McLaren Business Products

McLaren Print System Order

Order No: 9697
Order Date: 2015-03-10
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 bachelor 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 LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician. Indicate which one applies.

Patient Name | Date of Birth

Name of Referring Agency | Referring Agency Telephone No. ( ) -

Referring Agency Address (Number, Street, Building, Suite No., 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 a dementia as established by clinical examination and evidence of meeting A(1), 5 criteria below and does **NOT** have intellectual disability/related condition or another primary psychiatric diagnosis of mental illness.

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 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.

Physician Signature | Date Signed | Name (Typed or Printed) | Telephone Number ( ) -

AUTHORITY/COMPLETION: Title XIX of the Social Security Act is voluntary, but if NOT completed, Medicaid will not reimburse the nursing facility. The Department of Community Health is an equal opportunity employer, services, and programs provider.

COPY DISTRIBUTION: **ORIGINAL** - Nursing Facility retains in Patient file
COPY - Attach to Form DCH-3877 and send to Local CMHSP
COPY - Patient Copy or Legal Representative

DCH-3878 (6/14) Previous Editions Obsolete

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