payor status.

The attached PASRR form must be completed* by a physician, social worker, or other healthcare professional that is familiar with the applicant's medical /mental health history and current level of psychosocial functioning **PRIOR to admission to Greenwood House.**

*When the applicant is coming from another nursing facility, rehab, or hospital, that facility is responsible for completing and sending the PASRR form. **When the applicant is coming from home or an ALF, then the individual's physician or licensed professional completes it.**

***The form must indicate a "negative screen" and be signed by the professional in the bottom space in Section 9 on the last page. (Only "exempted hospital discharges" resulting from positive screens will be signed in Section 8.)**

If needed, please call Joan Kritz (609-718-0595) or Betsy Kaplan (609-718-0585) of the Social Work Services Department with questions regarding this requirement.

The PASRR form should be faxed to the attention of Social Work Services at 609-530-1635 or 609-530-0031 prior to the day of admission to Greenwood House.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL I SCREEN

- Please print and complete all questions.
- This form must be completed for all applicants **PRIOR TO** nursing facility (NF) admission in accordance with Federal PASRR Regulations 42 CFR § 483.106.
- **ALL POSITIVE LEVEL I SCREENS are to be faxed to the appropriate agencies including Office of Community Choice Options (OCCO), Division of Developmental Disabilities (DDD) and/or Division of Mental Health and Addiction Services (DMHAS), as applicable.**
- **ALL 30-DAY EXEMPTED HOSPITAL DISCHARGE SCREENS are to be faxed to OCCO, DDD and/or DMHAS, as applicable.**
- For first time identification of mental Illness (MI) and/or intellectual disability/developmental disability/related condition (ID/DD/RC), the Level I Screener must provide written notice to the applicant and/or their legal representative that MI and/or ID/DD/RC is suspected or known and that a referral is being made to DMHAS and/or DDD for a PASRR Level II Evaluation. The Notice of Referral for a PASRR Level II Evaluation form (LTC-29) can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage at **http://www.state.nj.us/humanservices/doas/home/forms.html.**
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

SECTION I – DEMOGRAPHICS AND CLINICAL ASSESSMENT STATUS

Name of Applicant *(Last Name, First Name)*		Social Security Number
Current Location Address	County of Current Location	Date of Birth

Current Location Setting

☐ Acute Care Hospital ☐ Home/Apartment ☐ Residential Health Care Facility ☐ Group Home/Boarding Home
☐ Psychiatric Hospital/Unit ☐ Assisted Living Residence ☐ Other (Specify): _____

Clinical Assessment/Authorization Status

☐ Current Assessment/Authorization Date: _____
☐ Referred to OCCO for Clinical Assessment (No MCO Enrollment) - Referral Date: _____
☐ Private Pay ☐ Other (Specify): _____

SECTION II – MENTAL ILLNESS SCREEN

1. Does the individual have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or, another mental disorder that may lead to chronic disability? ..... ☐ Yes ☐ No

   Specify Diagnosis(es) based on DSM-5 or current ICD criteria and include any current substance-related disorder diagnosis(es):

   _____

2. Has the individual had a significant impairment in functioning related to a suspected or known diagnosis of mental illness?

   (Record YES if ANY of the three subcategories below are checked) .....☐ Yes ☐ No

Check all that apply:

a. ☐ ***Interpersonal functioning***. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

b. ☐ ***Concentration, persistence, and pace***. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

c. ☐ ***Adaptation to change***. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions; agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

3. Within the last 2 years has the individual (record YES if EITHER/BOTH of the two subcategories below are checked): .... ☐ Yes ☐ No

a. ☐ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

b. ☐ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   If yes, explain and provide dates:

   _____

   _____

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION II - SCREENING OUTCOME for MI Screen Questions 1 through 3 (check one outcome only)

☐ **Positive Screen MI**	**If ALL Questions 1 through 3 are answered YES, screen is Positive for MI.** **Continue to Section III for ID/DD/RC Screen**
☐ **Negative Screen MI**	**If Questions 1 through 3 are answered with any combination of NO, screen is Negative for MI.** **Continue to Section III for ID/DD/RC Screen**

SECTION III – INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY/RELATED CONDITIONS SCREEN

4. **Intellectual disability (ID) is a significantly decreased level of intellectual functioning measured by a standardized, reliable test of intellectual functioning and encompasses a wide range of conditions and levels of impairment with concurrent impairments in adaptive functioning. The ID must have manifested prior to the age of 18.**
   Does the individual have a current diagnosis or a history of intellectual disability (mild, moderate, severe or profound) and/or is there any presenting evidence (cognitive or behavior characteristics) that may indicate the person has an intellectual disability with date of onset prior to age 18? ..... ☐ Yes ☐ No
   If yes, explain: _____

5. **Related conditions (RCs) are severe, chronic developmental disabilities, but not forms of intellectual disabilities, that produce similar functional impairments and require similar treatment or services. RCs must have manifested prior to the age of 22.**
   Does the individual have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction, learning, understanding/use of language, capacity for independent living (e.g., autism, seizure disorder, cerebral palsy, Spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf or closed head injury)? ..... ☐ Yes ☐ No
   If yes, explain: _____

6. Does the individual currently receive services or previously received services paid through the Division of Developmental Disabilities (DDD) (e.g., day habilitation, group home, case management, Community Care Waiver, Real Life Choices, Family Support of Self Determination), or other agency? ..... ☐ Yes ☐ No

7. Was a referral made from an agency that serves individuals with ID/DD/RC in the past? ..... ☐ Yes ☐ No
   If yes, referred from what agency? _____

SECTION III - SCREENING OUTCOME for ID/DD/RC Screen Questions 4 through 7 (check one outcome only)

☐ **Positive Screen ID/DD/RC**	**If ANY responses to Questions 4 through 7 are YES, screen is Positive for ID/DD/RC**
☐ **Negative Screen ID/DD/RC**	**If ALL responses to Questions 4 through 7 are No, screen is Negative for ID/DD/RC**

(continue to next page)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION IV – PASRR LEVEL I SCREENING OUTCOME AND REFERRAL, IF INDICATED

STEP 1: Determine Screening Outcomes for Sections II and III (check ONE response for EACH Section):

☐ Positive ☐ Negative	**Section II – MI Screen**
☐ Positive ☐ Negative	**Section III – ID/DD/RC Screen**

STEP 2: Determine Final Level I Screening Outcome (check ONE final screening outcome only):

☐	**Negative Screen**	**If Step 1 Section II Negative Section III Negative**	**Admit to NF**
☐	**Positive Screen MI Only**	**If Step 1 Section II Positive Section III Negative**	**Refer to DMHAS**
☐	**Positive Screen ID/DD/RC only**	**If Step 1 Section II Negative Section III Positive**	**Refer to DDD**
☐	**Positive Screen MI and ID/DD/RC**	**If Step 1 Section II Positive Section III Positive**	**Refer to both DMHAS and DDD**

ALL POSITIVE PASRR LEVEL I SCREENS ARE TO BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. NF ADMISSION IS CONTINGENT UPON RECEIPT OF LEVEL II EVALUATION AND DETERMINATION.

For first time identification of MI and/or /ID/DD/RC, the Level I Screener must provide written notice to the NF applicant or legal representative that MI and/or ID/DD/RC is suspected or known, and that a referral is being made to DMHAS and/or DDD for Level II Evaluation. The Notice of Referral for a Level II Evaluation form (LTC-29) can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage at: https://www.state.nj.us/humanservices/doas/home/forms.html

Remember, when referring for a Level II PASRR Evaluation and Determination, Section IX must be completed to ensure notification of the PASRR Level II Determination.

PASRR LEVEL II DETERMINATION REQUESTS, IF INDICATED

If the Level I Screening outcome is positive for MI and/or ID/DD/RC, the Level I Screener can request, as applicable, one of the following PASRR Level II determination requests:

- **If the Level I Screen is positive for MI only, a MI Primary Dementia Exclusion can be requested by completing Section V.**
- **If the Level I Screen is positive for MI and/or ID/DD/RC, a Categorical Level II Determination can be requested by completing Section VI.**
- **If the Level I Screen is positive for MI and or ID/DD/RC, a 30-Day Exempted Hospital Discharge can be requested by completing Section VII.**

(continue to next page)

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION V – MENTAL ILLNESS PRIMARY DEMENTIA EXCLUSION for Positive Level I Screens for Mental Illness

The Mental Illness Primary Dementia Exclusion applies to individuals who have a confirmed diagnosis of dementia and that the dementia diagnosis is documented as primary or more progressed than a co-occurring MI.

☐ **Primary Dementia Exclusion requested (check if applicable)**

For an individual with a Positive Level I Screen for MI with a diagnosis of Dementia and the Dementia is primary or more progressed than the co-occurring MI, a referral to the DMHAS for the PASRR Level II evaluation and determination is required prior to NF admission:

Fax the completed Positive Level I Screen, the Notice of Referral for PASRR Level II Evaluation (LTC-29), and the completed PASRR Level II Psychiatric Evaluation form, which can be downloaded from the New Jersey DHS, DMHAS at **https://nj.gov/humanservices/dmhas/forms/**, to the **DMHAS to 609-341-2307 and to the OCCO Regional Office (see Section XI).** The LTC-29 can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage **https://www.state.nj.us/humanservices/doas/home/forms.html**.

SECTION VI – CATEGORICAL DETERMINATION FOR LEVEL I POSITIVE SCREENS

Federal PASRR Regulation 42 CFR § 483.140 permits states to make a categorical determination and omit the full Level II Evaluation in certain circumstances that are time-limited or where the need for NF is clear. Categorical determinations are *not* "exemptions".

PASRR Level I Screeners can request a categorical determination for a positive Level I Screen based on any one of four categories. Complete this section if you are requesting a categorical determination for an individual with a positive Level I Screen for MI and/or ID/DD/RC, based on any one of the following:

(Check the box for the appropriate condition or circumstance)

- ☐ **Terminal Illness -** Terminally ill with a medical prognosis of life expectancy six months or less; not a danger to self or others.
- ☐ **Severe Physical Illness -** A medical condition of such severity that prohibits participation in or benefitting from specialized services.
- ☐ **Respite Care –** To provide short term respite to the caregiver, admission from a non–institutional setting not to exceed 30 days.
- ☐ **Protective Service (APS) -** Referred by APS when NF admission is necessary, not to exceed 7 days while alternative arrangements are made.

A referral to DMHAS for a categorical determination requires completion of the DMHAS Categorical Determination form, which can be found at the New Jersey DHS, DMHAS website: **https://nj.gov/humanservices/dmhas/forms/.** This completed Categorical Determination form, along with the completed positive Level I Screen, and the Notice of Referral for Level II PASRR Evaluation (LTC-29), must be faxed to **DMHAS at 609-341-2307 (see Section XI).**

A referral to DDD for a categorical determination requires the completed positive Level I Screen and the Notice of Referral for Level II PASRR Evaluation (LTC-29) be faxed to the **DDD Central Fax Number at 609-341-2349 (see Section XI).**

The Notice of Referral for Level II PASRR Evaluation (LTC-29) can be downloaded from the New Jersey Department DHS, Division of Aging Services forms webpage at: **https://www.state.nj.us/humanservices/doas/home/forms.html.**

All Positive Level I Screens are to be faxed to OCCO **(see Section XI)**.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION VII – 30-DAY EXEMPTED HOSPITAL DISCHARGE FOR LEVEL I POSITIVE SCREENS

☐ 30-Day Exempted Hospital Discharge - Applies only to INITIAL NF admission NOT resident review, NF readmission or inter-facility transfer. Complete this section for all Positive Screens meeting the following criteria:

EXEMPTED HOSPITAL DISCHARGE – An individual may be admitted to a skilled NF directly from the hospital after receiving inpatient care (non-psychiatric) at the hospital if:

- The individual requires skilled nursing facility services for the condition for which he/she received care in the hospital **AND**
- The attending hospital physician certifies before the NF admission that the individual is likely to require less than 30 days skilled nursing facility care.

Name of Physician (Print):	Signature of Physician:	Date:

NURSING FACILITIES PLEASE NOTE THE FOLLOWING IMPORTANT INFORMATION ABOUT 30-DAY EXEMPTED HOSPITAL DISCHARGES:

- **If the individual requires care beyond the initial 30-day period, the NF must notify DMHAS and/or DDD, as applicable, prior to the individual's 30th day in the NF, and must provide a written explanation of the reason for the continued stay including the anticipated length of stay.**
- **Federal regulations require that the PASRR Level II Evaluation and Determination be completed prior to the individual's 40th day in the NF.**
  - **Admission under the above exemption does not relieve the NF of its responsibility to ensure that specialized services are provided to an individual who has MI or ID/DD/RC needs and who would benefit from those services.**
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT FOR NF SERVICES DURING THE PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME AND CERTIFICATION OF SCREENING PROFESSIONAL COMPLETING LEVEL I FORM

Outcome of Level I Screen
(check ONE Negative or Positive screening outcome)

☐ **Negative Screen:** Admit to NF

☐ **Positive Screen:** Referring for Level II Evaluation and Determination prior to NF admission (check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

☐ **Positive Screen - Requesting Primary Dementia Exclusion Determination:** Referring for Level II Evaluation and Determination prior to NF admission.
☐ MI

☐ **Positive Screen - Requesting Categorical Determination:** Referring for a Categorical Level II Evaluation and Determination prior to NF Admission (check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

☐ **Positive Screen - 30-Day Exempted Hospital Discharge**
(check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

Attending hospital physician must certify Section VII. Fax completed form to OCCO, DMHAS and/or DDD, as applicable, and then the individual can be discharged to the nursing facility.

Name of Provider/Agency/Program:

Title of Screening Professional:

Screening Professional Phone Number:

Screening Professional Fax Number:

Name of Screening Professional Completing Form (print):

Signature of Screening Professional Completing Form:

Date:

REMEMBER: ALL POSITIVE PASRR LEVEL I SCREENS MUST BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. THANK YOU.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION IX – REQUIRED CONTACT INFORMATION FOR ALL POSTIVE LEVEL I SCREENS

1. **Name of Referring Entity** (Screening professional's affiliation such as agency, hospital, NF, other healthcare provider, MCO, etc.): _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
2. **Consumer's Residing Address/Street** (Consumer's primary residence): _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
3. **Name of Legal Representative** (Last Name, First Name): _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
4. **Name of Family Member** (if available and consumer or legal representative agrees to family contact/notification): _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
5. **Name of Attending Physician:** _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____

SECTION X – CONTACT INFORMATION

Division Of Mental Health and Addiction Services (DMHAS)	**Division of Aging Services (DoAS) Office of Community Choice Options (OCCO) Regional Offices**	**Division of Developmental Disabilities (DDD)**
Statewide PASRR Coordinator for Mental Health: **Phone:** 609-438-4152 or 609-438-4146; **Fax: 609-341-2307**	**NORTHERN REGIONAL OFFICE OF COMMUNITY CHOICE OPTIONS (NRO):** Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren Counties **Phone:** 732-777-4650; **Fax: 732-777-4681** **SOUTHERN REGIONAL OFFICE OF COMMUNITY CHOICE OPTIONS (SRO):** Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem Counties **Phone:** 609-704-6050; **Fax: 609-704-6055**	**DDD Central Fax Number:** **609-341-2349** **DDD Regional Offices - Phone Numbers** **NEWARK**: Bergen, Essex and Hudson **Phone:** 973-693-5080 **PLAINFIELD**: Hunterdon, Somerset and Union **Phone:** 908-226-7800 **FLANDERS**: Morris, Passaic, Sussex and Warren **Phone:** 973-927-2600 **FREEHOLD**: Middlesex, Monmouth and Ocean **Phone:** 732-863-4500 **TRENTON**: Burlington and Mercer **Phone:** 609-584-1340 **MAYS LANDING**: Atlantic, Cape May and Cumberland **Phone:** 609-476-5200 **VOORHEES**: Camden, Gloucester and Camden **Phone:** 856-770-6366