Revised March 2007

MAP-4093

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING (PAS)

PROVISIONAL ADMISSION TO A NURSING FACILITY

Applicant's Name _____

Social Security Number _____ **Date of Birth** _____

Name of Nursing Facility _____

Medicaid Provider Number _____ **Phone Number** _____

Address _____ **Fax Number** _____

Date Admitted to NF _____

Level I screen triggered mental illness ☐ **Yes**

Level I screen triggered mental retardation or related condition ☐ **Yes**

"Provisional Admission" means an individual who is admitted to a nursing facility for fourteen (14) days or less before a PASRR Level II is required; and

1. **The applicant is expected to stay in NF for fourteen (14) days or less; and** ☐ **Yes**
2. **The applicant has been diagnosed with delirium; or** ☐ **Yes**
3. **The applicant is in need of respite for the in-home caregiver, and the applicant is expected to return to that in-home caregiver upon discharge from the nursing facility.** ☐ **Yes**

Authorized Nursing Facility Staff _____ **Date** _____

NF Applicant Responsible Party _____

Note: **If an individual who is admitted to a NF under the provisional admission is later found to require more than fourteen (14) days of nursing facility services, a Level II PASRR shall be completed within the fourteen (14) day provisional admission. Therefore, nursing facility staff shall refer the individual for a Level II PASRR as soon as it is indicated that the resident requires more than fourteen (14) days of nursing facility services by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. PASRR evaluators shall complete the Level II PASRR written evaluation report within nine (9) working days from the referral date.**

Date Transmitted _____

Signature and Title _____
Print Name and Title _____
Original to Community Mental Health/Mental Retardation Center
Second Copy – Medical Records