Revised March 2007

MAP-4094

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

NOTIFICATION OF INTENT TO REFER FOR LEVEL II PASRR

Individual/Resident Name ______________________________

Social Security Number ____________________ **Date of Birth** ______________

Home Address (if not in facility) ______________________________

Name of Nursing Facility ______________________________

Medicaid Provider Number ______________________________

Facility Address ____________________ **Phone Number** ______________

Date Admitted to Nursing Facility ______________________________

Responsible Party ______________________________

Address ____________________ **Phone Number** ______________

Date Level I PASRR Completed ______________________________

This is the written notification to inform the individual and the responsible party that the Level I PASRR indicates:
(Please check appropriate box)

- **a diagnosis of mental illness,** ☐
- **or mental retardation,** ☐
- **or a related condition.** ☐

The individual is being referred to the Community Mental Health/Mental Retardation Center for a Level II PASRR. The Level II PASRR is an evaluation and determination of the need for nursing facility services, and if so, whether specialized services are needed.

Authorized Nursing Facility Staff ____________________ **Date** ______________

Print Authorized Nursing Facility Staff Name ______________________________

Original Copy to Individual or Responsible Party
Second Copy – Medical Records
Third Copy – Community Mental Health/Mental Retardation Center