

South Dakota PASRR Program PRE-SCREENING FORM

Type of Facility (select one):

Nursing Facility

Swing Bed

Type of Screen (select one):

Pre-Admission

Resident Review

APPLICANT DEMOGRAPHICS					
LAST NAME	FIRST NAME	MI	DATE OF BIRTH		
SOCIAL SECURITY NUMBER	MEDICAID NUMBER (IF APPLICABLE)	PRIMARY LANGUAGE			
CURRENT LOCATION OF APPLICANT					
FACILITY NAME	CITY	STATE			
PRIMARY CONTACT REGARDING PASRR	CONTACT EMAIL	CONTACT PHONE	FAX		
SECONDARY CONTACT REGARDING PASRR	SECONDARY CONTACT EMAIL	SECONDARY CONTACT PHONE			
ADMITTING FACILITY Unknown At This Time					
FACILITY NAME	FACILITY CONTACT REGARDING PASRR				
CITY	STATE	ZIPCODE	PHONE NUMBER		
DIAGNOSES					
PRIMARY ADMITTING DIAGNOSIS					
SECONDARY DIAGNOSES					
SCREENING QUESTIONS			YES	NO	Unknown
1. Does the individual have a condition of, or is there any presenting evidence* that may indicate the individual may have an intellectual or developmental disability?					
2. Is the individual being referred by an agency that provides support for individuals with intellectual or developmental disabilities and has the individual been determined to be eligible for that agency's services?					
3. Does this individual have a condition of, or is there any presenting evidence* that may indicate the individual may have mental illness? Indicate a "YES" response if the individual has any type of physician documented dementia diagnosis					
4. Prior to this nursing facility admission request, did this individual receive any Medicaid funded, State paid, or privately paid in-home services?					

*See PASRR Manual Exhibit A for presenting evidence definition.

If any of the answers for questions 1 through 3 (as listed in the table above) are "YES", or "Unknown" email Maximus at PASRR@state.sd.us with supporting documentation. If all the answers are "NO", the individual may be placed without further evaluation and this form is saved in the individual's file.

☐ This individual does not need to be referred for further evaluation.

☐ This individual was referred to Maximus on _____ and _____
(date) (time)

Signature of Designated Facility Representative

Date Signed