Michigan Department of Community Health

MENTAL ILLNESS / MENTAL RETARDATION / 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 either 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 ALL 5 criteria below and does **NOT** have mental retardation/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: Title XIX of the Social Security Act **COMPLETION:** 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

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Instructions for DCH-3878

- The **DCH-3878** is to be used ONLY when a person identified on a **DCH-3877** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II evaluation. If the individual under consideration meets one of the following exemptions, she/he may be admitted (under preadmission evaluation) or retained (under annual resident review) 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).

- 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.**

- 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 five (5), criteria will be subject to a LEVEL II evaluation. If the person under consideration meets this exemption category, please specify the type of dementia.

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, **or**
5. Dementia Not Otherwise Specified.