McLaren Business Products

McLaren Print System Order

Order No: 56970
Order Date: 2020-09-21
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Ship Location: 4 South McLaren Flint
Case Mangement Department 4 south
Flint , MI 48532
Forms
Quantity: 100
Paragon Dept No: 91570
Dept Name: Case Management
Company Number: 60

Order Total Price: 0.00

Item Number: DCH-3878
Item Description: Mental Illness / Mental Retardation / Related Condition Exemption Criteria Certification
Revision Date: 8/2017
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Finish: None
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Misc Info: Previous Editions Obsolete

Spec Info:

MENTAL ILLNESS/INTELLECTUAL DISABILITY/RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION
Michigan Department of Health and Human Services
(For Use in Claiming Exemption Only)
Level II Screening

INSTRUCTIONS:

- 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 physician and signed and dated by a physician's assistant, nurse practitioner 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.
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 a hospital stay, AND
2) requires nursing facility services for the condition for which he/she received hospital care, AND
3) will require less than 30 days of nursing services.

Physician/Physician's Assistant/Nurse Practitioner Signature	Date	Name (Typed or Printed)
		Telephone Number

AUTHORITY/COMPLETION: Title XIX of the Social Security Act. To 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 1 - Attach to form DCH-3877 and send to Local CMHSP
COPY 2 - Patient Copy or Legal Representative

DCH-3878 (Rev. 8-17) Previous edition obsolete 1