McLaren Business Products

McLaren Print System Order

Order No: 56969
Order Date: 2020-09-21
User: Sateesha Poplar
Phone: 810-342-2375

Ship Location: 4 South McLaren Flint
Case Mangement Department 4 south
Flint , MI 48532
Forms
Quantity: 500
Paragon Dept No: 91570
Dept Name: Case Management
Company Number: 60

Order Total Price: 0.00

Item Number: DCH-3877
Item Description: Preadmission Screening (PAS) / Annual Resident Review (ARR) Mental Illness / Mental Retardation / Related Conditio
Revision Date: 8/2017
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: Previous Editions Obsolete

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)
(Mental Illness/Intellectual 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.

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

1. No Yes ..... The person has a current diagnoses of Mental Illness or Dementia (Circle one)
2. No Yes ..... The person has received treatment for Mental Illness or Dementia (within the past 24 months) (Circle one)
3. No Yes ..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. No Yes ..... 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.
5. No Yes ..... The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22.
6. No Yes ..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition. These deficits appear to have manifested before the age of 22.

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

Explain any "Yes"

Note: The person screened shall be determined to require a comprehensive Level 1 CMHA 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

SECTION III - PHYSICIAN'S STATEMENT I certify to the best of my knowledge that the above information is accurate.

Physician signature | Date | Name (type or print)
Address (number, street, apt. number or suite number) | Degree/license
City | State | ZIP Code | 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

DISTRIBUTION: If any answer to items 1 – 6 in SECTION II is "Yes" send (1st) 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.

DCH-3877 (Rev. 8-17) Previous edition obsolete. 1

Spec Info: