



STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES  
DIVISION OF AGING

**LEVEL ONE NURSING FACILITY PRE-ADMISSION SCREENING FOR  
MENTAL ILLNESS/MENTAL RETARDATION OR RELATED CONDITION**

Completion of this form is mandatory for all persons applying for admission to a Medicaid certified bed to determine appropriateness of the nursing facility placement. The Missouri Care Options process does not exempt a person from (or take the place of) this Pre-Admission Screening.

**SECTION A. IDENTIFYING INFORMATION**

1. PERSON'S NAME (LAST, FIRST, MI)	2. DCN	3. SSN	4. DOB	5. SEX	6. RACE
7. PERSON'S MAILING ADDRESS (STREET, CITY, STATE, ZIP)			8. COUNTY		9. TELEPHONE NUMBER
10. NAME AND ADDRESS OF PROPOSED FACILITY				TELEPHONE NUMBER	
11. CHECK THE APPROPRIATE RESPONSE DESCRIBING THE PERSON'S <b>CURRENT</b> LIVING ARRANGEMENTS					
<input type="checkbox"/> IN OWN HOME OR OTHER NON-INSTITUTIONAL SETTING		<input type="checkbox"/> RESIDENTIAL CARE FACILITY		<input type="checkbox"/> NURSING FACILITY	
<input type="checkbox"/> GROUP HOME		<input type="checkbox"/> OTHER _____			
<input type="checkbox"/> HOSPITAL: (GIVE REASON FOR HOSPITAL ADMISSION HERE) _____					

**SECTION B. LEVEL ONE SCREENING CRITERIA FOR SERIOUS MENTAL ILLNESS**

1. DOES THIS PERSON SHOW ANY SIGNS OR SYMPTOMS OF MAJOR MENTAL DISORDER?  
 NO  YES - LIST HERE: \_\_\_\_\_  
 • GO TO NEXT QUESTION

2. HAS THIS PERSON EVER BEEN DIAGNOSED AS HAVING A MAJOR MENTAL DISORDER? **YOU MUST USE GUIDE #3 ON BACK.**  
 NO  YES - DX: \_\_\_\_\_  
 • GO TO NEXT QUESTION

3. IS THE **PRIMARY** REASON FOR NURSING FACILITY PLACEMENT DUE TO DEMENTIA, INCLUDING ALZHEIMER'S DISEASE OR RELATED DISORDER? **USE GUIDE #4 ON BACK.**  
 NO  YES - DX: \_\_\_\_\_  
 • IF NO, GO TO NEXT QUESTION  
 • IF YES, SKIP TO SECTION C, #1 & 2.

4. HAS THE PERSON HAD SERIOUS PROBLEMS IN LEVEL(S) OF FUNCTIONING IN THE LAST SIX MONTHS? **YOU MUST USE GUIDE #5 ON BACK.**  
 NO  YES  
 • GO TO NEXT QUESTION

5. HAS THE PERSON RECEIVED INTENSIVE PSYCHIATRIC TREATMENT IN THE PAST TWO YEARS? **YOU MUST USE GUIDE #6 ON BACK.**  
 NO  YES  
 • GO TO NEXT SECTION (C).

**SECTION C. LEVEL ONE SCREENING CRITERIA FOR MENTAL RETARDATION OR RELATED CONDITION**

1. IS THE PERSON KNOWN OR SUSPECTED TO HAVE MENTAL RETARDATION THAT ORIGINATED PRIOR TO AGE 18?  
 NO  YES - DX: \_\_\_\_\_  
 • GO TO NEXT QUESTION

2. IS THE PERSON KNOWN OR SUSPECTED TO HAVE A RELATED CONDITION? **YOU MUST USE GUIDE #7 ON BACK.**  
 NO  YES - DX: \_\_\_\_\_  
 • THIS COMPLETES THE LEVEL I SCREENING. IF YOU CHECKED YES ON #4 OR 5 IN SECTION B, A LEVEL II SCREENING IS INDICATED FOR SERIOUS MENTAL ILLNESS. IF YOU CHECKED YES ON #1 OR 2 IN SECTION C, A LEVEL II SCREENING IS INDICATED FOR MENTAL RETARDATION OR RELATED CONDITION. GO TO NEXT SECTION (D).

**SECTION D. SPECIAL ADMISSION CATEGORIES (to be used only when a Level II Screening is indicated)**

DOES THE PERSON'S CONDITION QUALIFY HIM/HER FOR A SPECIAL ADMISSION CATEGORY?  NO  YES

IF YES, CHECK ONLY ONE OF THE FOLLOWING, IF IT APPLIES. **YOU MUST USE GUIDE #8 ON BACK.**

1. TERMINAL ILLNESS - expected to result in death in six months or less.

2. SERIOUS PHYSICAL ILLNESS - **severe/end stage** disease (or physical condition) as listed on back.

3. RESPITE CARE - stays not more than thirty 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 or others.

5. DIRECT TRANSFER FROM A HOSPITAL - stays not more than 30 days for the condition for which the person is currently receiving hospital care.

**SECTION E. PERMISSION TO PERFORM SCREENING (Required for all Level II referrals)**

I HAVE RECEIVED NOTICE THAT I MAY NEED FURTHER EVALUATION BEFORE NURSING FACILITY PLACEMENT AND DO HEREBY AUTHORIZE THE RELEASE OF ANY PERTINENT MEDICAL/PSYCHIATRIC RECORDS TO THE STATE OF MISSOURI OR ITS LEGALLY AUTHORIZED REPRESENTATIVES.

SIGNATURE OF PERSON OR LEGAL GUARDIAN GRANTING CONSENT X	DATE X
WITNESS #1 (IF SIGNED BY MARK)	WITNESS #2 (IF SIGNED BY MARK)

**SECTION F. PHYSICIAN'S AUTHORIZATION AND SIGNATURE (Always required)**

I ATTEST THAT THE INFORMATION ON THIS FORM IS COMPLETE AND CORRECT AS KNOWN TO ME.

PHYSICIAN'S SIGNATURE, DISCIPLINE, AND LICENSE NUMBER X	DATE X
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**XXI INSTRUCTIONS FOR COMPLETING THE DA124C FORM  
LEVEL ONE NURSING FACILITY PRE-ADMISSION SCREENING FOR MENTAL  
ILLNESS/MENTAL RETARDATION OR RELATED CONDITION**

NOTE: FOLLOW INSTRUCTIONS GIVEN IN EACH SECTION AND USE GUIDES AS INDICATED.

**SECTION A.**

1. Patient's name (LAST, First, Middle)
2. Medicaid # - if unknown **leave blank**
3. Social Security Number
4. Date of Birth
5. Male or female (abbreviate)
6. White, Black, Native American, Chinese, Japanese, etc. (abbreviate)
7. Preferably home address; if not available give present address. If homeless, so state.
8. County that coincides with #7 address.
9. Patient's home phone # or number where he/she can be reached now.
10. Give full name (not initials) of proposed nursing facility and address.
11. Check one box to indicate the patient's current location **prior** to nursing facility placement.  
**NOTE:** If hospital, give reason for hospitalization.

**SECTION B. (NOTE: Questions #1, 2, and 3 must always be answered)**

1. NO or YES. If '**YES**', give signs & symptoms - no need for medical language - answer in your own words. Do not give diagnosis here.
2. NO or YES. Follow instructions - **use Guide #3** on back of the form. If a diagnosis is listed here it must also be listed on the DA124A/B, section B, #9.
3. NO or YES. The key word here is "**PRIMARY**" reason for nursing facility placement - **use Guide #4** on back of the form. If a diagnosis is listed here it must also be listed on the DA124A/B, section B, #9.  
**ANSWER #4 & 5 ONLY IF YOU MARKED NO FOR #3.**
4. NO or YES. Refers to level of functioning (if you listed any on #2). **Use Guide #5** on back of the form.
5. NO or YES. Refers to intensive psychiatric treatment in the past two years related to diagnosis (if you listed any) on #2. If so, **use Guide #6** on back of the form.  
**NOTE:** If question #4 and/or 5 is answered YES, check box one on "Notice to Applicant Form".

**SECTION C. (NOTE: Both questions in this section must be answered).**

1. NO or YES. If '**YES**', give diagnosis AND be sure diagnosis is listed on the DA124A/B, section B, #9.
2. NO or YES. If '**YES**', you must give diagnosis - **use Guide #7** on back of the form. If a diagnosis is listed here it must also be listed on the DA124A/B, section B, #9. Give patient's age at time of onset.  
**NOTE:** If either question (or both) is answered YES, check box one on "Notice to Applicant Form".

**SECTION D.**

**NOTE:** If all answers in Sections B and C are 'NO', skip this section. Also skip this section if the only 'YES' in Sections B and C is B#3. If any answers in Sections B and/or C lead you to believe the patient may need a Level II screening prior to nursing facility placement, review his/her condition to see if patient qualifies for a special admission. Notify COMRU @ 573-526-8609 to receive validation before the patient goes into the nursing facility. The Level II screening may take place after nursing facility placement. **Use Guide #8** on back of the form.

**SECTION E.**

Signature of person or legal guardian is required only when a Level II screening is indicated. If patient is his own guardian but can only make a mark, signature must have two witnesses sign and date this section. If no Level II is indicated no signature is required.

**SECTION F.**

Physician must sign and date this section - no exceptions. Give discipline and license number after signature.

DIVISION OF AGING - COMRU - 615 HOWERTON COURT  
P. O. BOX 1337 - JEFFERSON CITY, MO 65102  
573-526-8609 or 573-751-3082