

# LEVEL ONE FORM TRAINING

FEBRUARY 8, 2024



MISSOURI DEPARTMENT OF  
**HEALTH &  
SENIOR SERVICES**

Ammanda Ott, Registered Nurse Specialist/Supervisor  
Section for Long-Term Care Regulation  
Missouri Department of Health and Senior Services

# OBJECTIVES

Process  
Information and  
PASRR Intent

How to  
Complete the  
Level One Form

How to Check  
Status of an  
Application

## CURRENT STATUS WITH PROCESSING APPLICATIONS

In calendar year 2023, COMRU processed over 17,856 Level of Care Applications.

In November 2023, COMRU hired an additional Registered Nurse team member to assist with the review and approval of applications.

Additional Temporary Staff members from Division of Regulation and Licensure have also been assisting with the processing of overdue Level of Care/Level I applications.

# CURRENT STATUS WITH PROCESSING APPLICATIONS

## What can your skilled nursing facility do to help COMRU's processing times?

1. **Minimize corrections** by ensuring that all staff who complete level of care/Level I applications have viewed online training and understand the process for completion. Double check all submissions to make sure key elements are answered correctly. [Preadmission Screening and Resident Review \(PASRR\) | Nursing Homes & Other Care Options | Health & Senior Services \(mo.gov\)](#)
2. **Reduce the amount of time COMRU spends answering phone calls** by using the online application to check application status (remember...do not resave the application after you have submitted it to COMRU- unless you make changes to it).
3. **Respond quickly to correction requests and answer all questions/corrections appropriately** the first time so that determinations are not held up, resulting in further delays.
4. **Sign up for the LTC Bulletin**, *please subscribe to our weekly listserv at:* <https://cntysvr1.lphamo.org/subscribe/tc.html>

## PASRR INTENT

The PASRR process requires that all applicants to Medicaid-certified nursing facilities (regardless of whether their stay will be covered by private funds, Medicare, or Medicaid) be given a preliminary assessment to determine whether they might have a Serious Mental Illness (SMI) or an Intellectual Disability (ID). This is called a "Level I screen." Those individuals who meet certain criteria at Level I are then further evaluated: this is referred to as "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

The Federal Regulation 483.102 (a) This subpart applies to the screening or reviewing of all individuals with Mental Illness or Intellectual Disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnosis.

## PASRR INTENT

“Preadmission Screening and Resident Review (PASRR)” is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASRR requires that:

- 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability;
- 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and
- 3) receive the services they need in those settings.

Regulations governing PASRR are found at 42 CFR §483.100-§483.138.

Nursing Homes **MAY NOT** admit a resident suspected of having SMI or ID diagnosis without the Level II screening being completed. This is important as the Level II provides a comprehensive review of the residents past and current behavioral health conditions and the services needed to ensure their health and safety.

## PASRR INTENT

All clients entering/residing in a Medicaid certified bed must have a Level One Form completed.

A new online application does not need to be submitted to COMRU if the client is not applying for Medicaid or does not trigger a Level 2 screening (per Level One Form). If the client later applies for Medicaid or triggers a Level 2 screening, a new online application must be completed and submitted to COMRU.

If the client already has an online application (Level I form /Level of Care form) approved and has not been out of the SNF greater than 60 days, then a new online application is not required to admit to the SNF. The SNF would need to assess the client for a Change in Status or a Change in Condition per guidelines.

## LEVEL ONE NURSING FACILITY PRE-ADMISSION SCREENING FOR MENTAL ILLNESS / INTELLECTUAL DISABILITY OR RELATED CONDITION


This process is automated – the link to complete the online application is located on COMRU’s webpage. <https://health.mo.gov/seniors/nursinghomes/pasrr.php>

The automated system will give the submitter a “Return Code” that is unique to each individual application. Please ensure the submitter writes down this code as it will be utilized throughout the entire process.



# LEVEL ONE FORM

## Section A. Individual Identifying Information

<b>Last Name:</b>	<input type="text"/>	<b>First Name:</b>	<input type="text"/>
<b>Middle Initial:</b>	<input type="text"/>	<b>Suffix</b>	<input type="text"/>
<b>DCN (Medicaid Number):</b>	<input type="text" value="12345678"/> <small>8 characters remaining</small>	<b>SSN Number:</b>	<input type="text" value="xxx-xx-xxxx (must include dashes)"/>
<b>Date of Birth:</b>	<input type="text" value="mm-dd-yyyy"/>  M-D-Y	<b>Race:</b>	<input type="text" value=""/>
<b>Gender:</b>	<input type="text" value=""/>	<b>Education Level:</b>	<input type="text" value=""/>
<b>Occupation:</b>	<input type="text" value="Prior to Retired or Disabl"/>		

- Individual's First and Last Name  
This should be the individual's **legal name**
- Date of Birth  
This is entered in a "mm-dd-yyyy" format
- SSN Number  
Dashes must be entered between numbers  
"XXX- XX-XXXX"
- Occupation  
This would be the occupation prior to the Individual becoming disabled or retired  
If the individual never worked indicate  
"never worked"

# LEVEL ONE FORM

## Section B. Individual's Contact Information

Previous Residence Type (Residency Prior to This **Current** SNF Placement)

Street Address

1234 North West Street

City

State

Zip Code

- Previous Residence Type  
What type of setting was the Individual residing in **prior** to this admission?
  
- There is a drop-down menu with these options:
  - Home / Facility Residence
  - RCF (Residential Care Facility)
  - ICF (Intermediate Care Facility)
  - SNF (Skilled Nursing Facility)
  - ALF (Assisted Living Facility)
  - ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disability)
  - DMH Group Home / Individualized Supported Living
  - DMH Psychiatric Hospital and Facilities
  - Homeless / Shelter
  - Incarcerated

# LEVEL ONE FORM

## Legal Guardian or Designated Contact Person Information

\* must provide value

None  Legal Guardian  Designated Contact Person

First Name	Last Name	Relationship	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
E-mail			
<input type="text"/>			
Street Address			
<input type="text"/>			
City	State	Zip	Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### ➤ Legal Guardian or Designated Contact Person Information

If “None” is marked, the requested fields for the Legal/Guardian or Designated Contact information will disappear

If the individual has a **Legal Guardian**, please provide the requested information. This email will be used as the primary mode of providing letters and reports to the legal guardian. These records will be sent via an encrypted email. The email address is a required field on the application.

# LEVEL ONE FORM

## Section C. Referring Individual Completing Application

<b>First Name</b> <input type="text"/>	<b>Last Name</b> <input type="text"/>
<b>Position/Title</b> <input type="text"/>	<b>Type of Entity</b> <input type="text" value="▼"/>
<b>Name of Entity</b> <input type="text"/>	<b>Telephone Number</b> <input type="text"/>
<b>Email Address</b> <input type="text"/>	<b>Fax Number</b> <input type="text"/>

- This is the identifying information of the person completing the application prior to the physician's signature.

# LEVEL ONE FORM

## Section D. Level One Screening Criteria for Serious Mental Illness

1. Does the individual show any signs or symptoms of a Major Mental Illness?

Yes  No

Signs/Symptoms:

Please do not provide diagnosis

Expand

- Please provide the signs and symptoms that the individual is displaying.
- Diagnoses are not accepted.

# LEVEL ONE FORM

2. Does the individual have a current, suspected, or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition?

(Please refer to the Physician order/report and indicate ALL Major Mental Illness diagnosis)

Yes  No

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Schizophrenia            | <input type="checkbox"/> Schizoaffective Disorder       | <input checked="" type="checkbox"/> Bipolar Disorder                |
| <input type="checkbox"/> Psychotic Disorder       | <input type="checkbox"/> Major Depressive Disorder      | <input type="checkbox"/> Obsessive-Compulsive Disorder              |
| <input type="checkbox"/> Dysthymic Disorder       | <input type="checkbox"/> Panic Disorder                 | <input type="checkbox"/> PTSD                                       |
| <input type="checkbox"/> Conversion Disorder      | <input type="checkbox"/> Personality Disorder           | <input type="checkbox"/> Mood Disorder                              |
| <input type="checkbox"/> Somatic Symptom Disorder | <input type="checkbox"/> Dissociative Identity Disorder | <input type="checkbox"/> Anorexia Nervosa or other eating disorders |
| <input type="checkbox"/> Anxiety Disorder         | <input type="checkbox"/> Delusional Disorder            |   |

Other Mental Disorder in the DSM

Intermittent Explosive Disorder

Additional

- Please refer to the Physician's orders, History and Physical, and other supporting documentation to ensure that all the individual diagnoses are indicated on the application.
- More than one diagnosis can be marked by the submitter.
- If the diagnosis is not listed, mark the "Other Mental Disorder in the DSM" box and list the diagnosis in the box. Please list **only** Major Mental Illness diagnoses.
- A Level 2 screening is **not** automatically indicated if an individual has a Major Mental Illness diagnosis.

# LEVEL ONE FORM

### 3. Does the individual have any area of impairment due to serious mental illness?

(Record YES if any of the subcategories below are checked)



Yes



No

(Impairments indicated should be associated with the serious mental illness diagnosis indicated in Section D #2 above)

None

**Interpersonal Functioning:**

The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationship and social isolation.

**Adaptation to Change:**

The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (ideation, gestures, threats, or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention by mental health or judicial system.

**Concentration/Persistence/and Pace:**

The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors or requires assistance in the completion of these tasks.

- The submitter must choose at least one of the four categories.
- The submitter can choose more than 1 of the 3 categories:
  - Interpersonal Functioning
  - Adaptation to Change
  - Concentration/Persistence and Pace
- Adaptation to Change:
  - Requires intervention by mental health or judicial system. Is the individual currently receiving services in the community through Comprehensive Psychiatric Services (CPS – DMH)? If the individual is receiving services, this category would be marked.
- A Level 2 screening would be indicated if any of the three categories are marked and Dementia is **not** the primary mental illness diagnosis

# LEVEL ONE FORM

4. Within the last 2 years, has the individual:  
(Record YES if Either/Both of the two subcategories below are checked)

Yes  
 No

Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g. had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials?

**Check yes, if treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider individual positive for serious mental illness.**

- If treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the individual is positive for serious mental illness. Examples might include (not an exclusive list):

The individual went to the hospital and no psychiatric beds were available, so the individual was not admitted to the psychiatric unit even though the client was having an episode. Instead, the individual stabilized on the medical floor.

The submitter does not know whether the individual has had an inpatient stay due to the individual being a poor historian.

- A Level 2 screening would be indicated if this question is marked “Yes” and Dementia is **not** the primary mental illness diagnosis



# LEVEL ONE FORM

5. Does the individual have a substance related disorder?

Yes  No

Is the need for a skilled nursing facility placement associated with substance abuse?

Yes  No

When did the most recent substance abuse occur?

N/A  1-30 days  31-90 days  Unknown

- Must be a documented diagnosis of current substance use **or** history of substance abuse
- A Level 2 screening is not automatically indicated if an individual has a substance related disorder

# LEVEL ONE FORM

6. Does the individual have a diagnosis of Major Neurocognitive Disorder (MNCD) i.e., [dementia or Alzheimer's](#)?

Yes  No

- Please refer to the Physician's orders, History and Physical, and other supporting documentation to ensure that if a client has a MNCD diagnosis it is indicated on the application.
- If the individual does not have a diagnosis of Major Neurocognitive Disorder (MNCD) the additional questions in this section will disappear when answered "No".
- If the individual does have a diagnosis MNCD, then the following questions are required and should be completed to support the primary mental illness diagnosis.

# LEVEL ONE FORM

6. Does the individual have a diagnosis of Major Neurocognitive Disorder (MNCD) i.e., [dementia or Alzheimer's](#)?

Yes  No

Has the Physician documented MNCD as the primary diagnosis OR that MNCD is more progressed than a co-occurring mental illness diagnosis? (Provide documentation if answered yes)

Yes  
 No

Were any of the following criteria used to establish the basis for the MNCD:

Yes  No

Standardized Mental Status Exam (type)

Date Completed

  M-D-Y

Score

- Neurological Exam
- History and Symptoms
- Other Diagnostics:

Specify:

Expand

- Primary Diagnosis  
Is Dementia **primary over** the Serious Mental Illness diagnosis indicated in Section D #2?

# LEVEL ONE FORM

## Section E. Level One Screening Criteria for Intellectual Disability or Related Condition

1. Is the individual known or suspected to have a diagnosis of Intellectual Disability that originated prior to age 18?

 Yes

No

If Yes, indicated diagnosis:

- There is a drop-down menu with these options:
- Mild Intellectual Disability
  - Moderate Intellectual Disability
  - Severe Intellectual Disability
  - Profound Intellectual Disability
  - Unspecified Intellectual Disability

# LEVEL ONE FORM

## 2a. Does the individual have a suspected diagnosis or history of an Intellectual Disability/Related Condition?

(Please refer to the Physician order/report and indicate ALL Intellectual Disability Related Conditions)

Yes  No

Autism

Cerebral Palsy (CP)

Epilepsy/Seizure/Convulsions

age 26

Head Injury/Traumatic Brain Injury (TBI)

Down Syndrome

Birth

Spina Bifida

Prader-Willi Syndrome

Deaf or Blind

Muscular Dystrophy

Fetal Alcohol Syndrome

Paraplegia

Quadriplegia

Other Related Conditions:

Guillain Barre Syndrome

21

Additional

- Does the individual have a diagnosis or history of a Related Condition?

If “No” is indicated questions 2b thru 2d will disappear.

If “Yes” is indicated, choose the diagnosis and provide the age of onset in the blank.

If the diagnosis is not listed, click on “Other Related Condition” to type the diagnosis

- Mental Illness is **not** considered a “Related Condition”

# LEVEL ONE FORM

2b. Did the Other Related Condition develop before age 22?  Unknown  Yes  No

2c. Likely to continue indefinitely?  Yes  No

2d. Results in substantial functional limitation in three or more major life activities?  
([Impacted prior to the age of 22](#))

\* must provide value

No Functional Limitations

**Capacity for Independent Living**

**Learning**

Self-Direction

**Self-Care**

Mobility

Understanding and Use of Language

- Results in substantial functional limitations in three or more major life activities?
  - Reminder: The functional limitation(s) must have impacted the individual **prior to the age of 22**.
- A Level 2 screening would be indicated if the individual has a related condition prior to the age of **22 and 3** or more functional limitations.
- To assist with answering the questions in Section E, the submitter might have to ask the individual, guardian, or other sources as to whether or not the individual was receiving Developmental Disability Services (DD – DMH) in the community.

# LEVEL ONE FORM

## Section F. Special Admission Categories

(If the current SNF Admission does not qualify for any of the below indicated SACs, please leave this section blank.)

Special Admission Category instructions:

Click to display:

Reset SAC:

- 0 - None
- 1 - Terminal Illness  
*Expected to result in death in six months or less*
- 2 - Serious Physical Illness  
*Severe/end stage disease (or physical condition)*
- 3 - Respite Care  
*Stays not more than **thirty (30) days** to provide relief for in-home caregivers*
- 4 - Emergency Provisional Admission  
**Must be hotlined.** *Stays not more than 7 days to protect person from serious physical harm to self and others. Hotline must be reported to the Adult Abuse and Neglect Hotline (1-800-392-0210 or [https://apps4.mo.gov/APS\\_PORTAL/](https://apps4.mo.gov/APS_PORTAL/))*
- 5 - Direct Transfer From a Hospital  
*Stays not more than **thirty (30) days** for the condition for which the person is currently receiving hospital care. **Must include the hospital history and physical.***
- COVID 19 Waiver - *If admitted from the Hospital, provide a copy of History and Physical*

*(Not Valid for SNF Admissions after 05-11-2023)*


- A Special Admission Category (SAC) is **only** utilized if an individual triggers a Level 2 screening.
- The submitter does not have to choose a SAC for processing.
- SAC numbers 1 thru 5 must be **pre-approved** by COMRU prior to admitting to SNF. Failure to pre-approve these SACs may result in loss of Medicaid payment.
- The submitter will be able to view the determination of the SAC by logging back into the application (using the unique Return code).
- When SAC #3 or #5 is approved, it is the responsibility of the skilled nursing facility to subsequently notify COMRU via email ([COMRU@health.mo.gov](mailto:COMRU@health.mo.gov)) if the individual will exceed the thirty-day special admission stay. In order to avoid loss of Medicaid payment, notice must be made to COMRU within the first 14-20 days of the individual's stay to allow time for the processing of the Level 2 screening.
- If the individual discharges, transfers, or leaves the nursing facility for any reason the SAC is considered completed and a new application request will need to be submitted to COMRU prior to the individual's return to any nursing facility.

# LEVEL ONE FORM

## Section G. Physician's Authorization and Signature

I attest that the information on these forms is complete and correct as known to me.

Applicant is not currently a danger to self and others  Applicant is currently a danger to self and others

Physician Signature <a href="#">Add signature</a>	Physician Date: <input type="text"/>  Today M-D-Y
Physician Name <input type="text" value="(Provide Physician Name)"/>	License Number <input type="text"/>
Discipline <input type="text" value="(Provide Discipline)"/>	

**Survey Link:**

<https://redcapdrlltcc.azurewebsites.net/redcap/surveys/?s=WA9KMWXC7L7LAMTP>

- Once the Level I form has been completed, it is then sent to the Physician for their signature.
- The submitter will need to scroll down to the end of the application and click the “Save and Return Later.” button.

### Send to Physician

Scroll to the bottom and click "Save & Return Later"

Make sure to provide the form URL and Return Code when sending the information.

<https://redcapdrlltcc.azurewebsites.net/redcap/surveys/?s=RNMP48LRWY>

Record ID: \_\_\_\_\_



# CHECKING STATUS

## Central Office Use Only (DRL/COMRU)

**Client:** \_\_\_\_\_

### Level of Care Determination by DRL Central Office (COMRU)

**Application Submitted to COMRU:** \_\_\_\_\_

**Application Accepted:** \_\_\_\_\_ | **Correction:** \_\_\_\_\_

**Meets level of care:** \_\_\_\_\_

**Application Type:** \_\_\_\_\_

### Point Count

There is a mandated [18 point count](#) for SNF placement



**DHSS COMRU**

\_\_\_\_\_

**Submitter**

**Signature:**

**Date:**

\_\_\_\_\_

## LEVEL ONE FORM

- The submitter can also log back into the application (using the Return Code) to verify the Physician has signed/completed the application. This is the same process as the previous slide.
- If the submitter is a hospital and the application **did not trigger** a Level 2 screening, the hospital can email the Return Code and Application link to the SNF for review. This should be provided to the SNF in the referral packet. The SNF would complete the remainder of the application (Nursing Facility Level of Care Assessment) and submit to COMRU for processing.
- If the submitter is a hospital and the application **triggers** a Level 2 screening, the hospital would continue to complete the rest of the application for submission.

# CHECKING STATUS

## Level of Care Determination by DRL Central Office (COMRU)

Application Submitted to COMRU: Complete

Application Accepted: \_\_\_\_\_ | Correction: \_\_\_\_\_

Meets level of care: \_\_\_\_\_

Application Type: \_\_\_\_\_

## Point Count

There is a mandated [18 point count](#) for SNF placement



33

DHSS COMRU

Submitter

Signature:

Date:

\_\_\_\_\_

# CHECKING STATUS

Level of Care Determination by DRL Central Office (COMRU)

Application Submitted to COMRU: Complete



Application Accepted: No | Correction: [Correction Notice.pdf](#)

Meets level of care: \_\_\_\_\_

Application Type: Level 1

Point Count

There is a mandated [18 point count](#) for SNF placement



DHSS COMRU

33

Submitter

Signature:

Date:

\_\_\_\_\_

# CHECKING STATUS

Level of Care Determination by DRL Central Office (COMRU)

Application Submitted to COMRU: Complete

Application Accepted: Yes | Correction: [Correction Notice.pdf](#)

Meets level of care: \_\_\_\_\_

Application Type: Level 1

## Point Count

There is a mandated [18 point count](#) for SNF placement



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DHSS COMRU

Submitter

Signature:

Date:

\_\_\_\_\_

# CHECKING STATUS

Level of Care Determination by DRL Central Office (COMRU)

Application Submitted to COMRU: Complete

Application Accepted: Yes | Correction: [Correction Notice.pdf](#)

Meets level of care: Yes

Application Type: Level 1

There is a mandated [10 point count](#)  
for SNF placement

**33** DHSS COMRU

33 Submitter


Signature:




Date:

01-21-2024 14:48

# CHECKING STATUS

<p><u>Level of Care Determination by DRL Central Office (COMRU)</u></p> <p>Application Submitted to COMRU: Complete</p> <p>Application Accepted: Yes   Correction: <a href="#">Correction Notice.pdf</a></p> <p>Meets level of care: Yes</p> <p>Application Type: Level 2</p>	<p>for SNF placement</p> <p><b>33</b>                      DHSS COMRU</p> <p>33                              Submitter</p> <p>Signature:</p>  <p>Date:</p> <p>01-21-2024 14:48</p>
<p>If Level 2 indicated above:</p> <p>Special Admissions Category: Direct Transfer from a Hospital   Valid: Yes</p> <p>Date Referred to DMH for Level 2 Screening: _____</p> <p>Date Due from DMH: _____</p>	<p>DHSS Determination: _____</p> <p>Information from COMRU: <a href="#">SAC Admit Notif Attchmt.pdf</a></p>

# CHECKING STATUS

<p><u>Level of Care Determination by DRL Central Office (COMRU)</u></p> <p>Application Submitted to COMRU: Complete</p> <p>Application Accepted: Yes   Correction: <a href="#">Correction Notice.pdf</a></p> <p>Meets level of care: Yes</p> <p>Application Type: Level 2</p>	<p>for SNF placement</p> <p><b>33</b>      DHSS COMRU</p> <p>33      Submitter</p> <p>Signature:</p>  <p>Date:</p> <p>01-21-2024 14:48</p>
<p>If Level 2 indicated above:</p> <p>Special Admissions Category: None   Valid: _____</p> <p>Date Referred to DMH for Level 2 Screening: 01-19-2024</p> <p>Date Due from DMH: 02-01-2024</p>	<p>DHSS Determination: _____</p> <p>Information from COMRU: _____</p>



# CHECKING STATUS

When you check the status on these applications you are looking at the Level 2 Determination DMH.

- You can see below on the left, this was referred to Bock for a Mental illness evaluation and Bock Associates has uploaded the evaluation and determination letter on the right.

At the bottom it shows the application status as appropriate for NF.

- The example on the right shows someone who has had a previous Level 2 and does not require a review. It indicates that the client has already been screened, and then has the previous evaluation and determination uploaded.

At the bottom it shows that a Level II evaluation is not required and to refer to the documents uploaded for the determination.

If Level 2 indicated above: Special Admissions Category: COVID 19 Waiver   Valid: Yes Date Referred to DMH for Level 2 Screening: 03-31-2023 Date Due from DMH: 04-13-2023		DHSS Determination: _____
<b>Level 2 Determination (DMH)</b>  Mental Illness: Referred To Bock Associates for Level 2 evaluation Intellectual Disability: _____ Previous Level 2 Determination: _____ Previous Level 2 Screening: _____ DMH Determination: _____ Application Status: Appropriate for Nursing Facility Placement	<b>Bock Associates</b>  Level 2 Evaluation [redacted].pdf Level 2 Determination [redacted].pdf	

If Level 2 indicated above: Special Admissions Category: None   Valid: _____ Date Referred to DMH for Level 2 Screening: 04-06-2023 Date Due from DMH: 04-19-2023		DHSS Determination: _____
<b>Level 2 Determination (DMH)</b>  Mental Illness: NL2R (Already Screened - SNF to obtain previous Level 2 evaluation) Intellectual Disability: _____ Previous Level 2 Determination: <a href="#">Determination Letter.pdf</a> Previous Level 2 Screening: <a href="#">showdocument.pdf</a> DMH Determination: _____ Application Status: Application was not referred for L2 Screening ( <b>NL2R</b> )	<b>Bock Associates</b>  Level 2 Evaluation _____ Level 2 Determination _____	

# CHECKING STATUS

**Be sure to print/save the processed application for the resident's medical record! Surveyors will ask for the documentation during survey!**

## **Online Applications will be deleted:**

1. When the online application has not been submitted to COMRU within 60 days of the physician signature.
2. The processed applications will be deleted from the COMRU online system 60 days after completion.
3. When a correction has not been returned back to COMRU within 60 days of notification.



# THANK YOU

FOR MORE INFORMATION CONTACT

AMMANDA OTT

573-522-3092 (OPTION #4)

[COMRU@HEALTH.MO.GOV](mailto:COMRU@HEALTH.MO.GOV)

