Michigan Department of Community Health

PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness / Intellectual Disability/ Related Conditions Identification)

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**

SECTION I – Patient, Legal Representative, and Agency Information

Patient Name (First, MI, Last)			Date of Birth (M/D/Y)	Gender ☐ **Male** ☐ **Female**	
Address (Number and Street)			County of Residence	Social Security Number	
City	State	ZIP Code	MEDICAID Beneficiary ID Number	MEDICARE ID Number	
Does this patient have a court-appointed guardian or other legal representative? ☐ **NO** ☐ **YES** ▶			If YES, Give Name of Legal Representative		
County in which the Legal Representative was appointed			Address (Number, Street, Apt. Number or Suite Number)		
Legal Representative Telephone Number ( ) -			City	State	ZIP Code
Referring Agency Name			Telephone Number ( ) -	Admission Date (Actual or Proposed)	
Nursing Facility Name (Proposed or Actual)			County Name		
Nursing Facility Address (Number and Street)			City	State	ZIP Code

Sections II & III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or a physician.

SECTION II – Screening Criteria (All 6 items must be completed.)

1. ☐ NO ☐ YES .... The person has a current diagnosis of **MENTAL ILLNESS** or **DEMENTIA**. ***(Circle One)***
2. ☐ NO ☐ YES .... The person has received treatment for **MENTAL ILLNESS** or **DEMENTIA** within the past 24 months. ***(Circle One).***
3. ☐ NO ☐ YES .... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ NO ☐ YES .... There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment.
5. ☐ NO ☐ YES .... The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy.
6. ☐ NO ☐ YES .... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition.

Note: If you check "YES" to items 1 and/or 2, circle the word "**mental illness**" or "**dementia.**"

Explain any "YES"

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "YES" UNLESS a physician certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature		Date	Name (Typed or Printed)
			Degree / License
Address (Number, Street, Apt. Number or Suite Number)			
City	State	ZIP Code	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.

DISTRIBUTION: If any answer to questions 1 – 6 in SECTION II is "YES"
send **ONE copy** to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested.
The nursing facility must retain the original in the patient record and providea copy to the patient or legal representative.

Mental Illness / Intellectual Disability / Related Condition Identification Criteria

Instructions for DCH-3877

The DCH-3877 is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or physician.

Preadmission Screening: The DCH-3877 must be completed by hospitals as part of the discharge planning process or by physicians seeking to admit an individual to a nursing facility from other than an acute care setting. **Check the PAS box.**

Annual Resident Review: The DCH-3877 must be completed by the nursing facility. **Check the ARR box.**

Section II – Screening Criteria – All 6 items on the form must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "YES" for an individual cited as having a diagnosis "by history" only.
2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.
3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.
4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations.
5. **Intellectual Disability / Related Condition:** An individual is considered to have a severe, chronic disability that meets **ALL** four (4) of the following conditions:
   a) It is manifested before the person reaches **age 22**.
   b) It is likely to continue indefinitely.
   c) It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d) It is attributable to:
      - Intellectual Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to Intellectual Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual Disability, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine presence of a developmental disability, causal factors, and treatment recommendations.

NOTE: When there are one or more "YES" answers to questions 1 – 6 under SECTION II, a Mental Illness / Intellectual Disability / Related Condition Exemption Criteria Certification, DCH-3878 must be completed only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.