

## McLaren Print System Order

Order No: 9980  
 Order Date: 2015-03-21  
 User: anna parsian  
 Phone: 810-342-2375

Ship Location: Shannon Smith & Anna Parsian  
 401 South Ballenger Hwy - 4 South  
 Flint , MI 48532

Forms  
 Quantity: 500  
 Paragon Dept No: 91570  
 Dept Name: Case Management 4-South  
 Company Number: 60

Order Total Price: 24.90

Item Number: DCH-3878  
 Item Description: Mental Illness / Mental Retardation / Related Condition Exemption Criteria Certification  
 Revision Date: 6/2014  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: 5 Hole Top  
 Misc Info: Previous Editions Obsolete

Michigan Department of Community Health  
**MENTAL ILLNESS / INTELLECTUAL DISABILITY / RELATED CONDITION  
 EXEMPTION CRITERIA CERTIFICATION**  
 ( For Use in Claiming Exemption Only )

**INSTRUCTIONS:**

- This form must be completed by a registered nurse, licensed teacher or master social worker, licensed professional counselor, psychologist, physician's assistant or physician and signed and dated by a physician.
- The patient being screened shall require a comprehensive LEVIT 1 evaluation UNLESS any of the exemption criteria below is met and verified by a physician. Indicate which one applies.

Patient Name		Date of Exam
Name of Referring Agency		Referring Agency Address to:
Referring Agency Address (Number, Street, Building, Suite No., etc.)		City, State, ZIP Code
<p><b>Exemption Criteria</b></p> <p><input type="checkbox"/> <b>COMA:</b> YES, I certify the patient under consideration is in a comatose/negative state.</p> <p><input type="checkbox"/> <b>DEMENTIA:</b> YES, I certify the patient under consideration has a dementia as established by clinical examination and evidence of memory loss. I certify below and does NOT have intellectual disability/related condition or another primary psychiatric diagnosis of mental illness.</p> <p>Specify the type of dementia: _____</p> <p>1. There is demonstrable evidence of impairment in short term or long-term memory as indicated by the inability to learn new information or remember three aspects after five minutes, and the inability to remember past personal information or facts of common knowledge.</p> <p>2. Exhibits at least one of the following:</p> <ul style="list-style-type: none"> <li>Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words, has difficulty defining words, concepts and similar tests.</li> <li>Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues.</li> <li>Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.</li> <li>Personality change, altered or accentuated personality traits.</li> </ul> <p>3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.</p> <p>4. The disturbance has NOT occurred exclusively during the course of delirium.</p> <p>5. <b>OTHER:</b></p> <p>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</p> <p>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.</p> <p><input type="checkbox"/> <b>HOSPITAL EXEMPTED DISCHARGE:</b>                  YES, I certify that the patient under consideration is:                  1) being admitted after a hospital stay, AND                  2) requires nursing facility services for the condition for which she/he received hospital care, AND                  3) is likely to require less than 30 days of nursing services.</p>		
Physician Signature	Date Signed	Physician License or Provider
Signature		Physician Number
<p><b>AUTHORITY:</b> This form is the State Department of Community Health's standard form for use in claiming exemption. It is subject to change without notice and is available for viewing on-line.</p>		<p>The Department of Community Health is an equal opportunity program, services, and program provider.</p>

**COPY DISTRIBUTION:** ORIGINAL: Nursing Facility where patient is held. The COPY: Submit to form DCH-3878 and return to Local Center. COPY: Patient Copy or Legal Representative.

