

PREADMISSION SCREENING/RESIDENT REVIEW (PAS/RR) IDENTIFICATION SCREEN

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT

Last Name		First Name	MI
Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female	Date of Birth (mm/dd/yyyy)	Social Security Number	
Medicaid Recipient <input type="checkbox"/> Yes <input type="checkbox"/> Managed Care <input type="checkbox"/> Pending <input type="checkbox"/> No			
Medicaid Number (12 digits) if applicable		Managed Care Plan Name (If applicable)	
<input type="checkbox"/> YES <input type="checkbox"/> NO Does applicant/resident have additional health care insurance with another company? If so, name of insurance company			

Living arrangement/options at the time of the request for PASRR: (Check one below)

<p>Independent Living Option</p> <input type="checkbox"/> Own/Leases Home/Apartment-Lives Alone <input type="checkbox"/> Own Home/Apartment Lives with Others (Friends/Family) <input type="checkbox"/> Home Owned/Leased by Individual <input type="checkbox"/> Living with Family <input type="checkbox"/> Homeless	<p>Institutional Setting</p> <input type="checkbox"/> ICF/MR <input type="checkbox"/> Private Psychiatric Hospital (Hospital Name) <input type="checkbox"/> Regional Psychiatric Hospital (Hospital Name) <input type="checkbox"/> Prison <input type="checkbox"/> Nursing Facility	<p>Community-Based Residence</p> <input type="checkbox"/> Group Home (Non ICF/MR) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other (please specify)
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SECTION B: REASONS FOR SCREENING

(Indicate using **ONE** of the boxes below)

Preadmission Screening Codes (If seeking admission into nursing facility)

- 1 – Ohio resident seeking nursing facility admission.
- 2 – Individual residing in a state other than Ohio, seeking nursing facility admission.

You can use this space as well...Indicate PAS-PSYCH

INSTRUCTIONS: IF #1 OR #2 ABOVE IS SELECTED, GO TO SECTION C.

Resident Review Codes (If seeking to remain in nursing facility) **Resident's Date of Admission** _____

- 3 - Expired Time Limit for Hospital Exemption: (Check one)
 - a) seeking approval for an unspecified period of time
 - b) seeking approval for a specified period of time
(please complete Section G (1) and (2) in addition to the remainder of this form)
 - c) seeking an extension to an approved RR for a specified period of time
(please complete Section G (3) and (4) in addition to the remainder of this form)