

Applicant			
	LAST NAME	FIRST NAME	MIDDLE NAME

SECTION III Level I Screen for Major Mental Condition

1. Diagnosable Major Mental Disorder: Does the individual have any of the following major mental conditions as diagnosable under the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM-III-R):

- YES
 NO

If YES, check the major mental condition(s) diagnosed or diagnosable for the individual, consistent with DSM-III-R. *Exclude conditions, behaviors, and symptoms caused by a diagnosed (a) major or minor neurocognitive disorder, with or without behavioral disturbances; (b) physical health condition; or (c) non-severe mental health condition:*

- | | | |
|---|---|--|
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Schizoaffective Disorder | <input type="checkbox"/> Somatoform Disorder |
| <input type="checkbox"/> Bipolar Disorder: Bipolar Type I <u>or</u> Bipolar Type II | <input type="checkbox"/> Major Depression | |
| <input type="checkbox"/> Panic or other Severe Anxiety Disorder ★ | | |
| <input type="checkbox"/> Severe Personality Disorder ★ | | |
| <input type="checkbox"/> Other Psychotic Disorder ★ | | |
| <input type="checkbox"/> Other Major Mental Condition with Severe Impairments or Risk of Chronic Disability:
Specify Name of Condition in DMS-III-R: _____ | | |

★ *This is a category of major, moderate, or mild diagnoses. See DMS-787 Instructions for a list of specific diagnoses considered Major Mental Conditions for PASRR purposes.*

2. Level of Impairment: In the past 3-6 months, has the major mental condition(s) identified in Question 1 resulted in at least one of the following functional limitations in the individual's major life activities?

YES If YES, check which of these three limitations apply. Check all that apply. Must check at least one for a Yes answer to Question 2. *The limitations are defined in the instructions and 42 CFR § 483.102(b)(1)(ii):*

- Interpersonal functioning Concentration, persistence, & pace Adaptation to change

NO

N/A Check N/A if the answer to Question 1 is NO.

3. Recent Treatment History: Does the individual's treatment history indicate at least one of the following:

- A. Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization).
- B. Within the last 2 years, due to the major mental condition(s) identified in Question 1, experienced an episode of significant disruption to their normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

YES If YES, which treatment history above applies (must check at least one for a Yes answer):
 A. B. Both A and B.

NO

N/A Check N/A if the answer to Question 1 is NO.

Applicant			
	LAST NAME	FIRST NAME	MIDDLE NAME

SECTION III Continued

4. **Major Neurocognitive Disorder (MNCD):** Does the individual have a primary diagnosis of a major neurocognitive disorder (formerly called dementia, and includes Alzheimer's and related conditions)?

YES Check YES if the individual has a primary diagnosis of a major neurocognitive disorder, with or without behavioral disturbance.

NO Check NO if (a) MNCD is not diagnosed, (b) MNCD is a secondary diagnosis, or (c) the person is diagnosed with a minor neurocognitive disorder diagnosis.

SECTION IV

APPLICANT'S STATEMENT

I understand that as a condition of my admission to or a continued stay in a Medicaid-certified skilled nursing facility, a screen (Level I) for indicators of major mental condition and/or intellectual disabilities and related conditions is required by federal law.

I have been informed that the results of the Level I screen may indicate the need for further evaluation (Level II).

I understand that the Level II evaluation will be performed by Bock Associates for the State of Arkansas and that I will be notified in writing of the results of the Level II evaluation.

Signature of Applicant or Responsible Party/Legal Guardian

Date

Signature of Person Completing Level I Screen (Form DMS-787)

Date