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 will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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