Please Print

NORTH CAROLINA LEVEL I SCREENING FORM
THIS MUST REMAIN IN THE INDIVIDUAL'S RECORD

CONFIDENTIAL

Patient Name: _____ SS #: _____

Mailing Address: _____ Medicaid # _____ Sex _____

_____ DOB: _____ Pmt. Status: _____ Marital Status: _____

Referring Facility: _____ Admit Date to Nursing Facility: _____

Facility Address: _____ Admitting Facility: _____

_____ Address: _____

Telephone: _____ Contact Person: _____

Submitted By: _____ Telephone: _____

Submitter's Signature & Title: _____ Patient's Current Location: _____

Address: _____

Does the individual desire NF services? ☐ Yes ☐ No County: _____

SECTION I: MENTAL ILLNESS SCREEN

1.A. Psychiatric Diagnoses excluding Dementia, Alzheimer's, and/or Organic Brain Disorders

- ☐ Anxiety/panic disorder
- ☐ Bipolar Disorder
- ☐ Delusional Disorder
- ☐ Schizoaffective disorder
- ☐ Eating disorder (specify) _____
- ☐ Personality disorder (specify) _____
- ☐ Other: _____
- ☐ Psychotic disorder
- ☐ Somatoform disorder
- ☐ Schizophrenia
- ☐ Major Depression

1.B. Psychiatric Medication **Diagnosis / Purpose**

_____ _____

_____ _____

_____ _____

NC Medicaid USE ONLY: Meets diagnosis criteria for diagnosis/chronicity? ☐ Y ☐ N ☐ UTD

2.A. Psychiatric treatment received in past 2 years (excluding treatment for Dementia, Alzheimer's and/or Organic Brain D/O's) Include dates of the hospitalization(s)

- ☐ Inpatient psych. hosp. _____
- ☐ Partial hosp./day treatment _____
- ☐ Outpatient treatment _____

2.B. Intervention(s) to prevent hospitalization(s). Include date(s)

- ☐ Supportive living (due to MI) _____
- ☐ Housing intervention (due to MI) _____
- ☐ Legal intervention (due to MI) _____
- ☐ Other:

NC Medicaid USE ONLY: Meets criteria for duration? ☐ Y ☐ N ☐ UTD

Role limitations in past 6 months due to MI (excluding medical problems, Dementia, Alzheimer's and/or Organic Brain D/O) :
Indicate: "F" Frequently, "O" Occasionally, or "N" Never

3.A. Interpersonal Functioning (excluding medical problems, Dementia, Alzheimer's and/or Organic Brain D/O)

F	O	N	Altercations	F O N	Social isolation/avoidance
F	O	N	Evictions	F O N	Excessive irritability
F	O	N	Fear of strangers	F O N	Easily upset/anxious
F	O	N	Illogical comments	F O N	Hallucinations
F	O	N	Other _____	F O N	Serious communication difficulties
F	O	N	Suicide attempt/ideations		

Please note dates: _____

3.B. Concentration/Task limitations within past 6 months due to MI (excluding medical problems, Dementia, Alzheimer's and/or Organic Brain D/O)

F	O	N	Serious difficulty completing age related tasks
F	O	N	Serious loss of interest in things
F	O	N	Serious difficulty maintaining concentration/attention
F	O	N	Numerous errors in completing tasks which she/he should be physically capable
F	O	N	Requires assistance with tasks for which she/he should be physically capable of accomplishing
F	O	N	Other

3.C. Significant problems adapting to typical changes within 6 months due to MI (excluding medical problems, Dementia Alzheimer's, and/or Organic Brain D/Os)

- Y N Requires mental health intervention due to increased symptoms
- Y N Requires judicial intervention due to symptoms
- Y N Symptoms have increased as a result of adaptation difficulties
- Y N Serious agitation or withdrawal due to adaptation difficulties
- Y N Other _____

Notes: _____

NC Medicaid USE ONLY: Meets criteria for disability? ☐ Y ☐ N ☐ UTD

MI Decision: Meets criteria for SMI? ☐ Y ☐ N ☐ UTD

SECTION II: MENTAL RETARDATION SCREEN

1.A. MR diagnosis: ____ N ____ Y
Mild ____ Moderate ____ Severe ____ Profound

1.B. Undiagnosed but suspected MR: ____ N ____ Y ____ N/A

1.C. History of receipt of MR services: ____ N ____ Y
(if yes, specify): _____

1.D. Onset before age 18: ____ N ____ Y
(if yes, specify age): _____

1.E. Education Level
History of gainful employment? ____ N ____ Y
Ability to handle finances? ____ N ____ Y

NC Medicaid USE ONLY: Meets criteria for MR? ☐ Y ☐ N ☐ UTD

SECTION III: RELATED CONDITIONS SCREEN

1.A. Related Condition diagnosis which impairs intellectual functioning or adaptive behavior: ____ Blindness
____ Cerebral Palsy ____ Autism ____ Epilepsy ____ Deafness
____ Closed Head Injury Other _____

1.B. Substantial functional limitations 3 or more of the following secondary to Related Condition and not a medical condition:
____ Self-care ____ Mobility ____ Learning
____ Self-direction ____ Capability for independent living
Understanding/use of language? ____ N ____ Y
specify if yes: _____

1.C. Was the condition manifested prior to the age 22?
____ N ____ Y

NC Medicaid USE ONLY: Meets criteria for Related Condition? ☐ Y ☐ N ☐ UTD

Comments related to applicant's MI, MR, and/or RC:

_____

_____

_____

Patient Name: _____ **Patient Social Security Number:** _____

STOP HERE IF THERE IS NO EVIDENCE OF MI, MR, and/or RC. OTHERWISE, CONTINUE.

SECTION IV: DEMENTIA (complete for both MI & MR)

1.A. Does the individual have a primary diagnosis of Dementia or Alzheimer's?

_____ N _____ Y (specify) _____

1.B. Does the individual have any other organic disorders?

_____ N _____ Y (specify) _____

1.C. Is there evidence of undiagnosed Dementia or other organic mental disorders?

Y N disoriented to time Y N disoriented to situation
Y N disoriented to place Y N paranoid ideation
Y N severe ST memory deficit

1.D. Is there evidence of affective symptoms which might be confused with Dementia?

Y N frequent tearfulness Y N severe sleep disturbance
Y N frequent anxiety Y N severe appetite disturbance

1.E. Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis?

_____ Dementia work-up _____ Thorough mental status exam
_____ Medical / functional history prior to onset of dementia
Other

Documentation must be provided to support diagnosis of Primary Dementia

NC Medicaid USE ONLY:
Does the individual have a primary dementia diagnosis?
Dementia decision: ☐ **Y** ☐ **N**

SECTION V: CATEGORICALS

Convalescent Care Exemption

1. Does the admission meet all of the following criteria?

_____ Admission to a NF directly from a hospital after receiving acute medical care in the hospital; and
_____ Need for NF care is required for the condition for which care was provided in the hospital; and
_____ The attending physician has certified prior to NF admission that the individual will require less than 30 calendar days NF services.

*** Individuals meeting all criteria are exempt for Level II screens for 30 calendar days. The receiving facility must update Level I screen at such time that it appears the individual's stay will exceed 30 days and no later than the 25th calendar day.**

NC Medicaid USE ONLY:
Meets convalescent exemption? ☐ **Y** ☐ **N**
Expiration Date:

The following decisions indicate the individual does meet NF eligibility and does not require specialized services for the time limit specified. An updated Level I Screen is required if the stay is expected to exceed 7 calendar days & no later than the 5th calendar day.

2.A. _____ Emergency protective service situation for MI/MR/RC individual needing 7 calendar day NF placement
2.B. _____ Delirium precludes the ability to accurately diagnose. An updated Level I is required at such time that the delirium clears and/or no later than 5 calendar days from admission
2.C. _____ Respite is needed for in-home caregivers to whom the MI/MR/RC individual will return within 7 calendar days

NC Medicaid USE ONLY:
Meets categorical determination? ☐ **Y** ☐ **N**
Expiration Date:

If the individual chooses admission to a NF, she/he meets the North Carolina Level of Care criteria for placement.
***Further evaluation requirements are specified below:**

3.A. _____ **Terminal illness with life expectancy of 6 months or less (Level II evaluation will be completed via paper based review)**
3.B. _____ **Coma or persistent vegetative state (Level II evaluation will be completed via paper based review)**

NC Medicaid USE ONLY:
Approval for Categorical/Exempted Admission: ☐ **Y** ☐ **N**

Mailing Information - Please Print:

Legal representive's name and address:

Name: _____

Street Address: _____

City: _____

State & Zip Code: _____

Primary physician's name and address:

Name: _____

Street Address: _____

City: _____

State & Zip Code: _____

NC MEDICAID SUMMARY - OFFICE USE ONLY

Date and Time Received: _____

_____ **Level I approved**
_____ **Requires Level II MI evaluation**
_____ **Requires Level II MR/RC evaluation**
_____ **Requires paper review**
_____ **Time limited approval**
Expiration Date: _____
_____ **Status Change**
_____ **Early ARR required**
_____ **Categorical ARR**

_____
NC Medicaid Reviewer **Date**

"CONFIDENTIAL"