

PREADMISSION SCREENING INSTRUMENT

FOR COMPLIANCE WITH

**1987 NURSING HOME REFORM ACT
OBRA-87, P.L. 100-203**

PA-PASARR-EV

**DEPARTMENT OF PUBLIC WELFARE
COMMONWEALTH OF PENNSYLVANIA**

NOTE: Whenever a completed copy of this form is to be sent to the Department of Public Welfare (DPW) for Departmental determination, all supportive documentation required for the determination and the assessor's name and telephone number must be included.

PREADMISSION SCREENING INSTRUMENT

DATE

APPLICANT'S/RESIDENT'S NAME		SOCIAL SECURITY NUMBER	AGE	BIRTHDATE	COUNTY OF RESIDENCE
Is the applicant/resident a Medicaid applicant/resident? <input type="checkbox"/> Yes <input type="checkbox"/> No				MAID No.	
From the list below, pick the code number of the target diagnosis(es) for the applicant/resident and place it in this box					
Using the list below, check the code number(s) of all disabilities the applicant/resident experiences. <i>CHECK ALL THAT APPLY</i>					
()	Code	Diagnosis	()	Code	Diagnosis
	01	None		18	Alzheimer's Disease or other dementia
	02	Mental Retardation		19	Other neurological impairment
	03	Cerebral Palsy		20	Stroke
	04	Epilepsy/seizure disorder		21	Arthritis
	05	Autism		22	Loss of Limb
	06	Blindness/severe visual impairment		23	Major Mental Disorder: Schizophrenic Disorder
	07	Deafness/severe hearing impairment		24	Major Mental Disorder: Schizoaffective Disorder
	08	Blindness and deafness		25	Major Mental Disorder: Delusional Disorder
	09	Spina Bifida		26	Major Mental Disorder: Major Mood Disorder
	10	Spinal cord injury		27	Major Mental Disorder: Psychotic Disorder not otherwise specified (NOS)
	11	Head injury/brain surgery			
	12	Learning disability		28	Major Mental Disorder: Panic or Severe Anxiety Disorder
	13	Cystic Fibrosis			
	14	Multiple Sclerosis		29	Major Mental Disorder: Somatoform Disorder
	15	Muscular Dystrophy		30	Major Mental Disorder: Personality Disorder
	16	Orthopedic impairment		31	Other: (Please Specify) _____
	17	Speech/language impairment			

DIAGNOSTIC IDENTIFICATION

A. MENTAL RETARDATION

A.1. Does the applicant/resident have a documented DX* of Mental Retardation? Examples of documentation include, but are not limited to psychological reports, psychiatric reports (including any done by an OPTIONS site), MH/MR Unit summaries, school records, and other professionally accepted diagnostic practices. (Attach documentation)

Yes - Go to A.2.

No - Go to B.1.

*DX = Diagnosis

A.2. Does the documentation substantiate the existence of the following characteristics?

Characteristic	Yes	No
Significantly subaverage intellectual functioning, generally meaning an IQ below 70 (or 2 standard deviations below the mean on any IQ test), certified by a licensed psychologist.		
Deficits in adaptive behavior, certified by a qualified mental retardation professional.		
Functional limitations manifested during the developmental period, meaning began before age 22.		
Are ALL THREE items checked "YES:" <input type="checkbox"/> Yes - Go to A.3. <input type="checkbox"/> No - Go to B.1.		

A.3. Indicate level of Mental Retardation, then go to B.1.

Mild
(55-69)

Moderate
(40-54)

Severe
(25-39)

Profound
(24 and below)

Not Known

B. OTHER RELATED CONDITION

"Other Related Conditions" include physical, sensory or neurological disabilities which manifested before age 22, are likely to continue indefinitely and result in substantial functional limitations in three or more of the following areas of major life activity: work, capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care. Examples of person with Other Related Conditions include: persons with paraplegia or quadriplegia (due to spinal cord injuries), spina bifida, cerebral palsy, blindness and deafness, epilepsy, head injuries or other injuries (such as gun shot wounds) so long as the injuries were sustained before age 22. It is important to note that a person can have an "Other Related Condition" **regardless of whether the ORC impairs their intellectual abilities.**

B.1. Is there documentation to substantiate that the applicant/resident meets the following criteria for an "Other Related Condition?" Examples of documentation may include a psychological evaluation, physician's note which indicate that the diagnosis and three functional limitations occurred prior to age 22, or a statement to this effect from the applicant/resident or family. (attach documentation)

a. The applicant/resident has a physical, sensory or neurological disability which is considered an "Other Related Condition." Specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. The condition manifested before age 22.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. The condition is expected to continue indefinitely.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are ALL three items checked "YES" <input type="checkbox"/> Yes - Go to B.2 <input type="checkbox"/> No - Go to C.1	

B.2 Indicate areas where the applicant/resident has a **SUBSTANTIAL FUNCTIONAL LIMITATION** which was manifested prior to age 22.

1. **Self Care:** A long-term condition which requires them to need significant assistance with personal needs such as eating, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of all activities normally required for self-care. Yes No
2. **Receptive and Expressive Language:** A long-term condition which prevents effective communication with another person without the aid of a third person, a person with special skill or with a mechanical device, or a long-term condition which prevents articulation of thoughts. Yes No
3. **Learning:** A long-term condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning. Yes No
4. **Mobility:** A long-term condition which impairs the ability to use fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place. Yes No
5. **Self-Direction:** A long-term condition which requires assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting own self-interest. Yes No
6. **Capacity for Independent Living:** A long-term condition that limits performing normal societal roles or which makes it unsafe for an individual to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours). Yes No

GO TO C.1

C. MENTAL ILLNESS

C.1. Is the applicant/resident seriously assaultive and/or self-abusive to the degree that he/she might endanger other residents of a nursing facility or might injure himself/herself without constant supervision by mental health personnel?

Yes No

C.2. For **PASARR** purposes, the Major Mental Disorders include the following. Please check "Yes" or "No" to indicate if a **CURRENT DX** exists and attach documentation. Examples of acceptable documentation include a current psychiatric assessment with diagnosis, psychological evaluation or other professionally accepted diagnostic practices by a qualified physician, psychiatrist, or licensed psychologist.

Schizophrenic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Schizoaffective Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delusional Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Major Mood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychotic Disorder Not Otherwise Specified _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Panic or Other Severe Anxiety Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Somatiform Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
If ANY of the above items are checked "YES" - Go to C.3 If ALL of the above items are checked "NO" - Go to D.1	

C.3. Does a review of the applicant's/resident's case history and/or medical record substantiate that the mental disorder is responsible for the functional limitations in the following areas? (See PASARR-ID for definitions.)

Interpersonal Functioning	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concentration, Persistence and Pace	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptation to Change	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIBE: _____ _____ _____	
If ANY of the above items are checked "YES" - Go to C.4 If ALL of the above items are checked "NO" - Go to D.1	

C.4. Does a review of the applicant's/resident's treatment history substantiate that the individual experienced at least one of the following:

Psychiatric treatment more intensive than outpatient care more than once in the past 2 years.	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIBE: _____ _____	
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 environment, or which resulted in intervention by housing or law enforcement officials. (Supportive services include crisis intervention, intensive case management, and/or other social service agency intervention.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIBE: _____ _____	

ALL ASSESSMENTS: GO TO D.1 SCREENING EXCEPTIONS

SCREENING EXCEPTIONS

D.1. Does the applicant/resident have any of the following conditions? Check "Yes" or "No" for each.

Condition	Yes	No	Condition	Yes	No
Ventilator-dependent			DX of Huntington's Disease		
DX of Chronic Obstructive Pulmonary Disease			DX of Amyotrophic Lateral Sclerosis		
DX of Severe Parkinson's Disease			DX of Congestive Heart Failure		
Other Severe Medical Condition List DX _____				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If ANY of these items are checked "Yes" - Go to D.2			•	If ALL of these items are checked "No" - Go to D.3	

D.2. Is the medical condition or combination of conditions so extreme that the person cannot focus upon, participate in or benefit from specialized services **and** for which a physician prescribes 24-hour medical supervision?

Yes - Go to D.5 No - Go to D.3

D.3. Is there any reason from the presenting evidence to suspect that a primary DX of Alzheimer's or any other dementia is appropriate?

Yes - Go to D.4 No - Go to E.1

D.4. Is the DX of Alzheimer's or any other dementia recorded in any formal document? Go to D.5 after answering this question. (MR/ORC* only)

Yes No

If yes, identify document: _____ and attach a copy to this form.

If no, indicate how/where DX was obtained: _____

D.5. If D.1 through D.4 are marked "yes," this applicant/resident qualifies for a screening exception that specialized services are not needed. Stop screening process and go to Section I.2; if the applicant/resident is not a screening exception, go to E.1 (MR/ORC) or E.3 (MI).

*An individual who has a primary DX of dementia along with a DX of a serious mental illness is a regular admission. Stop evaluation and correct PASARR-ID.

COMPLETE SECTIONS "E" AND "F" FOR ALL PREADMISSION ASSESSMENTS

SKIP SECTIONS "E" AND "F" FOR ANNUAL RESIDENT REVIEW. GO TO G.2

E. CHECKLIST TO IDENTIFY THE NEED FOR FUNCTIONAL LEVEL ASSESSMENTS. The purpose of this section is to help the assessor determine what assessments have been completed and what, if any, assessments are still needed.

E.1. (MR/ORC) - Has the applicant/resident been assessed to determine his/her functional level in the following areas? Indicate reference source for each functional level assessment identified and attach documentation. (**Note:** Information on the Options Assessment Form may be used as a source, if applicable.)

Sensorimotor Development (ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination) Yes No N/A

Source _____

Speech and Language Development (includes expressive and receptive language, disorders, i.e. communication disorders) Yes No N/A

Source _____

Social Development (includes interpersonal skills, recreation-leisure skills, and relationships with others) Yes No N/A

Source _____

Academic/Educational Development (grade level of school completed and/or functional learning skills) Yes No N/A

Source _____

Independent Living Development (includes meal preparation, budgeting and personal finances, survival skills, mobility skills [orientation to the neighborhood, town, etc.], laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills for individuals with visual impairments) Yes No N/A

Source _____

Vocational Development (include present vocational skills) Yes No N/A

Source _____

Affective Development (such as interests and skills involved with expressing emotions, making judgements, and making independent decisions) Yes No N/A

Source _____

Psychological Evaluation Yes No N/A

Source _____

Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systemic observation (include frequency and intensity of behavior) Yes No N/A

Source _____

Extent to which prosthetic, orthotic-corrective or mechanical-supportive devices can improve the individual's functional capacity Yes No N/A

Describe: _____

Extent to which non-oral communication systems can improve the individual's functional capacity Yes No N/A

Describe: _____

E.2. If applicant/resident also has a serious mental illness - Go to E.3

If applicant/resident does not have a serious mental illness:

- a. Go to F.1 (MR) or F.2 (ORC) if **ANY** of the items listed in Section E.1 are checked "No."
- b. Go to G.1 if **ALL** of the items listed in Section E.1 are checked "Yes" or "N/A."

E.3. (MI) Indicate if the following evaluations are present in the applicant/resident/s medical record and attach documentation.

Evaluation of the individual's neurological system in the areas of motor functioning, sensory function, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes. Yes No

Psychosocial evaluation of the individual, including current living arrangements and medical and support systems. Yes No

Comprehensive psychiatric evaluation (a complete history and mental status examination, including evaluation of intellectual functioning, memory and orientation, description of current behaviors, affect, suicidal or homicidal ideation, paranoia, delusions or hallucinations, and degree of reality testing). Yes No

Functional assessment of the individual's ability to engage in activities of daily living. Must include the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must also determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that nursing facility placement is required. Yes No N/A

E.4.

If ALL of the above items are checked "Yes" - go to G.1
If ANY of the above items are checked "No" - go to F.3

F. FURTHER DIAGNOSTIC INFORMATION

Mental Retardation

F.1. You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal law says that people with Mental Retardation may not need nursing facility services, and if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have Mental Retardation. The assessment information submitted thus far does not provide sufficient information to validate a DX of MR and/or determination the need for specialized services. The evaluation team will be consulting with the appropriate county MH/MR program and other agencies and individuals to help us assess mental retardation and your (relative's/friend's/ward's) need for nursing facility and specialized services.

Make Referral for Evaluation.

Results of Evaluation:

- a. Does the applicant/resident have a DX of Mental Retardation?
 Yes - Go to F.1(b) No - Go to I.2
- b. What level of Mental Retardation? Check One, then go to F.1(c).
 Mild (55 - 69) Severe (25 - 39)
 Moderate (40 - 54) Profound (24 and below)
- c. Does the applicant/resident need specialized services? (Go to G.1 after answering.)
 Yes No

Other Related Conditions

F.2. You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal law says that people with certain "Other Related Conditions" may not need nursing facility services, and if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have a "Related Condition." The assessment information submitted thus far does not provide sufficient information to validate a DX of an "Other Related Condition" and/or determine the need for specialized services. Therefore, you (your relative/friend/ward) will be referred to a licensed psychologist who will determine your intellectual functioning (IQ) measurement, assess your need for specialized services and confirm that you have an Other Related Condition. You may also be referred to a developmental disabilities expert (e.g. occupational or physical therapist or adaptive equipment specialist) if functional level assessments are needed.

Make Referral for Evaluation.

Results of Evaluation:

a. Does the applicant/resident have a DX of "Other Related Conditions?"
 Yes - Go to F.2(b) No - Go to I.2

b. What is the applicant/resident's intellectual functioning measurement?
Describe _____
Go to F.2(c)

c. Does the applicant/resident need specialized services? (Go to G.1 after answering.)
 Yes No

Mental Illness

F.3. You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal law says that people with serious mental illness may not need nursing facility services, and if so, should generally be in places more suited to their needs. You (your relative/friend/ward) may have a serious mental illness. We have to get a professional evaluation to know whether you have a diagnosis of a major mental disorder and whether specialized services are needed.

NOTE: Under federal law and regulations, an evaluation and DX must be obtained from someone who is a qualified physician, psychiatrist or licensed psychologist.

Make Referral for Evaluation.

Results of Evaluation":

a. Does the applicant/resident have a DX of a Major Mental Disorder which meets the criteria of a "serious mental illness?"
 Yes - Go to F.3(b) No - Go to I.2

b. Does the applicant/resident need specialized services?
 Yes No

c. Does the applicant/resident need health rehabilitative services provided by the nursing facility for his/her mental illness?
 Yes No

G. FINAL SCREEN

G.1. Who signed the assessments which provided information about the client's need for specialized services?

NAME	PROFESSIONAL QUALIFICATIONS	DATE

G.2. For resident review only. Has the resident resided in a nursing facility for at least 30 consecutive months?
 Yes No

H. DESIRE FOR SPECIALIZED SERVICES

H.1. You must now explain to the applicant/resident, his/her legal representative and family member or significant other (if the individual agrees to family participation) that:

Federal regulations state that in order for a person with a serious mental illness, mental retardation, or an "Other Related Condition" to have his/her specialized needs met, the individual must receive all services necessary to assist him/her in maintaining or achieving as much independence and self-determination as possible. I am going to explain a kind of care called "specialized services," which is designed to help people learn to cope with their conditions.

An individual may choose to participate in or forego specialized services. People who want "specialized services" want a program in which they will learn, grow and develop through practice and teaching to prevent the loss of skills and abilities. Some people may not be able to tolerate these specialized services. Some people may want nursing services in a place that only provides food, safety, comfort, and medical attention.

Explain "specialized services" as appropriate using the definitions below then go to H.2.

SPECIALIZED SERVICES FOR MI

Specialized services for MI target group members who reside in the community are defined as those appropriate community-based mental health services needed by the individual. This includes those types of services currently provided by the county community mental health system such as case management (e.g., intensive case management, resource coordination, administrative case management); supervised living arrangements (e.g., community residential rehabilitation, long-term structured residence, supported housing, personal care homes); psychiatric outpatient clinic services, partial hospitalization services, crisis and emergency services, psychosocial rehabilitation and any other county mental health services.

If an MI target group member is admitted to a nursing facility, some of these same services may be needed by the individual and should be provided by the facility as health rehabilitative services. If the Office of Mental Health determines that more intensive specialized services are needed, these services will be provided in an inpatient psychiatric setting.

Specialized services for individuals with a serious mental illness are authorized by the Office of Mental Health through their regional offices. The services shall be based on the individual's needs.

SPECIALIZED SERVICES FOR MR

DEFINITION:

For individuals with mental retardation residing in nursing facilities, specialized services consist of services which are provided on a continuous basis by qualified mental retardation personnel.

These specialized services are combined with services provided by the nursing facility or other service providers, and result in treatment which includes aggressive, consistent implementation of a program of specialized and generic training, treatment and related services.

Specialized services are directed toward the acquisition of the behavior and skills necessary for an individual to function with as much self-determination and independence as possible, or the prevention, or deceleration of regression, or loss of current optimal functional status.

SPECIALIZED SERVICES FOR ORC

Specialized services for individuals with ORC are defined as services specified by the State which combined with nursing facility and special rehabilitative services provided by the nursing facility result in:

1. the acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible; and
2. the prevention or deceleration of regression or loss of current optimal functional status.

Specialized services are authorized for applicants/residents with an "Other Related Condition" by the Office of Social Programs or its agent. For individuals with ORC, specialized services primarily include: Service Coordination/Advocacy Services; Peer Counseling/Support Groups; Training; Community Integration Activities; Equipment/Assessments/Related Education Services and Transportation.

Explain Further and Answer Questions As Needed

H.2. Do you understand what I have told you about specialized services?

Yes - Go to H.3

No - Try Again

H.3 Do you want that kind of service for yourself (your relative/friend/ward)?

Yes

No

H.4 Obtain signature of either the applicant/resident or his/her legal representative to indicate that he/she has been offered the choice to receive specialized services, then go to I.1.

APPLICANT'S/RESIDENT'S SIGNATURE:	DATE:
WITNESS SIGNATURE: IF AN (X) SIGNED ABOVE:	DATE:
REPRESENTATIVE'S SIGNATURE:	DATE:

I. NOTICE OF REFERRAL FOR FINAL DETERMINATION

I.1. You must now explain to the applicant/resident, legal representative and family member or significant other (if the individual agrees to family participation) that:

For Persons With Mental Retardation:

Federal law states that all applications for nursing facility services for people with mental retardation must have a separate determination regarding their need for nursing facility care and specialized services. In Pennsylvania this determination is made by the DPW Office of Mental Retardation. Since our primary evaluation indicates that you (your relative/friend/ward) may have mental retardation, we are forwarding this form and related information to the Office of Mental Retardation. The Office of Mental Retardation will be notifying you regarding your mental retardation diagnosis, and whether you have been determined to need nursing facility care and/or specialized services.

For Persons With Mental Illness:

Federal law states that people with a serious Mental Illness may not need nursing facility services, and if so, should generally be in places more suited to their needs. You have (your relative/friend/ward has) been given a diagnosis of a Major Mental Disorder. We must forward this form and the related information to the DPW Office of Mental Health to obtain a final determination decision regarding your need for nursing facility care and specialized services.

For Persons With "Other Related Conditions":

Federal law states that people with "Other Related Conditions" may not need nursing facility services, and if so, should generally be in places more suited to their needs. It is also possible that some people may be eligible for nursing facility services, and with their consent, could be supported in the community with the necessary supports and specialized services. There fore, we must forward this form and the related information to the DPW Office of Social Programs/Community Services Program for Persons with Physical Disabilities (CSPPPD) Contractor. This office/contractor will provide you with a final determination decision regarding your need for nursing facility care and specialized services.

I.2. Questions about the preparation of this form should be referred to the person completing this form.

PRINT NAME:	TITLE:	DATE:
SIGNATURE:	DATE:	TELEPHONE: ()

I.3. Assessor should complete the attached notification sheet. Make a copy of the assessment packet for their records, then forward the assessment packet to the appropriate Program Office or its designee for a final determination

NOTIFICATION SHEET

THIS FORM MUST BE COMPLETED FOR ALL FIRST-TIME ASSESSMENTS.

A. COPIES OF THE EVALUATION REPORT SHOULD BE SENT TO THE FOLLOWING:

1. THE APPLICANT/RESIDENT

NAME:	SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER: ()
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2. THE LEGAL REPRESENTATIVE - AN INDIVIDUAL DESIGNATED BY STATE LAW TO REPRESENT THE APPLICANT/RESIDENT. THIS INCLUDES A COURT-APPOINTED GUARDIAN OR AN INDIVIDUAL HAVING POWER OF ATTORNEY.

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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3. STATE PROGRAM OFFICE OR ITS DESIGNEE

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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4. ADMITTING/RETAINING NURSING FACILITY (if known)

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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ATTENTION:

5. APPLICANT/RESIDENT'S ATTENDING PHYSICIAN

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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6. DISCHARGING HOSPITAL (if individual is seeking nursing facility admission directly from a hospital)

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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ATTENTION:

B. THE FOLLOWING INDIVIDUALS MUST BE NOTIFIED WHEN THE APPLICANT/RESIDENT IS SCHEDULED FOR AN ANNUAL RESIDENT REVIEW?

1. THE LEGAL REPRESENTATIVE (see name listed above in A.2)

2. FAMILY MEMBER/SIGNIFICANT OTHER (complete only if the individual or legal representative has agreed to family participation)

NAME:	TELEPHONE NUMBER: ()
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ADDRESS:

CITY:	STATE:	ZIP CODE:
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NOTE TO PROGRAM OFFICE: Please detach this form from the PASARR-EV and forward to OMAP/Bureau of LTC Client Services