HAZEL FINDLAY - 989.224.8936
1101 S. Scott Rd. - St. Johns, MI 48879
Continuing Care Close to Home

Patient Name: _____

Patient Date of Birth: _____

Physician Checklist for SNF Admission

Requirements needed prior to admission:

Physician Progress Notes (H&P) from the last 15 months _____

Any recent lab work or imaging (if applicable) _____

List of medications (over-the-counter, vitamins, and prescribed) _____

Durable Power of Attorney Paperwork/Guardianship Paperwork (if applicable) _____

Copy of insurance cards and Driver's License/ID _____

Complete Preadmission Screening (PAS/ARR) - 3877 form _____

Complete Level II Screening - 3878 form (if applicable) _____

Complete Decision Making Ability form _____

The **Preadmission Screening (PAS/ARR) - 3877 form** can be completed by a RN, BSW, MSW, licensed professional counselor, PA, NP, or physician. If there are any yeses to the questions on page 2 of the **Preadmission Screening (PAS/ARR) - 3877 form** then a **Level II Screening - 3878 form** will need to be completed. The **Level II Screening - 3878 form** will need to be completed by a PA, NP, or physician. Documents can be faxed or emailed to the Admissions Coordinator.

Jeremy Sodman
Admissions Coordinator
1101 S. Scott Rd.
Hazel I. Findlay Country Manor
(989) 224-8936 ext. 1172
Fax: (989) 224-1706
j.sodman@hazelifindlay.org

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Developmental Disability/Related Conditions Identification)

Michigan Department of Health and Human Services

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**
☐ **Hospital Exempted Discharge**

SECTION I – Patient, Legal Representative and Agency Information

Patient Name (First, MI, Last)			Date of Birth (MM/DD/YY)	Gender ☐ Male ☐ Female	
Address (number, street, apt. or lot #)			County of Residence	Social Security Number	
City	State	Zip Code	Medicaid Beneficiary ID Number	Medicare ID Number	
Does this patient have a court-appointed guardian or other legal representative? ☐ No ☐ Yes ➔			If Yes, give Name of Legal Representative		
County in which the legal representative was appointed			Address (number, street, apt. number or suite number)		
Legal Representative Telephone Number			City	State	Zip Code
Referring Agency Name			Telephone Number	Admission Date (actual or proposed)	
Nursing Facility Name (proposed or actual)			County Name		
Nursing Facility Address (number and street)			City	State	Zip Code

Sections II and III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

Patient Name

SECTION II – Screening Criteria (All 6 items must be completed.)

1. The person has a current diagnosis of **Mental Illness** or **Dementia** (Circle one or both)	☐ No	☐ Yes
2. The person has received treatment for **Mental Illness** or **Dementia** (within the past 24 months) (Circle one or both)	☐ No	☐ Yes
3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.	☐ No	☐ Yes
4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.	☐ No	☐ Yes
5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22.	☐ No	☐ Yes
6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual/developmental disability or a related condition. These deficits appear to have manifested before the age of 22.	☐ No	☐ Yes

Note: If you check "Yes" to items 1 and/or 2, circle the word "**Mental Illness**" and/or "**Dementia**."

Explain any "Yes"
Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature		Date	Name (type or print)
Address (number, street, apt. number or suite number)			Degree/License
City	State	Zip Code	Telephone Number

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION II is "Yes", send ONE copy to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Developmental Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right-hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility. **Check the appropriate box in the upper right-hand corner.**

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

   Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.

3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.

4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual/Developmental Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets ALL 4 of the following conditions:

   a. It is manifested before the person reaches **age 22**.

   b. It is likely to continue indefinitely.

   c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

d. It is attributable to:

- Intellectual/Developmental Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
- cerebral palsy, epilepsy, autism; or
- any condition other than mental illness found to be closely related to Intellectual/ Developmental Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual/Developmental Disability and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

Note: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

MENTAL ILLNESS/INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

Michigan Department of Health and Human Services
(For Use in Claiming Exemption Only)
Level II Screening

INSTRUCTIONS:

- Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies.

Patient Name	Date of Birth	
Name of Referring Agency	Referring Agency Telephone Number	
Referring Agency Address (Number, Street, Building, Suite Number, etc.)		
City	State	Zip Code

Exemption Criteria

☐ **COMA:** **Yes,** I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA:** **Yes,** I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below.

Yes, I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness.

Yes, **I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition.**

Specify the type of dementia:

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
   - Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.

Patient Name	Date of Birth

5. **EITHER:**
   a. Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, **OR**
   b. An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **HOSPITAL EXEMPTED DISCHARGE:**

Yes, I certify that the patient under consideration:

1. is being admitted after an inpatient medical hospital stay, **AND**
2. requires nursing facility services for the condition for which he/she received hospital care, **AND**
3. is likely to require less than 30 days of nursing services.

Physician/Physician Assistant/Nurse Practitioner Signature and Credentials	Date

Name (Typed or Printed)	Telephone Number

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

COPY DISTRIBUTION:
ORIGINAL- Nursing Facility retains in Patient file
COPY - Attach to form DCH-3877 and send to Local Community Mental Health Services Program (CMHSP)
COPY - Patient Copy or Legal Representative

INSTRUCTIONS FOR COMPLETING LEVEL II SCREENING

The **DCH-3878** is to be used ONLY when the individual identified on a **DCH-3877, Preadmission Screening (PAS)/Annual Resident Review (ARR)** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, he/she may be admitted or retained at a nursing facility without additional evaluation. However, a completed copy of the DCH-3878 must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.

Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use an **"X"** to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia.
- Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability or a related condition.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type
2. Vascular Dementia
3. Dementia due to Other General Medical Conditions
4. Substance - Induced Persisting Dementia
5. Dementia Not Otherwise Specified
6. Lewy Body Dementia

Decision Making Ability

Resident Name (printed)_____

Medical Record/identifier number_____

☐ Resident has been reviewed and determined able to participate in medical treatment decisions.

OR

☐ Resident has been reviewed and determined unable to participate in medical treatment decisions because of inability to understand medical condition including risks and benefits of treatment and/or is not able to make or communicate medical decisions due to:

□Dementia, other cognitive impairment_____

□Mental illness, mental deficiency_____

□Physical illness or disability_____

□Other cause_____

_____

(Attending physician signature) (Date)

_____

(Second physician or licensed psychologist signature) (Date)

Annual review of decision-making ability by attending physician:

□No change in decision making ability.

□Able to participate in medical treatment decisions.

_____

(Attending physician signature) (Date)

Originated: April 2015 Reviewed/revised: 02/25/2022

Our mission is to help people live to their highest potential as individuals who seek independence, good health, and personal fulfillment.