MUST BE COMPLETED BY SCREENER
Type of Request ☐ NF ☐ Vent SCNF

New Jersey Department of Human Services
Office of Community Choice Options
EARC-PAS - ENHANCED AT-RISK CRITERIA SCREENING TOOL

If on Managed Care Medicaid STOP. No EARC required. Refer to the Medicaid MCO for Authorization. If individual is on Medicaid not yet enrolled in MCO then EARC is required if criteria is met.

FOR OCCO USE ONLY

☐ **AUTHORIZED: ☐ NF ☐ Vent SCNF**

VALID THROUGH: _____ ***Valid for this Hospital Admission only.***

IMPORTANT: THIS AUTHORIZATION IS NOT A GUARANTEE OF MEDICAID PAYMENT. MEDICAID PAYMENT IS CONTINGENT UPON FULL CLINICAL AND FINANCIAL ELIGIBILITY WITHIN 90 DAYS OF ADMISSION TO THE NF AS PER N.J.A.C. 8:85-1.8(b).

☐ **NOT AUTHORIZED NF**

Requires on-site PAS in Hospital. OCCO Regional Office will schedule on-site PAS assessment.

OCCO Reviewer Comments: _____

Name of Reviewer (Print)	Signature of Reviewer	Date of Review

SECTION 1 - IDENTIFYING INFORMATION

Patient Name *(Print)* - Last First		Social Security Number
Street Address		Date of Birth (Month / Day / Year) / /
City, State, Zip Code	County of Residence	Gender ☐ Male ☐ Female

Where did the patient live at time of admission?

☐ Private Home/Apartment (alone) ☐ Private Home/Apartment, with care (family or agency)

☐ Facility (Specify): _____

SECTION 2 - MENTAL ILLNESS, INTELLECTUAL DISABILITY AND/OR DEVELOPMENTAL DISABILITY

1. Does the patient have any history of **mental illness** (such as but not limited to Schizophrenia, Bipolar Disorder, Major Depression, Anxiety Disorder, Psychotic Disorder), **intellectual disability**, or **developmental disability** (such as but not limited to Cerebral Palsy, Epilepsy, Autism, Spina Bifida)? **YES** ☐ **NO** ☐

   a. Date of Level I PASRR Screen: _____

   b. Level I Screen Outcome: ☐ Negative ☐ Positive

   c. Level II Determination outcome (If applicable): ☐ Negative ☐ Positive

   d. Did physician certify NF placement as 30-day exempted hospital discharge? **YES** ☐ **NO** ☐

NOTE: For all PASRR Positive Screens, include a copy of the completed PASRR Level I Screen (Form LTC-26) with this EARC-PAS request. ***If patient triggers positive and requires specialized services, 1) Hospital patient cannot transfer to NF and 2) NF patient cannot remain in NF. Provider to contact DDD/DMHAS to coordinate specialized services.*** EARC-PAS referrals will not be authorized until OCCO confirms PASRR Positive Level I Screens as a 30-Day Exempted Hospital Discharge and/or receives results of PASRR Level II Determination from DMHAS and/or DDD that Specialized Services are not required.

SECTION 3 - INSURANCE INFORMATION

1. Medicare Number: _____

   ☐ Traditional Medicare Coverage: ☐ Part A ☐ Part B

   ☐ Medicare HMO

   Number of Days Authorized: _____

2. Does the patient have other insurance that will cover 100% of the skilled nursing facility stay, including co-insurance payment at 100% if they exceed the first 20 days of Medicare? **YES** ☐ **NO** ☐

   a. Name of Carrier: _____

   b, Number of Days Authorized: _____

   c. Type: ☐ Primary ☐ Secondary ☐ Supplemental

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(Continued)

Patient Name *(Print)* - Last	First	Social Security Number

SECTION 3 - INSURANCE INFORMATION, Continued

1. Did patient apply for Medicaid and is application pending?.....Yes ☐……..No ☐
2. Is Medicaid expected to pay for any of the cost of the nursing facility stay? .....…Yes ☐……..No ☐
3. Will the patient's funds last less than six (6) months in a nursing facility?.....…Yes ☐……..No ☐

SECTION 4 - COGNITIVE STATUS AND ADL SELF PERFORMANCE

1. How well does patient make decisions about organizing the day (e.g. when to eat, choose clothes, when to go out)?
   ☐ Independent ☐ Modified Independence ☐ Minimally Impaired ☐ Moderately Impaired ☐ Severely Impaired
2. Can patient recall 3 items from memory after 5 minutes? ..... Yes ☐ ……No ☐
3. How well does patient express or make self-understood (expressing information content, however able)?
   ☐ Understood ☐ Usually Understood ☐ Often Understood ☐ Sometimes Understood ☐ Rarely/Never Understood
4. ADL Self Performance (score over past 3 days)

	Independent	Set Up	Supervision	Limited Assistance	Extensive Assistance	Maximal Assistance	Total Dependence	Did Not Occur
Bed Mobility	☐	☐	☐	☐	☐	☐	☐	☐
Transfer	☐	☐	☐	☐	☐	☐	☐	☐
Locomotion (indoor/outdoor)	☐	☐	☐	☐	☐	☐	☐	☐
Dressing (Upper and/or Lower body)	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐
Toileting (toilet use and/or toilet transfer)	☐	☐	☐	☐	☐	☐	☐	☐
Bathing (over last 7 days excluding washing of back and hair).	☐	☐	☐	☐	☐	☐	☐	☐

SECTION 5 - MEDICAL

1. Diagnosis (es): _____

	YES	NO
2. Does the patient have catastrophic illness, a debilitating and/or a chronic illness affecting functional status that may require long term care services?	☐	☐

Specify Major Health Needs:

_____

_____

3. Is this patient ventilator dependent?……☐……☐

SECTION 6 - FINANCIAL

INCOME

	YES	NO
1. Patient's monthly income is at, or below, the current NJ Care Special Medicaid Program's maximum monthly income limit of $1,041 **or**	☐	☐
2. Patient's monthly income is at, or below, the current Medicaid institutional cap of $2,313	☐	☐

NOTE: If patient's income is >$2,313 and assets are minimal, patient may still qualify for NF Medicaid Reimbursement.

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(Continued)

Patient Name *(Print)* - Last	First	Social Security Number

SECTION 6 – FINANCIAL, Continued

ASSETS

Check one: This is an indication that the patient may become Medicaid Eligible within the next (6) months by spending down assets in a nursing facility as private pay

☐ Patient has no spouse in the community and resources no greater than $4,000 (plus $1,500 burial fund), **or**

☐ Patient has no spouse in the community and resources at or below $53,000 (plus $1,500 burial fund), or

☐ Patient has a spouse in the community with combined countable resources at or below $128,420 (plus $1,500 burial fund).

SECTION 7 - INITIAL PLAN OF CARE

Provide information and counsel patient and/or patient's family or authorized representative(s) about:

1. ***Long-term care supportive services including discharge to community with supportive services, referral to ADRC/AAA and placement in Nursing Facility/Sub-Acute,***
2. ***How to submit an application to determine financial eligibility for Medicaid benefits, and***
3. ***Medicaid eligibility dependent upon both clinical and financial eligibility. NF Preadmission Screening (PAS) utilized to determine clinical eligibility following NF admission.***

Patient Choice of Setting - Check all that apply:

☐ Nursing Facility – Long Term

☐ Sub-Acute Nursing Facility Placement – Short Term

Provider feels there is a potential for discharge of the patient to the Community in the future? ……. ☐ Yes ☐ No

Patient/family expresses an interest in returning to Community? …… ☐ Yes ☐ No

Was a referral made to County ADRC/AAA? …… ☐ Yes ☐ No

☐ Other: _____

I acknowledge that I was prescreened and received counseling. I also consent to the Plan of Care proposed above.

Name of Patient/Authorized Representative (Print)	Check One: ☐ Patient ☐ Authorized Representative
Signature of Patient/Authorized Representative	Date

SECTION 8 - ATTESTATION

I screened the above named patient and counseled the patient on Discharge Options. I attest to the information that appears on this At-Risk Criteria Screening Tool.

Name of Certified EARC-PAS Assessor (Print)		Certified EARC-PAS Assessor Certification No.
Certified EARC-PAS Assessor Telephone		Certified EARC-PAS Assessor Fax
Signature of Certified EARC-PAS Assessor		Date Screen Completed by Certified EARC-PAS Assessor
Name of Hospital	County	Date of Admission to Hospital
Fax to: OCCO Regional Office ☐ **NRO Fax (732) 777-3600** ☐ **SRO Fax (609) 704-6055**		**Date/Time Faxed**

1. **FAX all three pages of the completed EARC-PAS Screening Tool to OCCO Regional Field Office.**
2. **Transfer of Hospital Patient to Medicaid Certified NF cannot occur until OCCO issues EARC-PAS authorization.**