MENTAL RETARDATION/RELATED CONDITION EVALUATION, (MR/RC)

Section I: IDENTIFYING DATA

1. Name: Last	First	MI	2. Assessment date	3. Date of birth

4. Medicaid #	5. SSN	6. Gender ☐ Male ☐ Female	7. Age

8. Assessment location: *ARRs should be completed only if individual is still in a Medicaid certified Nursing Facility bed classification. Verify continued residence in appropriate bed type (marked by asterisk) before completing ARR.

☐ Hospital/General:	☐ Hospital/State:	☐ Nursing Facility:	☐ Community Setting:
☐ medical unit	☐ psychiatric bed	☐ Medicare distinct part bed	☐ rest home/domiciliary
☐ psychiatric unit	☐ Medicaid certified NF bed*	☐ rest home bed (in NF)	☐ group home
☐ Medicaid certified NF bed*	☐ Other: (Specify):	☐ Medicaid certified NF bed*	☐ family/caregiver's home

9. Facility/ Residence name & address	10. Permission for Family Interview from Individual or Guardian? ☐ Yes ☐ No Is family available? ☐ Yes ☐ No	11. Original Admit Date

12. Type of Assessment	13. Source(s) of information	14. Legal Representative
☐ Pre-admission Screen ☐ Annual Resident Review ☐ Status Change *(diagnosis on record)*:	☐ Interview with Individual ☐ Staff ☐ Record/Document review ☐ Interview with family ☐ Other (Specify): _____	☐ Yes ☐ No 15. DSM-IV-TR Axis I _____ Axis II _____

16. Name, address & phone # of Legal Representative

Section II: NARRATIVE: Provide a brief snapshot of the individual's presentation at the time of assessment: significant events, pertinent information regarding medical status, mental retardation/related conditions, reason for seeking NF admission and any other information relevant to determine the need for a Nursing Facility placement and assess for Specialized Service needs.

Section III: SOCIAL HISTORY/SOCIAL DEVELOPMENT

1. Primary living situation for past year	2. Marital status	3. Reason for admission
☐ Independent ☐ With spouse/family ☐ Board and care ☐ Nursing Facility ☐ Other (specify) _____ Length of residence: _____	☐ Never married ☐ Married/cohabiting ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown	☐ Medical ☐ Cognitive ☐ ADL ☐ Other (specify): _____

4. Race/Ethnicity: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Native American ☐ Other (specify):	5. Date of MR/RC Onset

6. Education: ☐ None ☐ Elementary school ☐ Middle/Junior high school ☐ High school	Special Education ☐ Yes ☐ No

7. Social history:

A. Employment history (nature of work/ longevity): _____

_____

B. The individual has vocational skills/ability to sustain work: ☐ Yes ☐ No

C. The individual has current social/ professional/ familial support systems: ☐ Yes ☐ No

D. The individual has current social/ professional/ familial support systems: ☐ Yes ☐ No

E. Engages in recreational/leisure time activities: ☐ Yes ☐ No

8. Attitude in Social Environment

☐ Cooperative
☐ Oppositional
☐ Agitated
☐ Guarded

9. Socialization

☐ Appropriately responds to others' initiations
☐ Appropriately initiates contact with others
☐ Inappropriate responses/interactions (describe): _____
☐ Withdrawn

10. Summary of social history: (Specify additional relevant information on questions #6 –#9 and note significant life events that impact current status): _____

_____

_____

Section IV: FUNCTIONAL ASSESSMENT/PLACEMENT POTENTIAL

1. Identify functional capabilities (list any aids used): *0 = Good* *1 = Fair* *2 = Loss*

( ) A. Vision* _____ ( ) B. Hearing _____ ( ) C. Transfer _____
( ) D. Ambulation _____ ( ) E. Bowel continence _____ ( ) F. Bladder continence _____

* If deficits/losses exist with visual capabilities, describe the individual's orientation skills: _____

_____

2. Identify individual' receptive and expressive communication capabilities: *Y = Yes* *N = No* *O = Occasionally*

Receptive

☐ Y ☐ N ☐ O Turns head toward speaker
☐ Y ☐ N ☐ O Understands one-step instructions
☐ Y ☐ N ☐ O Understands multi-step instructions
☐ Y ☐ N ☐ O Initiates actions when instructed
☐ Y ☐ N ☐ O Shakes head/ nods appropriately in response to questions
☐ Y ☐ N ☐ O Points to an item on request

Expressive

☐ Y ☐ N ☐ O Summarizes topic/story logically
☐ Y ☐ N ☐ O Says at least ten words which can be understood
☐ Y ☐ N ☐ O Speaks in at least 3-4 word sentences

Expressive deficits/problems _____

_____

3. Identify individual's functional achievement in education: *Y = Yes* *N = No*

Reading

☐ Y ☐ N Can recognize simple words
☐ Y ☐ N Can recognize/ read 3-4 word sentences
☐ Y ☐ N Can read at approximately 6th grade level

Mathematics

☐ Y ☐ N Can perform simple addition/subtraction
☐ Y ☐ N Can perform simple mathematics

4. Identify level of assistance needed with the following:

0 = Independent *1 = Minimal supervision/aids* *2 = Moderate assistance/supervision* *3 = Unable/dependent*

( ) A. Treat own minor physical problems
( ) B. Schedule medical or mental health treatment
( ) C. Keep scheduled medical/ mental health appointments
( ) D. Take medications as prescribed
( ) E. Use transportation
( ) F. Prepare meals
( ) G. Maintain an adequate, balanced diet
( ) L. Manage finances
( ) M. Use money correctly
( ) N. Bathe/shower
( ) O. Dress/undress
( ) P. Dress appropriately to season
( ) Q. Groom self
( ) R. Feed self

( ) H. Respond to emergencies/ask for assistance
( ) I. Able to monitor own health status
( ) J. Care of clothing
( ) K. Able to locate community resources (grocery, MD, hospital)
( ) S. Housework
( ) T. Bedmaking
( ) U. Shopping
( ) V. Toileting

5. Significant medical problems/treatment, if applicable (attach additional pages as needed):

Diagnosis/ condition	Onset date	Medication(s)/treatment	Dates treated	Status: active/inactive/stable

6. The level of support needed for activities of daily living and medical needs can be provided in an alternative community setting (other than a Nursing Facility): ☐ Yes ☐ No

7. Corrective or adaptive devices can improve this individual's functional capabilities: ☐ Yes ☐ No

8. Summarize the impact of medical problems on independent functioning (note additional information relevant to #6 & #7):

_____

Placement recommendations can be located on the "Placement Determination Form"

Section V: SENSORIMOTOR DEVELOPMENT

1. Describe individual's capabilities with the following:

Y = Yes N = No O = Occasionally

Mobility assistance required
☐ Y ☐ N ☐ O None
☐ Y ☐ N ☐ O Needs assistive devices (specify):_____
☐ Y ☐ N ☐ O Needs help of one

Gross motor dexterity
☐ Y ☐ N ☐ O Can reach for and lift a book
☐ Y ☐ N ☐ O Can brush own hair
☐ Y ☐ N ☐ O Can straighten up/correct position

Fine motor dexterity
☐ Y ☐ N ☐ O Can pick up a pencil
☐ Y ☐ N ☐ O Can button shirt
☐ Y ☐ N ☐ O Can feed self with fork

Positioning
☐ Y ☐ N ☐ O Sits upright for 30 seconds with head/ back straight and steady
☐ Y ☐ N ☐ O Rolls over independently
☐ Y ☐ N ☐ O Moves to and from lying position

Visual motor perception
☐ Y ☐ N ☐ O Can touch the evaluator's extended index finger
☐ Y ☐ N ☐ O Can copy a circle/square

Eye/hand coordination
☐ Y ☐ N ☐ O Can touch nose with finger
☐ Y ☐ N ☐ O Can extend both arms and touch index fingers together

2. Describe the extent to which prosthetic, orthotic, corrective, or mechanical supportive devices could improve individual's sensorimotor capabilities: ☐ Yes ☐ No

3. Additional comments related to Sensorimotor Development (if applicable*):

_____

_____

Section VI: AFFECTIVE DEVELOPMENT –AT TIME OF ASSESSMENT OR BY REPORT
(check all that apply)

1. Emotional
   ☐ Easily frustrated
   ☐ Easily angered

2. Judgement/independent decisions
   ☐ Can select own clothing
   ☐ Can respond appropriately to printed signs

- ☐ Mood congruence
- ☐ Preoccupied
- ☐ Withdrawn
- ☐ Obsessive/ritualistic
- ☐ Can identify a plan in an emergency situation
- ☐ Can ask for help when needed
- ☐ Can develop a plan/schedule for the day
- ☐ Other _____

Section VII: SPECIALIZED SERVICES COMPARISON

1. The individual can:
   - A. Take care of most personal needs: ☐ Yes ☐ No
   - B. Understand simple commands: ☐ Yes ☐ No
   - C. Communicate basic needs and wants: ☐ Yes ☐ No
   - D. Be employed at a productive wage level without systematic long-term supervision or support: ☐ Yes ☐ No
   - E. Learn new skills without aggressive and consistent training: ☐ Yes ☐ No
   - F. Generalize trained skills to other environments without aggressive and consistent training: ☐ Yes ☐ No
   - G. Demonstrate behaviors appropriate to time, situation, and place without supervision: ☐ Yes ☐ No
   - H. Make decisions requiring informed consent: ☐ Yes ☐ No

2. Identify any other skill deficits or specialized training needs that necessitate the availability of trained Mental Retardation personnel, 24 hours per day, to teach the individual functional skills, if applicable:

_____

_____

Section VIII: PARTICIPATION IN HOSPITAL OR COMMUNITY TREATMENT PROGRAMS

1. History of participation in Hospital or Community treatment programs:

Facility/program	Date(s)	Purpose/ Reason for Admission

Section IX: BEHAVIORAL OBSERVATIONS

1. Behavioral assessment: Check conditions present within the past 6 months and circle adjacent codes:

Frequency: **H** = Hourly **D** = Daily **W** = Weekly **M** = Monthly
Severity: **Mi** = Mild **Mo** = Moderate **S** = Severe
Status: **A** = Acute **CN** = Chronic/no change **CD** = Chronic/deteriorating **CI** = Chronic/improving

Behavior	Frequency	Severity	Status
☐ Sadness	H D W M	Mi Mo S	A CN CD CI
☐ Tearfulness	H D W M	Mi Mo S	A CN CD CI
☐ Hopefulness	H D W M	Mi Mo S	A CN CD CI
☐ Worthlessness	H D W M	Mi Mo S	A CN CD CI
☐ Restlessness	H D W M	Mi Mo S	A CN CD CI
☐ Insomnia	H D W M	Mi Mo S	A CN CD CI
☐ Hypersomnia	H D W M	Mi Mo S	A CN CD CI
☐ Grieving	H D W M	Mi Mo S	A CN CD CI
☐ Anxious	H D W M	Mi Mo S	A CN CD CI
☐ Excessive complaints	H D W M	Mi Mo S	A CN CD CI
☐ Reclusive	H D W M	Mi Mo S	A CN CD CI

☐ Resistant	H D W M	Mi Mo S	A CN CD CI
☐ Hoarding	H D W M	Mi Mo S	A CN CD CI
☐ Stealing	H D W M	Mi Mo S	A CN CD CI
☐ Suicidal talk/ideation	H D W M	Mi Mo S	A CN CD CI
☐ Suicide attempt(s)	H D W M	Mi Mo S	A CN CD CI
☐ Homicidal talk/ideation	H D W M	Mi Mo S	A CN CD CI
☐ Alcohol/drug abuse	H D W M	Mi Mo S	A CN CD CI
☐ Self-injurious	H D W M	Mi Mo S	A CN CD CI
☐ Physically aggressive	H D W M	Mi Mo S	A CN CD CI
☐ Verbally aggressive	H D W M	Mi Mo S	A CN CD CI
☐ Sexually inappropriate	H D W M	Mi Mo S	A CN CD CI
☐ Sexually aggressive	H D W M	Mi Mo S	A CN CD CI
☐ Uncooperative	H D W M	Mi Mo S	A CN CD CI
☐ Angry	H D W M	Mi Mo S	A CN CD CI
☐ Abrasive	H D W M	Mi Mo S	A CN CD CI
☐ PICA behavior	H D W M	Mi Mo S	A CN CD CI
☐ Destructive	H D W M	Mi Mo S	A CN CD CI
☐ Requires restraints	H D W M	Mi Mo S	A CN CD CI
☐ Disruptive	H D W M	Mi Mo S	A CN CD CI
☐ Wandering	H D W M	Mi Mo S	A CN CD CI
☐ Confused	H D W M	Mi Mo S	A CN CD CI
☐ Suspicious	H D W M	Mi Mo S	A CN CD CI
☐ Refuses medication	H D W M	Mi Mo S	A CN CD CI

☐ Weight gain/loss (specify): _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ None of the above

Section X: SUMMARY OF PSYCHOLOGICAL AND ADAPTIVE TESTING

NOTE: IQ testing is to be performed if recent (within past 3 years) intellectual testing is unavailable or if there is an apparent change in intellectual functioning. If recent testing is available, submit a copy with PASARR evaluation. Write N/A on this section if not applicable.

1. Intellectual testing (specify): _____ Date performed: _____

   Verbal IQ _____ Performance IQ _____ Full Scale IQ _____

   Comments (discuss any additional exams performed or available): _____

   _____

2. Adaptive Testing (specify): _____ Date performed: _____

   Results: _____

2. Axis III Diagnosis: _____

   _____

Licensed Psychologist Signature: _____ Date: _____

_____

(printed psychologist's name)

Section XI: RECOMMENDATIONS/IMPRESSIONS

Currently receiving:

- ☐ Pre-vocational/sheltered workshop
- ☐ Behavioral management
- ☐ Communication/speech training
- ☐ Self-help skills
- ☐ Day Treatment program in Nursing Facility
- ☐ Day Treatment program outside Nursing Facility
- ☐ Personal care
- ☐ Case management
- ☐ Occupational or Physical Therapy
- ☐ Case management
- ☐ Psychotropic medication monitoring
- ☐ Reading/writing skills training
- ☐ Community living skills training
- ☐ Competitive employment
- ☐ Adaptive equipment (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____
- ☐ None

Service recommendations:

- ☐ Pre-vocational/sheltered workshop
- ☐ Behavioral management
- ☐ Communication/speech training
- ☐ Self-help skills
- ☐ Day Treatment program in Nursing Facility
- ☐ Day Treatment program outside Nursing Facility
- ☐ Personal care
- ☐ Case management
- ☐ Occupational or Physical Therapy
- ☐ Case management
- ☐ Psychotropic medication monitoring
- ☐ Reading/writing skills training
- ☐ Community living skills training
- ☐ Competitive employment
- ☐ Adaptive equipment (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____
- ☐ None

Section XII: INTERVIEW SUMMARY AND OBSERVATIONS

_____

_____

_____

_____

_____

_____

_____

Section XIV: CERTIFICATION

_____ _____

Evaluator's signature and credential(s) Date

_____

Evaluator's printed name

_____ _____

Licensed Psychologist Signature and credential(s) Date

Psychologist's printed name: _____

MEDICAL ASSESSMENT: This information is to be obtained in dual evaluations if a recent (within the past 12 months) History and Physical is not available to address and document medical history; or if there has been a significant change in the individual's condition to warrant a medical assessment. If a recent H&P is available (within last 12 months), copy and submit with completed PASARR evaluation. Complete this step for all Dual MI/ MR/ RC Evaluations.

H&P Documentation is attached to this review? ☐**YES** ☐**NO**

If yes, please refer to attachment for Medical History. *If no, please see attached Medical Assessment.*

North Carolina PASARR Placement Determination

Name: _____ SSN: _____

Nursing Facility care, as ordered by a physician, must be provided 24 hours per day, with a minimum of 8 hours of licensed nurse (RN or LPN) coverage daily. Daily care by a licensed nurse must include:

- Observation and assessment of the total needs of the individual;
- Planning and management of the MD-approved treatment plan;
- Providing direct patient care, either personally or by supervision of direct care staff

To be eligible, the individual should be determined to have either a **medical condition** or a **treatment need** which requires nursing services. Assistance with ADLs, routine medication administration, and other custodial care activities **do not** constitute need for Nursing Facility placement.

INDICATORS FOR NURSING FACILITY CARE CAN INCLUDE:
(Following each applicable criterion, please identify specific need[s] that support Nursing Facility placement.)

☐ **Rehabilitation Services** – as ordered by MD and provided by a licensed Physical, Occupational, Respiratory, or Speech Therapist. Rehabilitation services provided by technicians or aides can often be provided in a less restrictive setting.

_____

_____

☐ **Major Surgery** – post-operative period, e.g., cholecystectomy, colostomy, mastectomy, etc., to provide for rehabilitation and instruction in self-care.

_____

_____

☐ **Severe Medical Conditions** – requiring daily care, e.g., CHF, COPD, CVA, unstable diabetes, myocardial infarction, contagious diseases requiring isolation, etc. This criterion reflects illnesses which are debilitating and chronic to the extent that the individual can no longer care for self at home or to the extent that a rest home, even with the assistance of home health nursing, is unable to adequately care for the individual.

_____

_____

☐ **Oxygen Therapy** – when monitoring need or regulating flow rate temporarily or intermittently. Continuous oxygen used in a stable condition should not be the sole consideration for Nursing Facility care.

_____

_____

☐ **Chronic Skin Conditions** – requiring daily dressing changes with aseptic technique and use of prescription drugs (decubiti, abrasions, tears). This does not include skin conditions treated with topical ointments alone. Would also qualify if the individual has a skin condition in conjunction with a medical condition that might complicate healing, such as diabetes.

_____

_____

☐ **Medication Monitoring** – requiring close observation and assessment with corresponding documentation, e.g., IV, NG, gastrostomy, frequent IM's, medication regulation, observation during the initial stabilization period, etc. Individuals with medication noncompliance and/or needing administration of routine medication may be managed in a less restrictive setting than a Nursing Facility when this is the sole medical need.

_____

_____

North Carolina PASARR Placement Determination

☐ **Complex Nutritional Deficits** – requiring professional observation, assessment, and documentation, e.g., parenteral feedings, gastrostomy or NG tubes, etc. Specialized diets alone do not qualify for Nursing Facility placement, nor does food preparation. Weight loss, without attendant medical conditions, does not meet criteria. If a medical problem resulted in weight loss, that loss must be clinically significant and must require a specific plan of treatment (I & O, frequent weight monitoring, diagnostic tests, etc.).

_____

_____

☐ **Behavioral Problems** – related to a **medical condition** (dementia, delirium, other organic conditions, etc.), requiring treatment or observation by skilled professional personnel, to the extent deemed appropriate for a Nursing Facility.

_____

_____

☐ **Nursing Needs** – medical conditions/needs requiring nursing for the purpose of maintaining or restoring maximum functioning. These may include bowel and bladder training, gait training, etc., for individuals with restorative potential. This criterion does not include individuals with Mental Retardation or Related Conditions, unless there is an attendant medical condition/medical need.

_____

_____

☐ **Indwelling Tubes** – Requires maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities and, due to physical or cognitive impairments, the individual is unable to supply self-care and/or no other resources are available to assist with such care.

_____

_____

PLACEMENT DETERMINATION:

NURSING FACILITY APPEARS APPROPRIATE:

☐ The individual has medical care needs which must be provided 24 hours per day, with a ~~minimum of 8 hours per day of licensed nursing care. Nursing Facility placement appears~~ appropriate.

NURSING FACILITY DOES NOT APPEAR APPROPRIATE. I RECOMMEND:

☐ Rest home/home for aged/ domiciliary care home
☐ Home Health services
☐ ICF/MR
☐ Inpatient psychiatric care
☐ Group home for children/adults with MR or other developmental disabilities
☐ Other – specify: _____

_____ Date: _____

Evaluator's signature and credential(s)

_____

Evaluator's printed name