

# Training: ODM 03622

Preadmission Screening and Resident Review  
Identification (PASRR) Screening Tool

# Preadmission Screening and Resident Review (PASRR)

- Federal and State regulations require that individuals are screened for indications of serious mental illness and/or developmental disabilities before being admitted to a nursing facilities and on a systematic basis following a significant change in their condition
- PASRR regulations apply to all applicants and residents of Ohio Medicaid certified nursing facilities, regardless of the individual's method of payment (payer source)
- The purpose of PASRR is to ensure that individuals are admitted to the setting most appropriate for their needs



# PASRR Statutes and Regulations



- Below are the corresponding PASRR statutes and regulations
  - **BECOME FAMILIAR WITH THEM**

- Federal Statutes

- §1919(e)(7) of the Social Security Act
- 42 CFR §483.100 - §483.138

- State Regulations

- OAC 5160-3-15 Preadmission screening and resident review definitions
- OAC 5160-3-15.1 Preadmission screening requirements
- OAC 5160-3-15.2 Resident review requirements
- OAC 5123:2-14-01 Developmental disabilities
- OAC 5122-21-03 Serious mental illness

# Preadmission Screening and Resident Review (PAS/RR) Identification Screen (ODM 3622)

- Designed to screen individuals seeking admission to a nursing facility for indications of developmental disabilities and/or serious mental illness.
- **Must be completed BEFORE the individual can be admitted to the nursing facility**
  - » ODM 3622 form is completed via the electronic system (HENS) and the system will then route the form to the appropriate entity.
  - » Paper forms are permitted to be faxed to the PASSPORT Administrative Agency (PAA) contact. **However**, ODM is strongly encouraging ALL entities to **utilize the electronic system** for a more efficient and timely process.

# Preadmission Screening and Resident Review (PAS/RR) Identification Screen (ODM 3622)

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- The ODM 3622 is eight (8) pages in length.
    - If you are submitting the ODM 3622 via fax or email, you **MUST** submit all pages.
  - The nursing facility is ultimately responsible for ensuring that the determination approving the NF admission is rendered before admitting the individual to its facility.

# Hospital Exemption Exception

- A Preadmission Screening Identification (ODM 3622) is **NOT** required for individuals who meet the following definition of a hospital exemption:

Individual admitted to NF directly from an Ohio hospital (non-psychiatric) after receiving acute inpatient care

**or**

Ohio resident admitted to NF directly from out-of-state hospital (non-psychiatric) after receiving acute inpatient care

Individual requires level of services provided by a nursing facility **for the condition for which they were treated in the hospital**

Attending physician provides written certification that individual is likely to require the level of services provided by a nursing facility for **less than thirty (30) days**

# Preadmission Screening and Resident Review (PAS/RR) Identification Screen (ODM 3622)

- The ODM 3622 comprises nine (9) sections:
  - » **Section A:** Identifying Information for Applicant/Resident
  - » **Section B:** Reasons for Screening
  - » **Section C:** Medical Diagnosis
  - » **Section D:** Indications of Serious Mental Illness
  - » **Section E:** Indications of DD or Related Conditions
  - » **Section F:** Return to Community Living Referral
  - » **Section G:** Request for Resident Review Approval for a Specified Period
  - » **Section H:** Mailing Addresses
  - » **Section I:** Submitter Information/Certification

## Section A: Identifying Information for Applicant/Resident

- Section A focuses on gathering information about the individual seeking admission into a nursing facility. Collected in this section are items such as first and last name, date of birth, social security number and Medicaid number.
- In order for the PAA to be able to pull up the individual in their record system (PIMS), the submitter needs to supply the individual's social security number.
- Other information collected in this section includes where the individual is residing at the time this form is being completed (e.g. in their home, hospital, nursing facility, or other community-based residence).

# Section A: Identifying Information for Applicant/Resident

## SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT

<b>SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/RESIDENT</b>		
<b>LAST NAME</b> Example	<b>FIRST NAME</b> Person	<b>MI</b>
<b>SEX</b> <input type="checkbox"/> M = Male <input checked="" type="checkbox"/> F = Female	<b>DATE OF BIRTH</b> (MM/DD/YYYY) 01/01/1948	<b>SOCIAL SECURITY NUMBER</b> 123-45-6789
<b>MEDICAID RECIPIENT</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> MANAGED CARE <input type="checkbox"/> PENDING <input type="checkbox"/> NO		
<b>MEDICAID NUMBER</b> (12 digits - if applicable) 123456789101	<b>MANAGED CARE PLAN NAME</b> (If applicable)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    Does applicant/resident have additional health care insurance with another company? If so, name of insurance company:		
<b>Living arrangement/options at the time of the request for PAS/RR: (Check one below)</b>		
<b>INDEPENDENT LIVING OPTION</b> <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	<b>INSTITUTIONAL SETTING</b> <input type="checkbox"/> ICF/IID <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	<b>COMMUNITY-BASED RESIDENCE</b> <input type="checkbox"/> Group Home (Non ICF/IID) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other (please specify)



## Section B: Reason for Screening

- Section B is divided into two (2) components:
  - » Preadmission Screening Codes
  - » Resident Review Codes

## Section B: Preadmission Screening Codes

- (1) or (2) is selected **only if individual is seeking admission to a nursing facility**
- Indicate if the individual is an Ohio resident or an out-of-state resident seeking admission to an Ohio nursing facility



If either (1) or (2) is selected,  go to section C.

### 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.

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

## Section B: Resident Review Codes

- If the individual is **already** in the nursing facility (NF) and is seeking to **REMAIN** in the NF then this section would apply.
- First, document the individual's **original date of admission**



Resident Review Codes: *(If seeking to remain in nursing facility)*

Resident's Date of Admission:

- Next, indicate the reason for initiating a Resident Review for the individual.
  - Expired Time Limit for **Hospital Exemption** (over 30 days)
  - Expired Time Limit for **Emergency Admission** (over 7 days)
  - Expired Time Limit for **Respite Admission** (over 14 days)
  - NF Transfer, No previous PAS/RR Records
  - Significant Change in Condition

## Section B: Resident Review Codes (cont.)



Approvals for specified periods of time or extensions to an approved specified period of time require additional sections to be completed. **Check only one** in the relevant category.

- 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 the 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 the form)*

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- 4 – Expired Time Limit for Emergency Admission:** *(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 the 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 the form)*

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- 5 – Expired Time Limit for Respite Admission:** *(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 the 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 the form)*

## Section B: Resident Review Codes (cont.)

- If question (7) applies, identify the change in condition by selecting either a, b, or c.
- Then identify the length of stay by selecting either d, e, or f. Approvals for **specified periods of time** or **extensions to an approved specified period of time** require additional sections to be completed.
- Finally, identify what has changed

**7 – Significant Change in Condition** *(Check either a, b, or c to identify the change in condition)*

- a) Decline
- b) Improvement
- c) Admission to psychiatric unit  
If admission to psychiatric unit provide hospital name and phone number below.  
Hospital Name:  Phone #:

*(Check either d, e, or f to identify length of stay being sought)*

- d) seeking approval for an unspecified period of time
- e) seeking approval for a specified period of time  
*(please complete Section G (1) and (2) in addition to the remainder of the form)*
- f) 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 the form)*

Please provide details regarding the Significant Change: 

# Section C: Medical Diagnosis

- Question (1) select Yes or No.
- Question (2), if you are conducting a PAS select NA. If conducting an RR, select Yes or No and enter diagnosis.



If the diagnosis at the RR request is different than the admitting diagnosis under the preadmission screen or hospital exemption, attach supporting documentation of the admission diagnosis and the RR diagnosis

<b>SECTION C: MEDICAL DIAGNOSIS</b>		
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	1) Does the individual have a documented diagnosis of dementia, Alzheimer’s disease, or some other organic mental disorder as defined in DSM-5 (or most recent version)?	
<b>If this is a Resident Review, please complete the remainder of this section. Check NA if this request is a PAS.</b>		
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	2) Please indicate current diagnosis if different from diagnosis submitted at admission. Diagnosis:      Example Diagnosis	
<i>Please list below the top six medical diagnosis at time of admission if different from the resident review request.</i>		
<b>Diagnosis 1:</b> Additional Diagnosis	<b>Diagnosis 2:</b> Additional Diagnosis 2	<b>Diagnosis 3:</b>
<b>Diagnosis 4:</b>	<b>Diagnosis 5:</b>	<b>Diagnosis 6:</b>

## Section D: Indications of Serious Mental Illness (SMI)

- This section is comprised of five (5) questions.
  - D(1), D(2), D(2)(b), D(3), D(4) and D(5)
- Complete questions **D(1) through D(3) ONLY** to determine your response in D(5)
- Select Yes or No **AND** check all that apply for question D(1) shown below .

### SECTION D: INDICATIONS OF SERIOUS MENTAL ILLNESS

**All questions in Section D must be completed.**

YES    NO   1) Does the individual have a diagnosis of any of the mental disorders listed below?  
*(Check all that apply)*

a) Schizophrenia

b) Mood Disorder

c) Delusional (Paranoid) Disorder

d) Panic or Other Severe Anxiety Disorder

e) Somatoform Disorder

f) Personality Disorder

g) Other Psychotic Disorder

h) Another mental disorder other than DD that may lead to a chronic disability.

If so, describe: Other mental disorder

## Section D: Indications of SMI (cont.)

-  Question D(2) shown below is tricky! **LEAVE BLANK** for now.
- Indicate the # of times the individual utilized each service over the last 2 years.
  - If the total score equals **2 or more**, **THEN** answer **Yes** to question D(2), if not **leave blank** until you have answered question D(2)(b) shown on next slide

YES    NO      2) Within the past two (2) years, **DUE TO MENTAL DISORDER**, has the individual utilized psychiatric services more than once?

*Indicate the number of times the individual utilized each service over the last 2 years. If service was not utilized, enter "0"*

0	Ongoing case management from mental health agency? ("1" if continuously receiving over 2 years. If not, "0")
0	Emergency mental health services?
0	Number of admissions to the inpatient hospital settings for psychiatric reasons?
0	Number of admissions to partial hospitalization treatment programs for psychiatric reasons?
0	Number of admissions to Residential Care Facilities (RCFs) providing mental health services by a mental health agency?
0	<b>TOTAL SCORE</b>

## Section D: Indications of SMI (cont.)

- Answer question D(2)(b) shown below **even if you answered Yes to question D(2) as a result of the total score of 2 or more.**
- If you answered Yes to D(2)(b) **go back** and answer **Yes to question D(2).**
- If the total score from D(2) did not equal 2 or more **AND** the answer to D(2)(b) is No then **select No in question D(2).**

*If total score equals 2 or more, answer YES to Question D (2). **Regardless of score answer Question D (2)(b).***

**OR**

YES  NO

**b)** Within the past two (2) years, DUE TO MENTAL DISORDER, has the individual had a disruption to his/her usual living arrangements (e.g., arrest, eviction, inter or intra-agency transfer, non-hospital locked seclusion)?

**If YES, answer YES to Question D (2).**



# Section D: Indications of SMI (cont.)

- Answer question D(3) shown below.



**DO NOT ANSWER question D(4)**

- If Yes was selected to **at least two questions** from D(1), D(2) or D(3) then select Yes in question D(5).

YES  NO    3) Within the past six (6) months, DUE TO MENTAL DISORDER, has the individual experienced one or more of the following functional limitations on a continuing or intermittent basis?  
*(Check all that apply)*

<input type="checkbox"/> a) Maintaining Personal Hygiene	<input type="checkbox"/> g) Performing Household Chores
<input type="checkbox"/> b) Dressing Self	<input type="checkbox"/> h) Going Shopping
<input type="checkbox"/> c) Walking/Getting Around	<input type="checkbox"/> i) Using Available Transportation
<input type="checkbox"/> d) Maintaining Adequate Diet	<input type="checkbox"/> j) Managing Available Funds
<input type="checkbox"/> e) Preparing/Obtaining Own Meals	<input type="checkbox"/> k) Securing Necessary Support Services
<input type="checkbox"/> f) Maintaining Prescribed Medication Regimen	<input type="checkbox"/> l) Verbalizing Needs

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YES  NO    4) Within the past two (2) years, has the individual ever received SSI or SSDI due to a mental disorder?  
*(Check all that apply)*

*(This section is crossed out with red X's)*

YES  NO    5) Does the individual have indications of Serious Mental Illness?

**NOTE: The individual has indications of Serious Mental Illness if the individual answered YES to AT LEAST two questions of D(1) , D(2) or D(3)                     )**

## Section E: Indications of DD or RC

- This section is comprised of seven (7) questions



Please pay close attention to the instructions that appear below questions E(1) and E(2) shown below.

### SECTION E: INDICATIONS OF DD OR RELATED CONDITION

YES  NO

- 1) Does the individual have a diagnosis of developmental disability (mild, moderate, severe or profound) as described in the AAIDD manual “Intellectual Disability: Definition, Classification and Systems of Supports” (2009 or more recent version)?

***If YES, go to Question E (3) and answer Questions E 3 through E7***

YES  NO

- 2) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to DD because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with DD and requires treatment or services similar to those required for persons with DD?

***If NO, go to Question E(6). If YES, please specify AND answer Questions E3 through E7. Specify:***

- Complete the remaining questions as instructed.

## Section E: Indications of DD or RC (cont.)

- There are special instructions for question seven (7).
  - If the individual answered Yes to question E(1) then select Yes in question E(7).
  - If the individual answered Yes to question E(2),E(3),E(4) **AND** E(5) then select Yes in question E(7).
  - If the individual answered Yes to question E(6), then select Yes in question E(7).

YES  NO 3) Did the disability manifest before the individual's 22nd birthday?

YES  NO 4) Is the disability likely to continue indefinitely?

YES  NO 5) Did the disability result in functional limitations, prior to age 22, in 3 or more of the following major life activities. *(Check all that apply)*

a) Self Care

e) Mobility

b) Economic Self-Sufficiency

f) Understanding and Use of Language

c) Self Direction

g) Learning

d) Capacity for Independent Living

YES  NO 6) Does the individual currently receive services from a County Board of DD?

YES  NO 7) Does the individual have indications of DD or related condition?

**NOTE: The individual has indications of DD or related condition if the individual received a**

- Yes to Question E(1); OR
- Yes to all of the following in this Section: Questions: 2, 3, 4 AND 5; OR
- Yes to Question E(6)

## Section F: Return to Community Living Referral

- Section F requires you to assess the individual’s potential to return to a community setting.
- Indicate if a referral has been made to the HOME Choice Transition Program for a Long-Term Services and Supports Consultation.

<b>SECTION F: RETURN TO COMMUNITY LIVING REFERRAL</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO	1) Did you share with the individual the service and support alternatives to the nursing facility admission (for PAS) or continuation of the nursing facility stay (for RR)?  If service and support alternatives are not appropriate due to care needs, please explain why alternatives are not appropriate at this time: <div style="background-color: #e6f2ff; height: 40px; margin-top: 5px;"></div>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	2) Does this individual expect to return to live in the community either following the short term stay in the nursing facility or at some point in the future?		
<input type="checkbox"/> YES <input type="checkbox"/> NO	3) Do you believe that this individual could benefit from talking to someone about returning to the community following the short term stay in the nursing facility (for PAS) or during the continued stay in the nursing facility (for RR)?		
<input type="checkbox"/> YES <input type="checkbox"/> NO	4) Was this individual employed prior to the nursing facility placement? Occupation, if applicable:		
<input type="checkbox"/> YES <input type="checkbox"/> NO	5) Does the individual need assistance obtaining and/or returning to employment upon return to a community setting?		
6) What challenges or barriers do you believe could impede this individual’s return to the community? <b>Check all that apply and provide a brief description</b>			
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> a) Care needs are likely greater than community capacity  <input type="checkbox"/> b) Limited or no family/friend support available  <input type="checkbox"/> c) Guardian/Family likely to not support community living  <input type="checkbox"/> d) Lost housing during nursing facility stay               </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> e) Affordable housing limited  <input type="checkbox"/> f) Accessible housing limited  <input type="checkbox"/> g) Limited income to support community living  <input type="checkbox"/> h) Other, please describe below               </td> </tr> </table>		<input type="checkbox"/> a) Care needs are likely greater than community capacity <input type="checkbox"/> b) Limited or no family/friend support available <input type="checkbox"/> c) Guardian/Family likely to not support community living <input type="checkbox"/> d) Lost housing during nursing facility stay	<input type="checkbox"/> e) Affordable housing limited <input type="checkbox"/> f) Accessible housing limited <input type="checkbox"/> g) Limited income to support community living <input type="checkbox"/> h) Other, please describe below
<input type="checkbox"/> a) Care needs are likely greater than community capacity <input type="checkbox"/> b) Limited or no family/friend support available <input type="checkbox"/> c) Guardian/Family likely to not support community living <input type="checkbox"/> d) Lost housing during nursing facility stay	<input type="checkbox"/> e) Affordable housing limited <input type="checkbox"/> f) Accessible housing limited <input type="checkbox"/> g) Limited income to support community living <input type="checkbox"/> h) Other, please describe below		
<b>Brief Description:</b>			

## Section G: Request for Resident Review Approval for a Specified Period

- Complete this section **ONLY** if you are seeking a Resident Review for the individual for a Specified Period of Time.
- This section contains **two (2) distinct parts**.
  - The first part applies when it is part of an **INITIAL REQUEST** for a resident review approval for a specified period of time.
  - The second part applies when you are seeking to request an **EXTENSION** to specified period of approval on behalf of the individual.
- Let's review both of these parts separately.

# Section G: Request for RR Approval for a Specified Period – First Part

- Fill out the first part (**Initial Request**) of section G(1) **AND** G(2), if you checked the box next to question 3(b), 4(b), 5(b) or 7(e).

<b>SECTION G: REQUEST FOR RESIDENT REVIEW APPROVAL FOR A SPECIFIED PERIOD</b> <i>Complete only when seeking a Resident Review for a Specified Period of Time</i>	
<b>Initial Request</b>	
1) If seeking a resident review approval for a <u>specified period of time</u> , how much time is needed?	
a) Number of Days: <input type="text"/>	
2) Reason for Initial Request:	
<input type="checkbox"/> a) Individual requires more rehabilitation related to the recent hospital stay. Describe: <input type="text"/>	
<b>-OR-</b>	
<input type="checkbox"/> b) More time is needed to ensure a safe and orderly discharge due to: <i>(Check all that apply)</i>	
<input type="checkbox"/> i) Accessible housing barrier. <i>Describe:</i> <input type="text"/>	
<input type="checkbox"/> ii) Affordable housing barrier. <i>Describe:</i> <input type="text"/>	
<input type="checkbox"/> iii) Service and support limitations in the community. <i>Describe:</i> <input type="text"/>	
<input type="checkbox"/> iv) Lack of sufficient income. <i>Describe:</i> <input type="text"/>	
<input type="checkbox"/> v) Other. <i>Describe:</i> <input type="text"/>	
<b>NOTE: If requesting a resident review due to time needed for a safe and orderly discharge, the nursing facility shall attach a written discharge plan consistent with OAC 5160-3-15.2.</b>	

# Section G: Request for RR Approval for a Specified Period – Second Part

- Fill out the second part (**Request for an Extension to a Specified Period Approval**) of section G(3) **AND** G(4), if you checked the box next to question 3(c), 4(c), 5(c) or 7(f).

**Request for an Extension to a Specified Period Approval**

Resident's Date of Admission: \_\_\_\_\_

1) If seeking a resident review approval extension, how much time is needed?

a) Number of Days: \_\_\_\_\_

2) Reason for Extension Request:

a) Individual requires more rehabilitation following the recent hospital stay.  
Describe: \_\_\_\_\_

**-OR-**

b) More time is needed to ensure a safe and orderly discharge due to: *(Check all that apply)*

i) Accessible housing barrier. *Describe:* \_\_\_\_\_

ii) Affordable housing barrier. *Describe:* \_\_\_\_\_

iii) Service and support limitations in the community. *Describe:* \_\_\_\_\_

iv) Lack of sufficient income. *Describe:* \_\_\_\_\_

v) Other. *Describe:* \_\_\_\_\_

**NOTE: If requesting a resident review due to time needed for a safe and orderly discharge, the nursing facility shall attach a written discharge plan consistent with OAC 5160-3-15.2.**

## Section G: Request for RR Approval for a Specified Period – (cont.)



**BOTH** parts of section G require the NF to submit the following documentation:

- A. For purposes of extended rehabilitation, attach the following:
  1. The doctor's order **AND**
  2. Rehabilitation progress notes for the first 30 day NF stay **AND**
  3. Clinical prognosis
  
- B. For the purposes of discharge planning, attach:
  1. A detailed report of discharge planning activities as of the date of the RR request including:
    - a. Contacts made with services, benefits and housing providers.
    - b. The action items underway to ensure a safe and orderly discharge by the end of the requested RR timeline.
    - c. Medical and social reports as needed to support the request.

## Section H: Mailing Addresses

- Section H consists of five (5) distinct questions.
  - **Question 1:** Record the mailing address the individual wants the results of PAS/RR evaluation to be sent to.
  - **Question 2:** Record information about the individual's attending physician.
  - **Question 3:** If the individual has a guardian or legal representative, provide the information.
  - **Question 4:** Provide the name and address of the NF, if the individual is an applicant to or a resident of a NF.
  - **Question 5:** Provide the name of a contact person and the name of the discharging hospital, if the individual is being discharged from a hospital, and the submitter is not employed by the discharging hospital.

# Section I: Submitter Information/Certification

- In this section, you must provide the information requested and sign the acknowledgement that you understand that you may not admit or retain individuals with indications of SMI or DD without further review by OhioMHAS and/or DODD.

SECTION I: SUBMITTER INFORMATION/CERTIFICATION			
In order to process the screen, the submitter must provide his/her name and address and sign below. Complete the form fully and with accuracy. Incomplete forms may be returned with a request for further information. <b>The nursing facility may not admit or retain individuals with indications of Serious Mental Illness and/or DD or a related condition without further review by OhioMHAS and/or DODD (OAC rules 5160-3-15.1 and 5160-3-15.2).</b>			
Last Name		First Name	
Street Address		City	State
Telephone No.		County	
			Zip

<i>I understand that this screening information may be relied upon in the payment of claims that will be from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.</i>		
Signature	Title	Date (mm/dd/yyyy)
Employer		

# Now that you are familiar with HOW to fill out the ODM 3622, what's next?

- Complete the ODM 3622 via the electronic system (HENS), and the system will automatically route the form to the appropriate PASSPORT Administrative Agency (PAA) contacts who will make a determination about the individual – if they trip the screen for SMI and/or DD, they will be required to undergo a more thorough Level II evaluation by DODD and/or OhioMHAS before being admitted to the facility.
- Paper forms are permitted to be faxed or emailed to the PAA, however ODM is encouraging all entities to utilize the electronic system for a more efficient and timely process.
  - If you are filling out the ODM 3622 in paper form, once you have completed it you must ensure that it is routed to the appropriate PAA who will make a determination about the individual.

# PASSPORT Administrative Agency Contacts

- The PAA contact information for each region can be found by clicking the link below:

<http://aging.ohio.gov/FindServices#1086220-region-10b>

# Questions?

- If you have PASRR related questions, please send them via email to the following address:

[PASRR@Medicaid.ohio.gov](mailto:PASRR@Medicaid.ohio.gov)