IOSCO COUNTY MEDICAL CARE FACILITY

1201 Harris Avenue
Tawas City, Michigan 48763

THOMAS D. MEYER
ADMINISTRATOR

TELEPHONE:
(989) 362-4424

Dear Applicant,

Enclosed you will find the application for admission to Iosco County Medical Care Facility. There are forms for both you and applicants physician to fill out. When all forms are completed, signed and dated return them to the facility. When all forms are received the applicant's name will be placed on the waiting list for consideration for admission to the facility.

Due to the volume of applicants on our waiting list , each application is considered active for a 6 month period. You are responsible for keeping us updated as to status of the applicant. If no updates have been received in 6 months, the application for admission will be removed from the waiting list. Once the applicant's name has been removed from our waiting list, you must initiate the full application process to again place applicant on our waiting list. You may telephone our admissions at (989) 362-4424 ext. 1014 provide us with the updated information on the applicant. You may also fax the admissions office at (989) 362-2692.

For questions or information on billing issues or insurance coverage, please contact our billing department at (989) 362-4424 ext. 1023.

We thank you for choosing Iosco County Medical Care Facility as the provider of long term health care for the applicant.

Respectfully,

Thomas D. Meyer
Administrator
Iosco County Medical Care Facility

INSTRUCTIONS FOR COMPLETING APPLICATION

1. Responsible party to fill out pages 3-5 (application for admission).
2. Take the following forms to physician office for completion.
   a. "Physician Referral for Admission"
   b. "Preadmission Screening (PAS). Annual Resident Review (ARR)"
   c. "Mental Illness/Developmental Disability Exemption Criteria Certification"
3. Once all forms from the physician and family are completed return them to the facility so that applicant's name can be added to the waiting list.
4. Don't forget to bring the form containing financial information on the day of admission along with the following:
   a. Social Security Card
   b. All insurance cards including: Medicaid, Medicare, Prescription Drug Company, BCBS, etc.
   c. Guardianship papers of Power of Attorney/Pt. Advocate

MENTAL ILLNESS / MENTAL RETARDATION / RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

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.

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

Mental Illness / Mental Retardation / 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 mental retardation, 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 Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revised (DSM-IV-TR™).
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past twenty-four (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. **Mental Retardation / 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:
      - mental retardation 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 mental retardation because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with mental retardation, 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 is one or more "YES" answers to questions 1 – 6 under SECTION II, a Mental Illness / Mental Retardation / 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.

Michigan Department of Community Health

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

(Mental Illness / Mental Retardation / 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 regist ered nurse, licensed bachelor or mast er social worker, licensed pro fessional 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 prescr ibed antipsychotic or antidepre ssant medications within t he last 14 days.
4. ☐ NO ☐ YES............. There is presenting evidence of mental illness or dementia including si gnificant disturbances in thought, con duct, emotions, or judgment.
5. ☐ NO ☐ YES............. The person has a diagnosis of m ental retardation or a related conditi on, including but not limited to epileps y, autism, or cerebral palsy.
6. ☐ NO ☐ YES............. There is presenting evidence of deficits in intellectual functioning or adaptiv e behavior which suggests that the person may have mental retardat ion 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 reco rd and see that a copy goes to the patient or legal representa tive.

Please check the description that best explains the applicant's abilities:

	Needs no help	Oversight/Supervision	Needs some physical help	Totally done by others
Bathing				
Toileting				
Eating				
Turning in bed				
Transfer out of bed				
Walking				

Please provide us with any additional information that you feel is important for us to know in providing care to the applicant.

____

____

____

____

____

____

APPLICATION MUST BE SIGNED AND DATED

Person completing application: ______________________________

Date: ______________________________

IOSCO COUNTY MEDICAL CARE FACILITY

APPLICATION FOR ADMISSION

Name:_______________________________ Phone: _____________________

PERSONAL INFORMATION

Birth Place: __________________
Birth date: ___________________ Age: ______ Female:______ Male: ______
Marital Status: Married: ___ Single: ___ Widowed: ___ Divorced: ____ Since? ____
Now Residing At: ____

Funeral Home Preference: ___________________ Phone: __________________
Religion: __________ Primary Language: _________ Education Level: _________
Occupation: _____________________

INSURANCE INFORMATION

Social Security Number: ________________ Medicare Number: _______________

Medicaid Number: _____________ Medicare Part D Provider: ________________

Other Insurance: ______________ Contract Number: __________ Group: ______

****PLEASE BRING A COPY OF ALL INSURANCE CARDS ON ADMISSSION DAY****

FAMILY INFORMATION

Legal Guardian: Yes: ____ No: ____ If yes, who?______________________
Power of Attorney/Patient Advocate: Yes: ____ No: ____ If yes who?______________
PLEASE BRING A COPY OF GUARDIANSHIP OR POWER OF ATTORNEY/PT ADVOCATE PAPERS ON DAY OF ADMISSION.

Contact Person #1: _____________________ Relationship: ___________________
Address: ____
Home Phone Number: ___________________ Work/Cell Number: ______________

Contact Person #2: ______________________ Relationship: __________________
Address: ____
Home Phone Number: ___________________ Work/Cell Number: ______________

Contact Person #3: ______________________ Relationship: __________________
Address: ____
Home Phone Number: ___________________ Work/Cell Number: ______________

LIST OF INFORMATION NEEDED FOR BILLING DEPARTMENT ON DAY OF ADMISSION

PLEASE BRING THIS FORM ON THE DAY OF ADMISSION

LIST OF ALL INCOME (IF THERE IS A SPOUSE, LIST THEIR INCOME ALSO):

Amount of Social Security: _______________ Amount of Retirement_____________

Amount of any other income: ____

Name of Bank Checking Account: ____

Name of Bank Savings Account: ____

If there is a home, value of home: ____

If there is other property not home, the value of the other property: _____________

Do you have Long Term Care Insurance: ______ Yes _____ No

Company Name of Long Term Insurance: _____________________________________

Copy of all Insurance cards, Medicare, Social Security, BC/BS, Medicare D Prescription Plan, Health Plus, Aetna, AARP, or any other insurance cards.

MEDICAL INFORMATION

Current Diagnosis: ____
____
____

Current Medications: ____
____
____

Allergies: ____

Mental Status (Please check all that apply): Alert:___Comatose: ___Cooperative: ____
Confused:____ Restless:____ Anxious:___ Combative:____ Mental Illness History:____

Does the applicant have any specific behaviors that we should know about? If so explain
____
____

Is applicant able to follow simple instructions? Yes: ____ No: ____

Diet: _____________ Height: ____________ Weight: ___________ Usual Weight: ______

Does the applicant receive feeding through a tube in the stomach? __________________

Does the applicant have an IV for fluids?____________ Nutrition/TPN: _______________

Dentures: Yes: ____ No: ____ Hearing Aides: Yes:____ No:____ Glasses: Yes ____ No:___

Does the applicant have any open wounds: Yes: ____ No: ____

If yes please describe: ____

Bladder Control: (check one) Never Wet: ___ Dribbles: ___ No Control: ___ Catheter: ____

Bowel Control: (check one) Complete Control: ____ Has Accidents: ___ No Control: ___
Colostomy: ____

Other Information

Does the applicant use oxygen? Yes: ___ No: ___ If yes, how often: ______________________
Does the applicant require dialysis: Yes: ___ No: ___ If yes, who transports:______________
Is applicant in a Hospice program? Yes: ___ No: ___ If yes, what provider: _______________
Does the applicant have a tracheotomy: Yes: ___ No: ___
Does the applicant require insulin shots? Yes: ___ No: ___