SCREEN Form:

DOH-695 (2/2009)

CONFIDENTIALITY STATEMENT/DISCLAIMER NOTICE

SCREEN

A Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) must be completed before beginning the SCREEN form. Refer to the SCREEN Instructions (DOH-695i) when completing the SCREEN form.

IDENTIFICATION

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

DIRECT REFERRAL FACTOR FOR RESIDENTIAL HEALTH CARE FACILITY (RHCF)

	YES	NO	
7.	☐	☐	This person has a home in the community (owns or rents a home, lives in an Adult Care Facility or with family or friends) and that residence is still available OR appropriate community based living can be arranged OR this person is eligible for an Adult Care Facility.

Guideline: If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT (items 8 -12).
If item 7 is marked NO, explain on a separate sheet of paper and attach to this form; refer to RHCF. Proceed to REFERRAL RECOMMENDATION (item 21).

DIRECT REFERRAL FACTORS FOR COMMUNITY BASED ASSESSMENT

Answer all items 8-12

	YES	NO	
8.	☐	☐	This person understands information given and opposes placement/continued stay in a Residential Health Care Facility.
9.	☐	☐	This person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility. Evaluator specifically described all necessary community services and described private resources (such as insurance coverage, savings, income or financial aid provided by a spouse, relative or friend) that may be available to pay for such services. Medicare and Medicaid should NOT be included as private financial resources.
10.	☐	☐	This person has an informal support system. Individuals in this system are willing and are physically and mentally capable of caring for this person, and providing for most of his/her specific needs.
11.	☐	☐	All ADL responses = 1 or 2 (see PRI or HC-PRI PART III, 19-22)
12.	☐	☐	This person was independent in ADLs prior to most recent acute episode and shows good rate of return of physical and mental functioning.

Guideline: If any direct referral factor (items 8-12) is marked YES, refer to a Certified Home Health Agency (CHHA) for a community based assessment. Attach assessment to the SCREEN, then proceed to REFERRAL RECOMMENDATION (item 21). If all referral factors (items 8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS (Item 13).

HOME AND CAREGIVING ARRANGEMENTS

13. a. Estimate the total number of hours per day that the informal support(s) system is willing and able to provide supervision or assistance to this person. a. _____

b. Estimate the total number of hours per day that this person can be alone. b. _____

c. Add a and b (a+b=c) ..... c. _____

YES	NO	
☐	☐	d. Does **c**. total 12 or more hours?

Guideline: If item 13d. is marked YES, proceed to item 16.
If item 13d. is marked NO, proceed to item 14.

YES NO

14. ☐ ☐ Can the number of hours that this person is attended by self or informal supports be expected to increase to 12 or more hours per day within six months?

Guideline: If item 14 is marked YES, proceed to item 16.
If item 14 is marked NO, proceed to item 15.

15. If the answer to item 14 is NO, enter reason(s) (a, b, and/or c): _____

a. This person's physical and/or mental condition is not expected to improve to a degree that would permit increased self care within six months.
b. Person has no informal supports.
c. Informal supports are unable or unwilling to provide additional assistance, or person does not want care from informal supports.

Guideline: Proceed to item 16

YES NO

16. ☐ ☐ Is there a need for restorative services documented by a physician or rehabilitation specialist?

Guideline: If item 16 is marked YES, proceed to item 17.
If item 16 is marked NO, proceed to item 19.

YES NO

17. ☐ ☐ Can this person receive restorative services at home, at adult day care, or as an outpatient?

Guideline: If item 17 is marked YES, proceed to item 19.
If item 17 is marked NO, proceed to item 18.

18. If the answer to item 17 is NO, enter reason(s) (a, b and/or c): _____

a. Restorative services are not available in this person's community.
b. Restorative services are too costly or not covered in this person's community.
c. This person cannot access restorative services in their community.

Guideline: Proceed to item 19.

YES NO

19. ☐ ☐ Does this person have any risk factors that could cause undue risk to self or others if placed in the community?

If YES, enter reason(s) (a, b, c and/or d):_____

a. This person has a history of unpredictable behaviors and may injure self or others. This condition is not temporary.
b. Comatose (PRI or H-C PRI Part II, 17 A) or all ADL responses = 4 or 5 (PRI or H-C PRI PART III, 19-22).
c. Requires constant monitoring due to health threatening medical conditions.
d. Skilled services are needed at least one time per day and cannot be delegated to nonprofessionals or informal supports.

Guideline: Proceed to item 20.

YES NO

20. ☐ ☐ Based on the answer to item 19, can this person be placed safely in the community without causing undue risk to self or others?

Guideline: Proceed to item 21.

REFERRAL RECOMMENDATION

21. Based on the information obtained by the screener during the screen assessment, check the principal referral recommendation and reason. Explain as needed:

_____

a. RHCF:

1. ( ) A community based assessment was done by a Certified Home Health Agency (CHHA), and it was determined that this person cannot be cared for in the community. This community assessment represents this person's current status.

2. ( ) This person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility, or cannot live with family or friends).

3. ( ) Appropriate community based living cannot be arranged because this person cannot be adequately cared for in the community and/or is a risk to self or others.

4. ( ) Both community based and RHCF care are being investigated. Recommendation is RHCF.

b. RHCF for Restorative Services:

1. ( ) This person cannot receive restorative services in their community.

c. Community:

1. ( ) A CHHA completed a community based assessment and determined that this person can be cared for in the community.

Guideline: If RHCF (item 21 a) or RHCF for Restorative Services (item 21 b) is chosen, proceed to item 22.
If Community (item 21 c) is chosen, proceed to item 36.

DEMENTIA DIAGNOSIS

	YES	NO	
22.	☐	☐	Does this person have a dementia diagnosis (including Alzheimer's disease) documented in the medical record?

Guideline: Proceed to item 23.

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

	YES	NO	
23.	☐	☐	Does this person have a serious mental illness?

Guideline: Proceed to LEVEL I Review for Possible Mental Retardation/Developmental Disability (items 24 -26)

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer ALL items 24-26.

	YES	NO	
24.	☐	☐	Does this person have a diagnosis or documented history of mental retardation and/or a developmental disability, and did the mental retardation or developmental disability manifest itself prior to age 22, and is it likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of major life activity?
25.	☐	☐	Has this person ever been deemed eligible for and/or received MR/DD services, or has this person been referred by an agency that serves persons with MR/DD?

26. ☐ ☐ Does this person present with evidence of cognitive deficits and/or adaptive skill deficits that may indicate the presence of mental retardation or developmental disability?

Guideline: If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30).
If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).

CATEGORICAL DETERMINATIONS

Answer ALL items 27-30.

	YES	NO	
27.	☐	☐	Does this person qualify for convalescent care?
28.	☐	☐	Is this person seriously physically ill?
29.	☐	☐	Is this person terminally ill?
30.	☐	☐	Is this person to be admitted for a very brief and finite stay or a provisional emergency admission?

Guideline: If any of the items 27-30 are marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 31).
If all are marked NO, proceed to LEVEL II REFERRALS (item 33).

DANGER TO SELF OR OTHERS QUALIFIERS

	YES	NO	
31.	☐	☐	Based on your interview with this person (and/or available informants), and/or a review of this person's medical record, is there any evidence to suggest that this person is, or may have been, a danger to self or others during the past two years?

Guideline: If item 31 is marked YES, proceed to item 32.
If item 31 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

	YES	NO	
32.	☐	☐	Has this person been deemed a danger to self or others based on a current psychiatric evaluation by a licensed mental health professional?

Guideline: If item 32 is marked YES, proceed to LEVEL II REFERRALS (item 33).
If item 32 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

LEVEL II REFERRALS

33. Enter the Level II Referral(s): a, b, or c_____

a. Level II mental illness evaluation by the designated mental health review entity
b. Level II evaluation by the Office of Mental Retardation and Developmental Disabilities
c. Both a and b

Guideline: Proceed to item 34.

	YES	NO	
34.	☐	☐	I, as the qualified screener, acknowledge that this Patient/Resident/Person and his/her legal representative* have received verbal and written notification that this Patient/Resident/Person is being referred for a Level II Evaluation.

Guideline: **STOP !** Do not complete items 35 through 38 until you have obtained the Level II recommendations from the designated evaluator(s).

*Legal representative means an individual whose appointment is made and regularly reviewed by a state court or agency empowered under state law to appoint and review such officers, and having the authority to consent to health/mental health care or treatment of an individual.

LEVEL II RECOMMENDATIONS

YES NO

35. ☐ ☐ Specialized services are recommended based on the Level II Evaluation(s).

Guideline: Proceed to item 36.

PATIENT/RESIDENT/PERSON DISPOSITION

36. Enter one response (a,b,c,d,e,f,g,h,i,j.): _____

a. Home
b. Home with home care services
c. Adult Care Facility
d. Inpatient Psychiatric Care
e. OMR/DD Residential Placement
f. Adult Care Facility with home care services
g. RHCF for restorative services
h. RHCF for other services
i. Person died
j. Other (specify) _____

Guideline: Proceed to item 37

PATIENT/RESIDENT/PERSON AND/OR LEGAL REPRESENTATIVE AND/OR HEALTH CARE AGENT ACKNOWLEDGEMENT

37. I have had the opportunity to participate in decisions regarding the arrangements for my continuing care, and I have received verbal and written information regarding the range of services in my community.

_____ _____

Date Signature of the patient/resident/person being assessed and/or legal representative and/or health care agent

Guideline: Proceed to item 38.

QUALIFIED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN and I certify that I am a trained and qualified SCREENER and the information contained herein is a true abstract of this person's current condition and circumstances.

_____ _____

Print date, name and title of qualified SCREENER SCREENER Identification Number (Assigned by NYSDOH)

_____

Signature of qualified SCREENER

NOTIFICATION OF NEED FOR LEVEL II EVALUATION

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

_____

Print date, name and title of qualified SCREENER

SCREENER Identification Number
(Assigned by NYSDOH)

_____

Signature of qualified SCREENER