

The PAS consists of ten (10) domains, or sections, most of which have two (2) or more subsections. The table below lists the sections/subsections and identifies the populations for whom each subsection applies.

<b>Section/Subsection</b>	<b>Applies to:</b>
<b>I Intake</b>	All applicants
<b>II Functional Screen</b>	
IIA ADL's & IADL's	All applicants
IIB Communication/Sensory	All applicants
<b>III Cognitive Screen</b>	All applicants (caregiver response component applies only if caregiver is present)
<b>IV Mood/Psychosocial &amp; Behaviors</b>	
IVA Mood/Psychosocial	All applicants
IVB Behaviors	All applicants
<b>V Medical Screen</b>	
VA Medical Conditions	All applicants
VB Health-Related Services	All applicants
VC Medications	All applicants
VD Medical Stability	All applicants
VE Medical Summary	All applicants
<b>VI Social Supports</b>	
VI.1 Primary Caregiver	All applicants except Nursing Home and other institutional residents not seeking community placement.
VI.2 Formal Agency Supports	All applicants
<b>VII Home Environment</b>	All applicants except Nursing Home and other institutional residents not seeking community placement

<b>VIII Informed Choice</b>	
VIII.1 Individual Strengths	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII.2 Program Options & Desired Assistance	All applicants
VIII.3 Individual Choice	All applicants
<b>IX Level II Determination (PASRR)</b>	All applicants presented with Nursing Facility placement as an option in Section VIII
<b>X PAS Summary &amp; Physician Certification</b>	All applicants

The Pre-Admission Screening (PAS) Application for Long Term Care may be reviewed in its entirety on the following pages of this section.

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**I. INTAKE**

<b>*Screener(s)</b>		
*Screener 1 Name (Last, First) & Credential:		Screener 2 Name (Last, First) & Credential:
Screener 3 Name (Last, First) & Credential:		Screener 4 Name (Last, First) & Credential:
*Organization:		
*Mailing Address:		
*City:	*State:	*Zip Code:
*Telephone:	*Fax:	Email:
Provider Number (if applicable):		
*Location at time of screen (check box): <input type="checkbox"/> Person's Residence <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		

<b>*Person</b>		
*Name *First, Middle Initial, *Last):		
*Street Address:		
*City:	*County:	*State:
*Zip Code	Telephone:	
Medicaid Number:	*SSN:	
Medicare Number:	*DOB (MM/DD/CCYY)	*Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>*Designated Representative</b> <i>If none, enter "none" on Name line</i>		
*Name (*First, Middle Initial, *Last)		
*Street Address:		
*City:	*State:	*Zip Code:
*Relationship to Person:	Telephone:	
Comments:		

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**I. INTAKE - *continued***

<b>*Other Contacts</b>	
*Physician:	*Telephone:
*Physician Mailing Address, City, State, Zip:	
Case Manager (if different from screener):	Telephone:
Case Manager Mailing Address, City, State, Zip_ (if different from screener):	

<b>*Usual Living Arrangement</b>		
<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Nursing Facility	Other:
<input type="checkbox"/> Lives with Spouse	<input type="checkbox"/> Assisted Living Facility	
<input type="checkbox"/> Lives with other Relative	<input type="checkbox"/> ICF/MR	
<input type="checkbox"/> Lives with non-Relative	<input type="checkbox"/> Other (specify)	
Facility Name (if applicable):		

<b>*Application Type</b>
<input type="checkbox"/> New Long Term Care Applicant
<input type="checkbox"/> Recertification – Elderly & Disabled Waiver
<input type="checkbox"/> Recertification – Assisted Living Waiver
<input type="checkbox"/> Recertification – Traumatic Brain Injury/Spinal Cord Injury Waiver
<input type="checkbox"/> Recertification – Independent Living Waiver
Comments:

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN**

**A. ACTIVITIES OF DAILY LIVING (ADLs) & INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

<b>ADL SCALE</b>	
<b>0 =</b>	<b>Independent</b> - Person is independent in completing activity safely
<b>1 =</b>	<b>Supervision</b> - Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
<b>2 =</b>	<b>Physical Assistance</b> - Person can participate in activity but requires physical/hands-on assistance to complete safely
<b>3 =</b>	<b>Total Dependence</b> - Person is completely dependent on others to complete activity safely
<b>Activity</b>	<b>Score</b>
*1. <b>MOBILITY/AMBULATION</b> – How well is the person able to purposefully move within his or her residence/living environment?	
*2. <b>COMMUNITY MOBILITY</b> – How well is the person able to move around the neighborhood or community, including accessing buildings, stores and restaurants, and using any mode of transportation, such as: walking, wheelchair, cars, buses, taxis, bicycles etc.? This includes entering/exiting transportation, such as cars, buses and taxis.	
*3. <b>TRANSFERRING</b> – How much human assistance does the person need on a consistent basis for safe transfer, including from bed/chair to wheelchair, walker or standing position; onto and off of toilet; and into and out of bath or shower?	
*4. <b>EATING</b> – How well is the person able to eat and drink safely? This includes ability to cut, chew and swallow foods. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can feed self independently, or "1", "2", or "3" if s/he requires another person to assist.) <u>Excludes meal preparation</u>	
*5. <b>MEAL PREPARATION</b> – How well is the person able to safely obtain and prepare routine meals? This includes the ability to independently open containers and use kitchen appliances. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can prepare the tube/IV feeding independently, or "1", "2", or "3" if s/he requires another person to assist.)	
Comments:	

\* Denotes required fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

<b>ADL SCALE</b>	
<b>0 = Independent</b>	- Person is independent in completing activity safely
<b>1 = Supervision</b>	- Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
<b>2 = Physical Assistance</b>	- Person can participate in activity but requires physical/hands-on assistance to complete safely
<b>3 = Total Dependence</b>	- Person is completely dependent on others to complete activity safely
<b>Activity</b>	<b>Score</b>
*6. <b>TOILETING</b> – How well is the person able to use the toilet, commode, bedpan or urinal safely? This includes flushing, cleansing of self, changing of protective garment, adjusting clothing, washing hands, managing an ostomy or catheter. Excludes transfer and continence (Note – limited hands-on assistance includes emptying bedpans.)	
*7. <b>BATHING</b> – How well is the person able to bathe, shower or take sponge baths safely for the purpose of maintaining adequate hygiene and skin integrity? Includes washing hair. Excludes transfer (Note – limited hands-on assistance includes helping with hard to reach areas, such as the back.)	
*8. <b>DRESSING</b> – How well is the person able to safely dress and undress as necessary regardless of clothing type? This includes ability to put on prostheses, braces, anti-embolism hose and choice of appropriate clothes for the weather and for personal comfort. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. (Note: if person can dress independently, but normally requires 30 minutes or longer doing so, score as "Supervisory" (1).)	
*9. <b>PERSONAL HYGIENE</b> – How well is the person able to perform personal hygiene/grooming activities safely, including but not limited to combing hair, shaving, oral care? Exclude nail care and washing hair (which is addressed under bathing).	
*10. <b>MEDICATION MANAGEMENT</b> – How well is the person able to safely manage and administer pills, liquids, inhalers, nebulizers, eye drops, ear drops, self-administered injectables, IV medications, medication pumps? Excludes insulin and monthly injections, such as B-12 shots.	
Comments:	

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN – *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

<b>*11. INSULIN ADMINISTRATION</b>	How well is the person able to safely manage and administer insulin? If person does not use insulin, select N/A for all items.		
<b>Activity</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
DOES PERSON USE INSULIN? (Please check Yes, No, or N/A) (If Yes, answer Questions 11a, 11b, and 11c. Otherwise, skip to Question 12.)			
*11a. Can person administer finger sticks and understand Accu-Chek® (glucose testing) results?			
*11b. If on a fixed dose, can person self-inject insulin with a pre-filled syringe?			
*11c. If on a sliding scale, can person draw up the correct amount and inject insulin?			
Comments:			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used (Includes catheter and ostomy)

<b>CONTINENCE SCALE</b>	
<b>0 =</b>	<b>Complete voluntary control</b>
<b>1 =</b>	<b>Incontinent episodes less than weekly</b>
<b>2 =</b>	<b>Incontinent episodes once per week</b>
<b>3 =</b>	<b>Incontinent episodes two or more times per week</b>
<b>Activity</b>	
<b>Score</b>	
<b>*12. BLADDER CONTINENCE</b> – How well is the person able to voluntarily control the discharge of body waste from the bladder?	
<b>*13. BOWEL CONTINENCE</b> –How well is the person able to voluntarily control the discharge of body waste from the bowel?	
Comments:	

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

**14. UNDERLYING CAUSES OF ADL/IADL LIMITATIONS – Check all that apply**

Part A General Underlying Causes (across ADLs/IADLs)				Part B Specific to Medication Management	
Physical Impairments:		Physical Impairments (cont'd):		Physical Impairments:	
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Cannot Crush Pills
<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Physiological Defect	<input type="checkbox"/>	Cannot Open Blister Pack
<input type="checkbox"/>	Bladder Incontinence	<input type="checkbox"/>	Poor Dentition	<input type="checkbox"/>	Cannot Open Containers
<input type="checkbox"/>	Bowel Incontinence	<input type="checkbox"/>	Sensory Impairment – Hearing	<input type="checkbox"/>	Cannot use Ear/Eye Drops
<input type="checkbox"/>	Catheter	<input type="checkbox"/>	Sensory Impairment – Vision	<input type="checkbox"/>	Liquid Medications Only
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Poor Coordination
<input type="checkbox"/>	Decreased Endurance	<input type="checkbox"/>	Swallowing Problems	<input type="checkbox"/>	Unable to Draw Medication
<input type="checkbox"/>	Fine or Gross Motor Impairment	<input type="checkbox"/>	Tube Feeding	<input type="checkbox"/>	Unable to put Medication in Mouth
<input type="checkbox"/>	Fracture(s)	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Unable to Read Labels
<input type="checkbox"/>	Lack of Assistive Devices	<b>Supervision Need/Mental Health:</b>		<b>Supervision Need:</b>	
<input type="checkbox"/>	Limited Range of Motion	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	Complex Regimen
<input type="checkbox"/>	Muscle Tone	<input type="checkbox"/>	Cognitive Impairment	<input type="checkbox"/>	Does not Follow Frequency
<input type="checkbox"/>	Neurological Impairment	<input type="checkbox"/>	History of Falls	<input type="checkbox"/>	Does not Follow Dosage
<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Lack of Motivation/Apathy	<input type="checkbox"/>	Forgets to Take Medication
<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	Memory Impairment	<input type="checkbox"/>	Mixes Alcohol with Prescription Drugs
<input type="checkbox"/>	Oxygen Use	<b>Other (specify)</b>		<b>Other (specify)</b>	
<input type="checkbox"/>	Pain	<input type="checkbox"/>		<input type="checkbox"/>	
<p>Comments:</p>					

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

**15. ASSISTIVE DEVICES** – Check all devices that the person either uses today or needs. (Note that some devices with multiple ADL/IADL uses are listed only under the most common ADL/IADL application. Check box even if used or needed for a different ADL/IADL.)

Uses Today	Needs	Device	Uses Today	Needs	Device
<b>Mobility Related:</b>			<b>Toileting/Continance Related:</b>		
		Cane – Standard			Adult Diapers
		Cane – Quad			Bedside Commode/Bedpan
		Cane Grip Strap			In/Out Catheter
		Crutches			Raised Commode Seat
		Leg Brace			Toilet Paper Wiper Aid
		Motorized Scooter			Washable Bed Pads
		Prostheses			Zipper Hooks/Pulls
		Ramp	<b>Bathing Related:</b>		
		Walker – Not Wheeled			Handheld Shower Head
		Walker – Wheeled			Shower Chair
		Walker with Seat (trough)			Shower Slide/Swivel Chair
		Wheelchair – Standard			Specialized Brushes
		Wheelchair – Motorized	<b>Dressing Related:</b>		
		Wheelchair – Customized			Button Hook
<b>Transfer Related:</b>					Dressing Stick
		Bed Pull-Up Straps			Elastic Shoe Laces
		Furniture Risers			Long-Handled Shoe Horn
		Grab Bars/Hand Rails			Sock Aid
		Hospital Bed	<b>Personal Hygiene Related:</b>		
		Leg Lifters			Hair Dryer Stand
		Lift Chair			Velcro Handles/Cushion Holders for
		Lift/Ceiling Track System			Brushes, Razors, Toothbrushes
		Mechanical Lift (not chair)	<b>Medication Related:</b>		
		Overhead Trapeze			Alarm Device
		Raised Seat Cushion			Pillbox
		Shower Slide/Swivel Chair	<b>Communication Related:</b>		
		Transfer Board/Disk			Communication Board
<b>Eating/Meal Preparation Related:</b>					Other Communication Aid (specify)
		Adaptive Cups/Plates	<b>Other (Specify):</b>		
		Adaptive Utensils			
		Home Delivered Meals			
		Mechanically Altered Food			
<b>Comments:</b>					

\*Denotes required fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**B. COMMUNICATION/SENSORY – Enter score in box (must be whole number)**

		<b>Score</b>	<input type="text"/>
<b>*1. EXPRESSIVE COMMUNICATION</b> - How well is the person able to express him or herself in their own language, including non-English languages and American Sign Language (ASL) or other generally recognized non-verbal communication?			
0.	Person can fully communicate with no impairment or only mild impairment (e.g., slow speech)		
1.	Person can fully communicate with the use of assistive device		
2.	Person can communicate only basic needs to others		
3.	Person has no effective communication		
Comments:			

		<b>Score</b>	<input type="text"/>
<b>*2. ABILITY TO UNDERSTAND OTHERS</b> – How well is the person able to understand verbal information content?			
0.	Person understands		
1.	Person usually understands – may miss some part/intent of message		
2.	Person sometimes understands – responds adequately to simple, direct communication		
3.	Person rarely/never understands		
Comments:			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**II. FUNCTIONAL SCREEN - *continued***

**B. COMMUNICATION/SENSORY (cont'd) – Enter score in box (must be whole number)**

		<b>Score</b>	<input type="text"/>
<b>*3. VISION – The ability to see in adequate light, and with glasses (if used)</b>			
0.	ADEQUATE – Sees fine detail, including regular print in newspapers/books		
1.	MILDLY IMPAIRED – Sees large print, but not regular print in newspapers/books		
2.	MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects		
3.	HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects		
4.	SEVERELY IMPAIRED – No vision OR sees only light, colors and shapes; eyes do not appear to follow objects		
UNK	Unable to determine appropriate score		
Comments:			

		<b>Score</b>	<input type="text"/>
<b>*4. HEARING – The ability to hear, with hearing appliances (if used)</b>			
0.	HEARS ADEQUATELY – Normal talk, TV, phone		
1.	MILDLY IMPAIRED – Minimal difficulty when not in quiet setting		
2.	MODERATELY IMPAIRED – Hears in special situations only; speaker has to adjust tonal quality and speak distinctly		
3.	HIGHLY IMPAIRED – Absence of useful hearing		
UNK	Unable to determine appropriate score		
Comments:			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**III. COGNITIVE SCREEN (ORIENTATION)**

What is the person's level of awareness to person, place and time?

- Check appropriate boxes, based on responses (check "does not know" if person is non-responsive due to severe cognitive impairment, such as advanced Alzheimer's)
- A caregiver should be familiar with the person's orientation on a daily basis. It can be a relative or non-relative, including a staff member in an Assisted Living Facility or Nursing Home
- Instruct caregivers to consider the past 90 days

Check if Caregiver not present (skip Caregiver Judgment items in III.A.1 through III.A.4)

<b>1. PERSON</b>				Caregiver Judgment (if present)		
*At time of screen, does person know their:				Caregiver Judgment (if present)		
First Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Last Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Caregiver's Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

<b>2. PLACE</b>				Caregiver Judgment (if present)		
*At time of screen, does person know their:				Caregiver Judgment (if present)		
Immediate Environment	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Place of Residence	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
City	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
State	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**III. COGNITIVE SCREEN (ORIENTATION) - continued**

<b>3. TIME</b>						
<i>*At time of screen, does person know their:</i>				<i>Caregiver Judgment (if present)</i>		
Day	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Month	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Year	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Time of Day	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

* <input type="text"/>	← <i>Screener's Score</i>	<i>Caregiver's Score</i> → <input type="text"/>
<b>*4. OVERALL RATING OF ORIENTATION/SITUATIONAL AWARENESS</b>		
<b>0 = No problem</b> – Person is completely unimpaired or has slight impairment or confusion of doubtful clinical significance (e.g., misses the date by one day).		
<b>1 = Mildly or Moderately Disoriented/Confused</b> – Mild, but definite impairment or confusion (e.g., unsure about orientation to time, or some impairment in a few aspects of short term or long term memory) OR moderate impairment or confusion (e.g., unsure about where s/he is and what is occurring right now, or cannot recall important events in his/her life)		
<b>2 = Severely Disoriented/Confused</b> – Thoroughly disoriented or confused to person, place, time and what is occurring right now; significant impairment in short term and/or long term memory OR unable to respond due to severe cognitive impairment.		
Comments:		

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS**

**A. CURRENT MOOD/PSYCHOSOCIAL** – Check current Mood/PsychoSocial status as applicable (exception – check "Psychological Illness History" if illness was diagnosed but is no longer symptomatic)

<b>Mood/PsychoSocial</b>			
<b>PsychoSocial Problems</b>	<b>Check if Applicable</b>	<b>Significant Losses</b>	<b>Check if Applicable</b>
Psychological Illness Present		Death of Spouse	
Psychological Illness History		Death of Other Family Member or Friend	
Depression		Death of Pet	
Nervousness/Anxiety		Other (Specify in Comments)	
Crying		<b>Significant Changes</b>	
Insomnia		Change in Residence	
Nightmares		Divorce/Separation	
Loss of Appetite		Retirement	
Concerns Regarding Potential PsychoSocial Situation		Other (Specify in Comments)	
Poor Eye Contact		<b>Threats/Victimization</b>	
Withdrawal from Activities of Interest		Financial Concerns	
Loneliness/Isolation		Safety Concerns	
Other (Specify in Comments)		Victim of Assault/Theft	
		Victim of Abuse/Neglect	
		Other (Specify in Comments)	
<b>Comments:</b>			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - continued**

**B. BEHAVIORS**

- Consider behaviors during the past 90 days that required some level of intervention to address (You may mark "H" for behaviors that occurred historically, defined as greater than 90 days ago but within the past two years)
- For interventions, consider the most common level of intervention required
- "Easily altered" applies to persons who can be redirected verbally without difficulty
- "Not easily altered" applies to persons who can be redirected verbally with difficulty, or who require physical or chemical restraints (to the extent allowed by law)

<b>Frequency of Behavior:</b>	<b>If "Frequency of Behavior" is Greater than "0" What Intensity of Intervention is Required?</b>
0 = Has not occurred	0 = Behavior is easily altered
H = Has occurred historically (greater than past 90 days)	1 = Behavior is not easily altered
1 = Occasional behavior requiring intervention no more than once per week	
2 = Frequent behavior requiring intervention more than weekly, but less than daily	
3 = Constant behavior requiring daily intervention	

<b>*1. VERBALLY AGGRESSIVE: Threatening, screaming and/or cursing at others</b>	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Falsely accuses others of stealing <input type="checkbox"/> Spitting at others <input type="checkbox"/> Verbal threats <input type="checkbox"/> Screaming/cursing at others <input type="checkbox"/> Other (please specify): _____	
<b>*2. PHYSICALLY AGGRESSIVE: Hitting, shoving, scratching and/or sexually abusing others</b>	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Combative regarding personal care <input type="checkbox"/> Hits/shoves/scratches others <input type="checkbox"/> Intimidating/threatening physical harm <input type="checkbox"/> Sexually abusive <input type="checkbox"/> Throws items at others <input type="checkbox"/> Other (please specify): _____	
<b>*3. RESISTIVE: Inappropriately stubborn and uncooperative. Includes both passive and active behaviors.</b>	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Refuses to eat <input type="checkbox"/> Refuses to participate in personal care (non-violent) <input type="checkbox"/> Refuses to take necessary medications <input type="checkbox"/> Other (please specify): _____	
Comments:	

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - continued**

**B. BEHAVIORS (cont'd)**

<b>*4. WANDERING/ELOPEMENT:</b> Movement with no rational purpose, seemingly oblivious to needs or safety	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply) <input type="checkbox"/> Leaves home and becomes lost <input type="checkbox"/> Wanders – seeking exit <input type="checkbox"/> Wanders – NOT seeking exit  <input type="checkbox"/> Other (please specify): _____	
<b>*5. INAPPROPRIATE/UNSAFE:</b> Includes socially inappropriate behaviors, unsafe behaviors and disruptive behaviors. Excludes aggression toward others.	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply) <input type="checkbox"/> Breaks objects <input type="checkbox"/> Hiding items <input type="checkbox"/> Hoarding <input type="checkbox"/> Inappropriate noises <input type="checkbox"/> Inappropriate talk or actions <input type="checkbox"/> Inappropriate toileting/menses <input type="checkbox"/> Puts inappropriate non-food items in mouth <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Rummaging/takes belongings <input type="checkbox"/> Unsafe cooking <input type="checkbox"/> Unsafe smoking <input type="checkbox"/> Other (please specify): _____	
<b>*6. SELF-INJURIOUS:</b> Repeated behaviors that cause harm to self. Also can include suicidal behavior.	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply) <input type="checkbox"/> Biting/scratching/picking at self <input type="checkbox"/> Head slapping/banging <input type="checkbox"/> Suicidal  <input type="checkbox"/> Other (please specify): _____	
<b>*7. OTHER:</b> Delusions, hallucinations, manic symptoms, mood swings	
*BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	*REQUIRED INTERVENTION INTENSITY (circle) 0    1
*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" (check all that apply) <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations <input type="checkbox"/> Manic symptoms/mood swings  <input type="checkbox"/> Other (please specify): _____	
Comments:	

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**V. MEDICAL SCREEN**

**A. MEDICAL CONDITIONS**

- Check only those diagnoses that have a current relationship to ADL status, cognitive/behavioral status, medical treatments, skilled nursing care or risk of death

<b>1. Cardiovascular:</b>		<b>5. Musculoskeletal:</b>		<b>7. Ophthalmologic/EENT:</b>	
	Angina (chest pain)		Arthritis/Osteoarthritis		Blind
	Arteriosclerotic Heart Disease		Arthritis/Rheumatoid		Cataracts
	Cardiac Dysrhythmias		Degenerative Joint Disease		Diabetic Retinopathy
	Congestive Heart Failure		Fracture/Unspecified		Glaucoma
	Cerebral Vascular Accident		Fracture/Hip		Hearing Impaired/Deaf
	Deep Vein Thrombosis		Fracture/Pathological		Macular Degeneration
	Hypertension		Gout	<b>8. Psychiatric/Mood:</b>	
	Hypotension		Joint Repair or Replacement		Anxiety Disorder
	Myocardial Infarction		Missing Limb		Bipolar Disorder
	Peripheral Vascular Disease		Osteoporosis		Depression (major)
	Transient Ischemic Attack	<b>6. Neurological:</b>			Depression (other)
<b>2. Endocrine:</b>			ALS (Lou Gehrig's Disease)		Schizophrenia/other psychoses
	Diabetes IDDM (insulin dependent)		Alzheimer's	<b>9. Respiratory:</b>	
	Diabetes NIDDM (non-insulin dep.)		Aphasia		Asthma
	Hyperlipidemia		Autism		Bronchitis/Chronic
	Hyperthyroidism		Cerebral Palsy		Chronic Obstructive Pulmonary
	Hypothyroidism		Dementia (not Alzheimer's)		Disease
	Obesity		Developmental Disability		Emphysema
<b>3. Gastrointestinal:</b>			Hemiplegia		Influenza
	GI Ulcers		Huntington's Disease		Pneumonia
	Gastroesophageal Reflux Disease		Impairment/Central Nervous		Tuberculosis (positive Mantoux)
	Ulcerative Colitis		Mental Retardation	<b>10. Other:</b>	
<b>4. Genitourinary:</b>			Multiple Sclerosis		Allergies (specify type in comments)
	Renal Failure		Muscular Dystrophy		Anemia
	Urinary Retention		Neuropathy		Cancer
	Urinary Tract Infection		Paraplegia		Cellulitis
			Parkinson's Disease		Coma
			Quadriplegia		Constipation
			Seizure Disorder		Decubitus Ulcer (describe number and type(s) in comments)
			Traumatic Brain Injury		Explicit Terminal Diagnosis
					Functioning at Brain Stem Level
					HIV/AIDS
					Septicemia
					Other (specify in comments)
<b>Comments: Use Medical Summary at end of Medical Section, if needed.</b>					

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**V. MEDICAL SCREEN – continued**

**\*B. HEALTH-RELATED SERVICES** - Indicate frequency if receives today and amount is known

Health-Related Services Needed or Receiving (Indicate which)	Currently Receives	Needs	Service Frequency					
			1 to 3 Times/ Month	Weekly	2 to 6 Times/ Week	1 to 2 Times/ Day	3 to 4 Times/ Day	Over 4 Times/ Day
<b>Bladder/Bowel:</b>								
▪ Bowel Dilatation								
▪ Catheter Care								
▪ Ostomy Care								
<b>Feedings:</b>								
▪ Parenteral Feedings/TPN								
▪ Special Diet (specify)								
▪ Tube Feedings								
<b>Injections/IV:</b>								
▪ Intramuscular/Subcutaneous Injections								
▪ Intravenous Infusion Therapy								
<b>Medications:</b>								
▪ Drug Administration								
▪ Drug Regulation								
<b>Rehabilitative Nursing:</b>								
▪ Bowel/Bladder Training								
▪ Range of Motion								
▪ Teaching/Training								
▪ Turning and Positioning								
▪ Other Rehab Nursing								
<b>Respiratory:</b>								
▪ Chest-Physio Therapy								
▪ CPAP								
▪ Oxygen								
▪ Small Volume Nebulizer								
▪ Suctioning								
▪ Trach Care								
▪ Ventilator								
<b>Skin Care:</b>								
▪ Non Bowel/Bladder Care								
▪ Pressure/Other Ulcers								
▪ Wound Care								
<b>Therapies:</b>								
▪ Alcohol/Drug Treatment								
▪ Individual/Group Therapy – Psycho/Social								
▪ Occupational Therapy								
▪ Physical Therapy								
▪ Respiratory Therapy								
▪ Speech Therapy								
▪ Vocational Rehabilitation								
<b>Other Services &amp; Treatments:</b>								
▪ Chemotherapy/Radiation								
▪ Fluid Intake/Output								
▪ Hemodialysis								
▪ Peritoneal Dialysis								
▪ Restraints								
▪ Other (specify):								
<b>Comments:</b> Use Medical Summary at end of Medical Section, if needed.								

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**V. MEDICAL SCREEN – *continued***

**B. CURRENT MEDICATIONS**

- Include both prescribed and over-the-counter medications currently being taken
- Identify dosage, frequency and prescribing physician (as applicable) for all current medications
- Check Psychotropic box if a medication is being administered for the purpose of treating a behavioral health condition

Medications	Dosage	Frequency	Prescriber	Psychotropic
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Comments:

\*Denotes Required Fields





**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VI. SOCIAL SUPPORTS**

**N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY ( if checked, skip section)**

<b>*1. Primary Caregiver</b>	<input type="checkbox"/> Check if person has primary caregiver/contact, but person is not present at screening <input type="checkbox"/> Check if person has no caregiver or emergency contact		
*Name (*First, Middle Initial, *Last)			
*Relation <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other Relative _____ <input type="checkbox"/> Friend <input type="checkbox"/> Other _____			
Lives with Person? <input type="checkbox"/> Yes <input type="checkbox"/> No		Designated Representative? (If answered "No" to both, enter address below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Street Address: (Write "Same" if lives with person and/or "DR" if Designated Representative)			
*City:	*State:	*Zip Code:	*Telephone:
*Frequency of Support		*Type(s) of Support Typically Provided	
Individual is emergency contact only/not serving as caregiver (skip remainder of table)		Personal Care/ADLs (e.g., bathing, dressing etc.)	
Every day		Housekeeping/chores	
Several days per week		Meal Preparation	
At least once per week		Medication administration & oversight	
Less than once per week		Shopping/Errands	
* ← Estimated hours of support provided in previous seven days		Supervision for safety	
		Transportation	
		Other (specify in comments)	
*Caregiver's health (self-reported) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't Know			
*Caregiver's emotional well-being (self-reported) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't Know			
*Is caregiver able/willing to maintain current level of support in foreseeable future? If no, explain in comments <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comments:			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VI. SOCIAL SUPPORTS – *continued***

**2. Formal Agency Supports**

Check if person has no formal agency supports and complete "Needs" portion of table only

Agency 1 Name			Agency 2 Name		
Address (Street, City, Zip Code)			Address (Street, City, Zip Code)		
Telephone:			Telephone:		
<b>Receives</b>	<b>Needs</b>	<b>Long Term Care Services</b>	<b>Receives</b>	<b>Needs</b>	<b>Long Term Care Services</b>
		Adult Day Care			In-Home Respite
		Assisted Living			In-Home Nursing Respite
		Attendant Care			Institutional Respite
		Attendant Call System			Intermittent Skilled Nursing
		Case Management			Medication Administration/Oversight
		Chore Services			Personal Care
		Environmental Modifications			Programming
		Home Health Aide			Transition Services
		Home Health, Expanded			Transportation (Escorted and non-Escorted)
		Homemaker			Other (specify in comments)
		Home Delivered Meals			

Comments:

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VII. HOME ENVIRONMENT**

- N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY (if checked, skip section)
- Person resides in nursing facility or other institutional setting and is seeking placement in the community (check desired dwelling type and provide further details about availability of desired community placement in comments section, including whether placement arrangements have been made.)

<b>Characteristics</b>		For identified problems, address necessary action(s) in comments.	
<b>*Dwelling Type</b>	<b>Check One</b>	<b>*Heating/Cooling/Safety</b>	<b>Check if Present</b>
House		Air Conditioning Type: _____	
Apartment		Heat Type: _____	
Trailer		Working Smoke Detectors	
Congregate Housing		Fire Extinguishers	
Other (specify in comments)		Clear Pathways	
<b>*Structural Concerns</b>	<b>Check if Applicable</b>	911 System	
Accessibility		Emergency Response System	
Roof		Severe Weather Procedure	
Walls		<b>*Neighborhood</b>	<b>Check One</b>
Floor		High Crime	
Other (specify in comments)		Moderate Crime	
<b>*Sanitation Concerns</b>	<b>Check if Applicable</b>	Low Crime	
Pests			
Plumbing			
Sewage			
Comments:			

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VIII. INFORMED CHOICE**

The purpose of this section is to match the person's care needs, strengths and desires with DOM-covered long term care programs, to ensure the person, and person's family, is able to make an informed choice from the available DOM-covered options.

- N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY (if checked, skip section)**

<b>1. Person Strengths</b>		Document person's strengths as they relate to remaining in their home or another community setting. Check all that apply and provide additional detail in comments section, as appropriate.			
<b>Social Supports</b>		<b>Outside Activities/Networks</b>		<b>Resources</b>	
	Supportive Family		Active in church/faith-based organizations		Adequate housing
	Supportive Friends		Active in clubs/recreational groups		Financially secure
	Supportive Neighbors		Active in sports		Adequate transportation
	Other (specify in comments)		Employed		Safe environment
			Volunteers		Other (specify in comments)
			Other (specify in comments)		
<b>Health &amp; Wellness</b>		<b>Personal Outlook</b>			
	Adequate physical health		Positive self-image		
	Balanced mental health		Positive view of others		
	Adequate self-care ability (with support)		Positive view of the future		
	Adequate access to medical care		Desire to remain in (return to) home/community		
	Adequate communication skills		Sense of purpose		
	Commitment to health		Ability to ask for and accept help		
	Knowledge about how choices impact health		Other (specify in comments)		
	Other (specify in comments)				
<b>Comments:</b>					

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VIII. INFORMED CHOICE - *continued***

<b>*2. Program Options &amp; Desired Assistance</b>	Desired Assistance (CHECK ALL THAT APPLY within potential placement options)				
	<b>Nursing Facility</b>	<b>Assisted Living</b>	<b>Elderly/ Disabled Waiver</b>	<b>Independent Living Waiver</b>	<b>TBI/SCI Waiver</b>
Nursing Facility (all inclusive)					
Adult Day Care					
Assisted Living Placement					
Attendant Care					
Attendant Call System					
Case Management					
Chore Services					
Environmental Modifications					
Escorted Transportation					
Homemaker					
Home Health, Expanded*					
Home Delivered Meals					
In-Home Respite					
In-Home Nursing Respite					
Institutional Respite					
Medication Admin/Oversight					
Personal Care					
Programming					
Skilled Nursing, Intermittent					
Specialized Equipment/Supplies					
Transition Services					
Transportation					
* Home Health, Expanded can include: Home Health Aide, Skilled Nurse, Physical Therapy and Speech Therapy					
Comments:					

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**VIII. INFORMED CHOICE – *continued***

Person's Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

Note – If completing PAS electronically, record options presented below. Obtain signatures and initials on hard copy PAS or hard copy "PAS-Informed Choice" form. Retain hard copy document with signatures and initials for later DOM review (if requested)

<b>*3. Person Choice</b>			
<b>Option</b>	<b>Presented as Option, based on Screen?</b>		<b>Person's Choice (initial)</b>
	<b>Yes</b>	<b>No</b>	
Nursing Facility Placement			
Assisted Living Waiver			
Elderly/Disabled Waiver			
Independent Living Waiver			
TBI/SCI Waiver			
Other (specify):			
Comments:			

*\*Screener:*

I have informed the person and/or the person's legal representative of the available DOM-covered long term care options, including alternatives to Nursing Facility placement, based on the results of the PAS and the person's desired services.

\_\_\_\_\_  
 \*Signature                      \*Date                      \*Printed Name                      \*Credentials

*\*Person:* Name: \_\_\_\_\_

I hereby acknowledge my participation in this screening process, agree that I have had long term care program options explained to me and have indicated my choice by initialing in the appropriate box above. I also have been informed that the Medicaid program has financial eligibility requirements not addressed as part of this screen. I authorize the agency or attending physician to provide the DOM with information necessary to meet the federal requirements for review and/or assist me in seeking long term care services.

*\*Signed:* \_\_\_\_\_  
 Person/Legal Representative                      Date

*\*Signed:* \_\_\_\_\_  
 Witness                      Date

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**IX. LEVEL II DETERMINATION**

**THIS SECTION IS TO BE COMPLETED ON ALL PERSONS BEING CONSIDERED FOR PLACEMENT IN A NURSING FACILITY**

- Complete Part A to determine if person is exempt from Level II evaluation due to medical diagnosis or other qualifying factor. Yes answers must be supported by data entered in previous PAS sections, as indicated.
- Complete Part B to document if person has a mental illness or is mentally retarded/developmentally disabled (Part B must be completed if one of the exemption criteria are marked in Part A)
- Referrals must be made even if physician certifies that, in his/her opinion, a Level II evaluation is not indicated at this time (physician finding will be considered by DOM when making final determination regarding the person's need for an evaluation)

**A. Exemption Criteria**

<b>Criteria</b>	<b>As Documented in:</b>	<b>Yes</b>	<b>No</b>
1. Person has diagnosis of Alzheimer's Disease or other Dementia	Section V.A		
2. Person is in need of nursing care for a terminal illness with a life expectancy of six (6) months or less	Section V.A		
3. Person has severe physical illness such as coma, functioning at brain stem level or diagnosis such as severe COPD, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Severe Congestive Heart Failure	Section V.A and ICD-9 portion of physician certification form		
4. Person is ventilator dependent	Section V.B		
5. Person needs respite care for 10 days or less			
6. Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from a hospital			
7. Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement in a nursing facility not to exceed 7 days			

*If any question in Part A has been answered "Yes", person is exempt from Level II evaluation. (Part B must still be completed)*

\*Denotes Required Fields

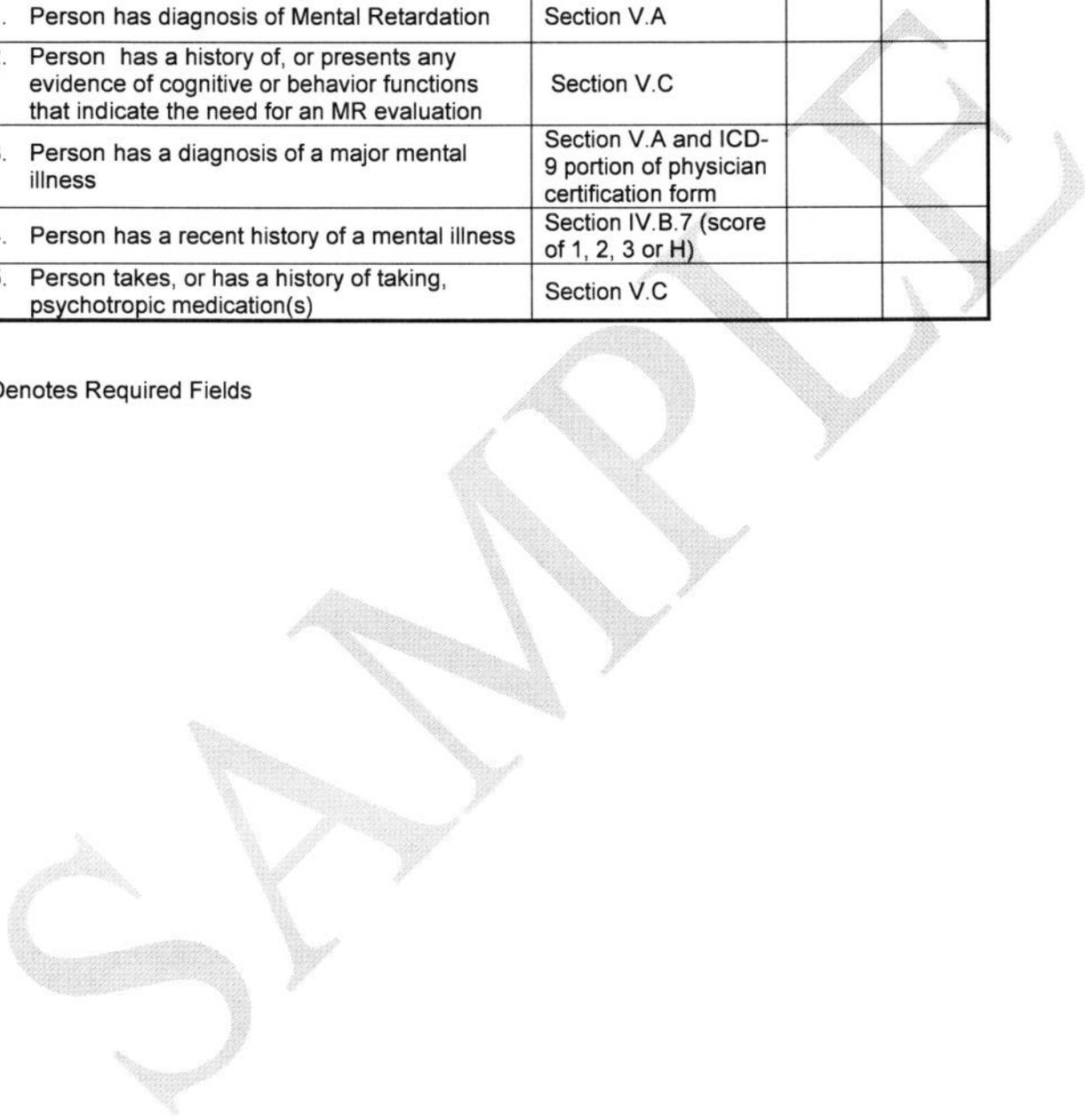
**MISSISSIPPI DIVISION OF MEDICAID**  
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**IX. LEVEL II DETERMINATION - *continued***

**B. Level II Referral**

<b>Criteria</b>	<b>As Documented in:</b>	<b>Yes</b>	<b>No</b>
1. Person has diagnosis of Mental Retardation	Section V.A		
2. Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation	Section V.C		
3. Person has a diagnosis of a major mental illness	Section V.A and ICD-9 portion of physician certification form		
4. Person has a recent history of a mental illness	Section IV.B.7 (score of 1, 2, 3 or H)		
5. Person takes, or has a history of taking, psychotropic medication(s)	Section V.C		

\*Denotes Required Fields



**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS)**

Hard copy PAS summary and certification instructions: **Transfer information from earlier PAS sections to summary, as directed below.** Obtain ICD-9 diagnosis data/certification from physician and forward to DOM/LTC along with PAS Informed Choice – Person Choice page or separate Informed Choice form.

PAS Score (to be completed by DOM/LTC only) →

*Name (Last, First, Middle):		
Medicaid Number:	Medicare Number:	
*SSN:	*DOB (MM/DD/CCYY)	*Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female

**II.A - ADL/IADL Level of Need for Assistance in past 30 days – Circle the appropriate numbers**

*ADL/IADL	Inde- pend- ent	Super- vision	Physical Assist	Total Depen.	ADL/IADL	Inde- pend- ent	Super- vision	Physical Assist	Total Depen.
1. Mobility/Ambulation	0	1	2	3	6. Toileting	0	1	2	3
2. Community Mobility	0	1	2	3	7. Bathing	0	1	2	3
3. Transferring	0	1	2	3	8. Dressing	0	1	2	3
4. Eating	0	1	2	3	9. Personal Hygiene	0	1	2	3
5. Meal Preparation	0	1	2	3	10. Medication Management	0	1	2	3

**\*II.A Question 11 - Insulin Dependence – Circle Yes, No or N/A (if not insulin-dependent)**

Needs assistance w/finger sticks and/or understanding glucose testing results	Yes	No	N/A	Needs assistance drawing-up and/or injecting insulin	Yes	No	N/A
---	-----	----	-----	--	-----	----	-----

**\*II.A - Bladder/Bowel Continence – Frequency of Incontinence in past 30 days - Circle the appropriate numbers**

Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week	Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week
*12. Bladder Incontinence	0	1	2	3	*13. Bowel Incontinence	0	1	2	3

**\*II.A Question 14 - Number of ADL Underlying Causes Recorded (Part A only) - Circle the appropriate number**

0	1	2	3	4	5	6	7	8	9	10 or more
---	---	---	---	---	---	---	---	---	---	------------

**\*II.B Question 3 - Vision – Level of Impairment – Circle the appropriate number**

	None	Mild	Moderate	High	Severe	Unknown
Vision	0	1	2	3	4	UNK

**\*III - Level of Orientation to Person, Place & Time (11 question test) - Circle the appropriate numbers**

*Incorrect answers (out of 11)	0	1	2	3	4	5	*Screener Judgment of Impairment Level	None	Mild/ Moderate	Severe
Mark here if unable to determine <input type="checkbox"/>	6	7	8	9	10	11		0	1	2

**\*IV.B - Behavior – Frequency in past 90 days requiring intervention – Circle the appropriate numbers (Mark "H" as 0)**

*Behavior Frequency	None	Less than Weekly	Less than Daily	Daily		*Intensity of Intervention	Easily Altered	Not Easily Altered
1. Verbally Aggressive	0	1	2	3	If > 0 →	1. Verbally Aggressive	0	1
2. Physically Aggressive	0	1	2	3	If > 0 →	2. Physically Aggressive	0	1
3. Resistive	0	1	2	3	If > 0 →	3. Resistive	0	1
4. Wandering/Elopement	0	1	2	3	If > 0 →	4. Wandering/Elopement	0	1
5. Inappropriate/Unsafe	0	1	2	3	If > 0 →	5. Inappropriate/Unsafe	0	1
6. Self-Injurious	0	1	2	3	If > 0 →	6. Self-Injurious	0	1

\*Denotes Required Fields

**MISSISSIPPI DIVISION OF MEDICAID**  
**Pre-Admission Screening (PAS) Application for Long Term Care**

**X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS) - continued**

*Name (Last, First, Middle):	*PAS Date:
------------------------------	------------

**\*V.A & V.D.8 - Selected Active Medical Conditions – Circle Yes or No**

Alzheimer's or non-Alzheimer's Dementia	Yes	No	Traumatic Brain Injury	Yes	No
Paralysis – Hemiplegia	Yes	No	Severe orthopedic or neurological impairment (as indicated by a "yes" in V.D.8 – Medical Status)	Yes	No
Paralysis – Paraplegia or Quadriplegia	Yes	No			

**\*V.B - Selected Health-Related Services – Indicate if person currently receives or needs (Circle Yes if either)**

Catheter Care	Yes	No	Physical Therapy	Yes	No
Occupational Therapy	Yes	No	Pressure/Other Ulcer Care	Yes	No
Ostomy Care	Yes	No	Tube Feeding	Yes	No
Oxygen	Yes	No	Turning and Positioning	Yes	No

**IX - Federal Pre-Admission Screen & Resident Review (PASRR) – For Nursing Facility Admissions – Circle Yes or No**

Part A – Level II Evaluation Exemption Criteria	Yes	No	Part B – Level II Referral Criteria	Yes	No
Person has diagnosis of Alzheimer's/Dementia?	Yes	No	Person has a diagnosis of Mental Retardation?	Yes	No
Person is in need of nursing care for terminal illness?	Yes	No	Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation?	Yes	No
Person has severe physical illness?	Yes	No	Person has a diagnosis of a major mental illness?	Yes	No
Person is ventilator dependent?	Yes	No	Person takes, or has a history of taking, psychotropic medications?	Yes	No
Person needs respite care for 10 days or less?	Yes	No			
Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from hospital?	Yes	No			
Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement not to exceed 7 days?	Yes	No			

**\*Person's Long Term Care Program Choice – Mark One (based on program selected in PAS Section VIII or on Informed Choice Form)**

Nursing Facility →	E&D Waiver →	Assisted Living Waiver →	
Independent Living Waiver →	TBI/SCI Waiver →	Other: _____ →	

**Screener:**

*Signature	*Date	*Printed Name
------------	-------	---------------

***This section to be completed by Physician***

*Primary Diagnosis					*Secondary Diagnosis				
Description	ICD-9 Code				Description	ICD-9 Code			

**\*Physician Certification:**

This person is appropriate for Medicaid long term care services. In the event of Nursing Facility placement, a Level II evaluation  IS INDICATED  IS NOT INDICATED at this time (check one).

*Signature	*Date	*Printed Name	*License Number
------------	-------	---------------	-----------------

\*Denotes Required Fields