

## Level 2 PASRR Invalidation

### Instructions for Evaluators

#### Dates

Date of Referral: Type in the date the referral was made to contractor.  
Date of Invalidation: Type in the date the evaluation was completed or attempted.  
Date of Birth: Type in the date of birth of the individual.

#### Name

Type in the last name of the individual; check correct spelling.  
Type in the first name of the individual; check correct spelling.  
Type in the middle name / initial of the individual; check correct spelling.  
If the individual does not have a middle name, leave it blank.

#### Nursing Facility Placement and Mailing Address

If the individual is currently in a nursing facility, check the "Current nursing facility resident" box and provide the name, and complete address of the facility.

#### Preadmission

Check the Preadmission box if the individual has not yet been placed in a Nursing Facility. Inform discharge staff to include the Invalidation in the discharge packet of information sent to the nursing facility.

#### **1. Categories for Invalidation**

Check **at least one** category of invalidation that disqualifies the individual for a Level 2 Initial Psychiatric Evaluation. Invalidations **must** be completed within 7 days of the referral as required in CFR, and in **DSHS PASRR** contract.

**Check box 1** if the individual:

- Has been discharged. This includes transfers to another facility, home or death of the individual.

**Check box 2** if the individual:

- Has a severe medical illness as the primary diagnosis.
- The diagnosis results in a level of impairment so severe that he/she could not be expected to benefit from specialized behavioral health treatment.
- List severe medical diagnoses.

**Check box 3** if the individual has:

- A diagnosis of a major neurocognitive disorder.

**Check box 4** if the individual:

- APPEARS to exhibit symptoms of a major neurocognitive disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). See form for symptom criteria.

**Check box 5** if the individual:

- Has been diagnosed with at least one serious mental illness **AND does not** have symptoms of serious mental illness as described in the **CRITERIA FOR SEVERITY OF SYMPTOMS** listed on Page 2 of the form.
- List all diagnoses using the most current DSM.

#### **2. Evaluator Comments**

Use the space provided to document related information to confirm individual's ineligibility for a Level 2 Evaluation. Include comments from the staff and family as appropriate.

#### **3. Evaluator Information**

**Signature:** Sign the form.

**Date:** Date of signature.

**Print Name and Title**

**County:** Where the Invalidation was completed.

**Contractor's Name:** If you are working for a contractor, write in the name of the contractor.

**Individual's Name:** May auto fill but needs to be completed to verify individual in case pages are separated.

#### Distribution of this document

Upon completion of Level 2 Invalidations:

- **Immediately send a copy to the Nursing Facility or hospital discharge staff.** The Invalidation must be included in the individual's clinical record.
- Original Invalidations are to remain with contractor / evaluator records.
- Invalidations with **Category 1 Discharge:** Send a copy of the Invalidation to the facility of discharge. **DO NOT** send a copy to DBHR. Category 1: discharge will not be reimbursed.
- All other Invalidations: Submit to DBHR with a completed A19 Invoice for processing and payment.