USE FOR MEDICAID CERTIFIED FACILITIES ONLY!

LTC-14 Rev. 9

LEVEL I SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION

Please Print. The Form MUST be Completed in Full.

NAME: ____ **SSN**: _____-____-_______ **DOB**: ____/____/____

PRESENT LOCATION: ❒ NF ❒ Hospital ❒ Community Setting **(Specify):** ____

____

Facility Name and Room # **Street** **City, State and Zip** **County**

LEGAL GUARDIAN, If Applicable: ________________________________ **Address**: ____

Note: Under OBRA '87, any individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 5,000 with respect to each assessment.

The Medical Records contain documentation to support information indicated and submitted on the Level I

REFERRAL SOURCE AND TITLE: ____ **DATE:** _______________________

PLACE OF EMPLOYMENT: ____________________________________**FAX #:**__________________**PHONE #:**____________________

1. Does the individual have a suspected diagnosis or history of mental retardation or a related condition? ❒ **Yes** ❒ **No**

   1a. Specify.
   ❒ **Mental Retardation** ❒ **Epilepsy**
   ❒ **Autism** ❒ **N/A**
   ❒ **Cerebral Palsy**

   1b. Did the **mental retardation** develop before the individual reached age 18? ❒ **Unknown** ❒ **Yes** ❒ **No** ❒ **N/A**

   1c. Did the **related condition** develop before the individual reached age 22? ❒ **Unknown** ❒ **Yes** ❒ **No** ❒ **N/A**

2. Does the individual have a suspected diagnosis or history of a serious mental illness that is not situational or related to a medical condition?
   ❒ **Yes** ❒ **No**

   2a. If yes, specify diagnosis:
   ❒ **Schizophrenia**
   Mood Disorder: ❒ **Major Depression** ❒ **Bipolar** ❒ **Depression**
   ❒ **Paranoid Disorder**
   ❒ **Anxiety Disorder**
   ❒ **Somatoform Disorder**
   ❒ **Personality Disorder**
   ❒ **Psychotic Disorder**
   ❒ **Unspecified Mental Disorder**
   ❒ **Panic Disorder**

3. Has the individual been prescribed or taken any **anti-depressant, anti-psychotic and/or anti-anxiety medications** on a **regular** basis within the last 14 days **for a general medical condition**?
   ❒ **Yes** ❒ **No**
   If yes, list medications:
   ____
   ____
   ____
   ____

4. Is there a diagnosis of Dementia, Alzheimer or any related organic disorders? ❒ **Yes** ❒ **No** If **yes,** complete the MSE

   Provide MSE Score: ____ Check if unable to test: ❒

   4a. If #4 is yes, Check level of consciousness:
   ❒ **Alert** ❒ **Drowsy** ❒ **Stupor** ❒ **Coma** ❒ **N/A**

   4b. If #2 & #4 are yes, which diagnosis is primary:
   ❒ **Dementia** ❒ **Mental Illness** ❒ **N/A**

5. Does the individual's current behavior or recent history within 1 year indicate that he/she is a danger to self or others (suicidal, self-injurious or combative)? ❒ **Yes** ❒ **No**

   If yes, explain: ____________________________________
   ____
   ____

6. This Level I is due to **one** of the following:

   ❒ **Significant behavioral change**
   ❒ **Significant mental health diagnosis change**
   ❒ **Significant medical decline**
   ❒ **Significant medical improvement**
   ❒ **New NF admit**
   ❒ **Previous Level I incorrect** (for nursing home use only)
   ❒ **No Level I upon NF admission** (for nursing home use only)

7. Is the individual applying for NF care due to the following conditions? (choose **one or more** of the following):

   ❒ **Long term care**
   ❒ **Convalescent care** (Valid **ONLY** with PT and/or OT orders and for a short term stay as prescribed by MD for 120 days or less)
   ❒ **Other short term NF stay**
   ❒ **Terminal illness** (Life expectance of 6 mo. or less)
   ❒ **Comatose**
   ❒ **Ventilator dependant**
   ❒ **Functioning only at brain stem level**
   ❒ **Cerebella degeneration**
   ❒ **Advanced Amyotrophic Lateral Sclerosis**
   ❒ **Huntington's Disease**