

OBRA Level 1

About this Domain (OBRA Level 1)

This domain contains information to screen an individual with or suspected to have a diagnosis of developmental disabilities or related condition prior to nursing facility placement.

To assure an individual with a mental illness diagnosis is offered mental health services.

Developmental Disability or Related Condition

Long Term Care Consultation Program

OBRA Level 1 Criteria

Screening for Developmental Disabilities or Mental Illness

This form must be completed for a person seeking admission to a Medical Assistance (MA) certified nursing or boarding care facility OR as a part of a community assessment

| | |
|--------------------------|----------------------------|
| Person's name (text box) | *Date of Birth* (text box) |
| *PMI #* (text box) | Doctor/Phone # (text box) |

Developmental Disability or Related Condition

In order to consider a person for referral for further evaluation and determination of need for specialized services, an individual may meet ANY of the following criteria: diagnosis, history, or evidence of Developmental Disability.

1. Does the person have a diagnosis of developmental disability or a related condition?
 - Yes
 - No
2. Has this person ever been considered to have developmental disability or a related condition in the past?
 - Yes
 - No
3. Is there any presenting evidence (cognitive or behavioral) that may indicate the presence of developmental disability or related condition?
 - Yes
 - No
4. Has the person been referred for nursing or boarding care facility placement by an agency that serves persons with developmental disability or related condition?
 - Yes
 - No

If you have answered YES to ANY of the previous questions, refer the person to the County offices for persons with developmental disabilities or related conditions for evaluation and determination of need for specialized services.

If the person is being admitted to a certified nursing or boarding care facility and is NOT subject to a level II referral, forward this form to the facility for inclusion in the person's record. If the person is not being admitted to a facility but is seeking community services, retain this form in the person's county record.



Assessment Domains

Reassessment

- Change
- No change

| | |
|-------------------------------------|-------|
| Signature of Screener | Date: |
| Signature of Screener (upon review) | Date: |
| Reassessment Signature of Screener | Date: |

Mental Illness

Long Term Care Consultation Program

Screening for Developmental Disabilities or Mental Illness

This form must be completed for a person seeking admission to a Medical Assistance (MA) certified nursing or boarding care facility OR as a part of a community assessment

| | |
|--------------------------|----------------------------|
| Person's name (text box) | *Date of Birth* (text box) |
| *PMI #* (text box) | Doctor/Phone # (text box) |

Mental Illness

In order to consider a person for referral for further evaluation and determination of need for specialized mental health services, the person must meet ALL of the following criteria on diagnosis, level of impairment and duration of illness.

1. Does the person have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition excluding a primary diagnosis of dementia, Alzheimer's disease, or other related cognitive conditions?
 - Yes
 - No

And

2. Has the major mental disorder resulted in significantly impaired functioning in major life activities that would be appropriate for the person's developmental stage within the past 3 to 6 months?
 - Yes
 - No

And

3. Does the person's treatment history indicate at least one of the following:
 - Psychiatric treatment more intensive than outpatient care (partial hospitalization or inpatient hospitalization) more than once in the last two years?
 - OR
 - Within the past two years and due to the mental disorder, the person has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment center, or which resulted in intervention by housing or law enforcement officials?
 - Yes
 - No

Assessment Domains

If your answer is YES to ALL of the questions above:

And the person is seeking admission to an MA certified nursing facility or boarding care facility, refer the person to the county local mental health authority for completion of a Level II evaluation and determination of need for specialized services.

If the person is seeking a community placement, retain the form in person's record and refer the client to others (county social services, county mental health office, physician, health plan) to receive necessary mental health services.

If your answer is NO to ANY of the questions above:

And the person is seeking admission to an MA certified nursing facility or boarding care facility, send the form to the admitting facility for inclusion in the person's records.

And the person is seeking a community placement, retain the form in person's file. If in the future the person is admitted to a nursing facility, review the form for accuracy and send to the facility

Reassessment

- Change
- No change

| | |
|-------------------------------------|-------|
| Signature of Screener | Date: |
| Signature of Screener (upon review) | Date: |
| Reassessment Signature of Screener | Date: |