# DCH-3877, PREADMISSION SCREENING (PAS)/ ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Developmental Disability/Related Conditions Identification)
Michigan Department of Health and Human Services
**Level I Screening**
(Revised 3-22)

## SECTION 1 – LEVEL I SCREENING

☐ **PAS** ☐ **ARR** ☐ **Change in Condition** ☐ **Hospital Exempted Discharge**

## SECTION 2 – PATIENT, LEGAL REPRESENTATIVE AND AGENCY INFORMATION

| | | | |
|---|---|---|---|
| Patient Name (First, MI, Last) | Date of Birth (MM/DD/YY) | Gender ☐ Male ☐ Female | |
| Address (number, street, apt., or lot #) | City | State | Zip Code |
| County of Residence | Social Security Number | 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 | Legal Representative Telephone Number | | |
| Address (number, street, apt., or lot #) | 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 3 and 4 of this form must be completed by a registered nurse, licensed bachelor, or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

## SECTION 3 – SCREENING CRITERIA (All 6 items must be completed.)

| | | |
|---|---|---|
| 1. The person has a current diagnosis of ☐ **Mental Illness** or ☐ **Dementia** (Check one or both) | ☐ No | ☐ Yes |
| 2. The person has received treatment for ☐ **Mental Illness** or ☐ **Dementia** (within the past 24 months) (Check one or both) | ☐ No | ☐ Yes |
| 3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. | ☐ No | ☐ Yes |
| 4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. | ☐ No | ☐ Yes |

5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. ☐ No ☐ Yes

6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual/developmental disability or a related condition. These deficits appear to have manifested before the age of 22. ☐ No ☐ Yes

**Note:** If you checked "Yes" to items 1 and/or 2, checked the word "**Mental Illness**" and/or "**Dementia**."

If yes, please explain

**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, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

**SECTION 4 - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.**

| Clinician Signature | Date | Name (type or print) |
|---|---|---|
| Degree/License | | Telephone Number |

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, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

**AUTHORITY:** Title XIX of the Social Security Act

**COMPLETION:** Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

**DISTRIBUTION:** If any answer to items 1 – 6 in SECTION 3 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 provide a copy to the patient or legal representative.

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

Mental Illness/Intellectual Developmental Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental 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, nurse practitioner or physician.

**Preadmission Screening or Hospital Exempted Discharge:** The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right-hand corner.**

**Annual Resident Review or Change in Condition:** This form must be completed by the nursing facility. **Check the appropriate box in the upper right-hand corner.**

**Section II** – Screening Criteria – All 6 items in this section 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 clinician 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 suggests the need for further evaluation to establish causal factors, diagnosis, and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual/Developmental Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets ALL 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/Developmental 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/ Developmental Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual/Developmental 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 the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

**Note:** When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.