Lapeer County Medical Care Facility
1455 Suncrest Dr., Lapeer, MI 48446
Phone: 810-664-8571 Fax: 810-664-1677
http://www.lcmcf.org

Dear Applicant:

Enclosed you will find the application for admission to Lapeer County Medical Care Facility. There are forms for both you and the applicant's 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, you are responsible for keeping us updated as to the status of the applicant. If no updates have been received in 12 months, the application for admission will be removed from the waiting list. Once the applicant's name has been removed from the waiting list you must initiate the full application process to place the applicant again on our waiting list. You may telephone Ronda Stone in our Admission Office at 810-664-8571, ext. 133 or email rstone@lcmcf.org to provide us with updated information on the applicant. You may also fax admissions at 810-664-1677.

For questions or information on billing issues or insurance coverage, please contact our Billing Department at 810-664-8571, ext.124 or ext. 284.

We thank you for choosing Lapeer County Medical Care Facility as the provider of long-term care services for the applicant.

K. Niemi RN

Respectfully,
Kristal Niemi, R.N.
Director of Nursing
Lapeer County Medical Care Facility

INSTRUCTIONS FOR COMPLETING APPLICATION

1. Responsible party to fill out pages 1- 4 (application for admission)

2. Take the following forms to physicians office for completion:

    a. "Physicians Referral for Admission"
    b. "Preadmission Screening (PAS)/Annual Resident Review (ARR)" (3877)
    c. "Mental Illness/Developmental Disability Exemption Criteria Certification" (3878)

3. Once all forms from the physicians and family are completed, return them along with copies of legal papers for guardianship, POA or Pt. Advocate to the admissions office at Lapeer County Medical Care Facility.

LAPEER COUNTY MEDICAL CARE FACILITY
ADMISSION APPLICATION

APPLICANT INFORMATION		
Name (as appears on Medicaid/Medicare card):		
Name (applicant prefers to be called):		
Current address:	Phone:	
City:	State:	Zip Code:
Date of Birth:	Age:	Male_____ Female_____
Birth Place:	Race:	
Primary Language:	Religion:	
Marital Status: (check one) Married:_____ Single:_____ Divorced:_____ Widowed:_____		
Occupation (before retirement):		
Education Level:	Military:	
Does applicant smoke? Yes _____ No _____ **(Facility has non-smoking/e-cigarette/vaping/smokeless tobacco policy for residents)**		
Social Security #:	Medicare #:	
Medicaid #:	Prescription Drug Insurance:	
Other Insurance:	Contract #:	Group #:
Physician preference: Hisham Ahmed M.D. _____ Edward Christy M.D. _____		
Hospital preference:		
Funeral Home:	Phone:	
Legal Guardian: Yes _____ No _____ If yes, who?		
Power of Attorney: Yes_____ No _____ Health Care? _____ Financial? _____ Who?		
Patient Advocate: Yes _____ No _____ If yes, who?		
*****MUST SUBMIT COPIES OF EXISTING LEGAL PAPERWORK WITH APPLICATION*****		
Contact Person #1:	Relationship:	
Address:		
City:	State:	Zip:
*Email:	Home Phone:	
Cell Phone:	Work Phone:	
Contact Person #2:	Relationship:	
Address:		
City:	State:	Zip:
*Email:	Home Phone:	
Cell Phone:	Work Phone:	

LAPEER COUNTY MEDICAL CARE FACILITY
ADMISSION APPLICATION

Contact Person #3:	Relationship:	
Address:		
City:	State:	Zip:
*Email:	Home Phone:	
Cell Phone:	Work Phone:	

MEDICAL INFORMATION

Current Diagnosis:

Current Medications:

Allergies:

Information needed due to having a child daycare within the facility

Are you registered as a sex offender under the Michigan Sex Offenders Registration Act, MCLA 28.721 et seq?

Yes _____ No _____

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? Yes _____ No _____

If so, please explain:

Is the applicant able to follow simple instructions? Yes _____ No _____

LAPEER COUNTY MEDICAL CARE FACILITY
ADMISSION APPLICATION

Diet:	Height:	Weight:	Usual Weight:

Bladder Control: (check one) Never Wet _____ Dribbles _____ No Control _____ Catheter _____ Urostomy _____

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

DOES THE APPLICANT	YES	NO	COMMENTS
Have Dentures			
Have Hearing Aids			Right, Left or Bilateral?
Have Glasses			
Feed Through A Stomach Tube			Nutrition/TPN
Have An IV For Fluids			
Require Dialysis			If yes, who transports? If yes, the location? If yes, what is the schedule?
Require Insulin Shots			
Enrolled In A Hospice Program			If yes who is your provider?
Require Use Of Oxygen			If yes, how often? How many Liters?
Require Use Of Ventilator			
Require Use Of Bi-Pap			If yes, who provides machine?
Require Use Of A C-Pap			If yes, who provides machine?
Have A Tracheotomy			
Have Open Wounds			If yes, describe
T.B. RISK ASSESSMENT (Applicant Has)	**YES**	**NO**	**COMMENTS**
Ever had a positive T.B. test or treated for active/suspected T.B.			
Productive Cough			
Coughing Up Blood			
Weight Loss			
Loss Of Appetite			
Lethargy Weakness			
Night Sweats			
Fever			

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

	NEEDS NO HELP	OVERSIGHT/ SUPERVISION	NEEDS SOME PHYSICAL HELP	TOTALLY DONE BY OTHERS
BATHING				
TOILETING				
EATING				

LAPEER COUNTY MEDICAL CARE FACILITY
ADMISSION APPLICATION

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

	NEEDS NO HELP	OVERSIGHT/ SUPERVISION	NEEDS SOME PHYSICAL HELP	TOTALLY DONE BY OTHERS
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:

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand and agree to the electronic submission and release of medical information by the Facility to the State of Michigan and the Center for Health Systems Research and Analysis. This information is required for regulatory compliance.

I understand I have the right to revoke this authorization, in writing, and at any time by sending such written notification to the Facility's privacy officer. I understand the revocation is not affected to the extent the Lapeer County Medical Care Facility has relied upon it or the Lapeer County Medical Care Facility has used the Authorization to release information or has disclosed the protected health information pursuant to the authorization.

I understand information used or disclosed pursuant to the authorization may be subject to further disclosure by the recipient and may or may no longer be protected by federal or state law.

I further understand that I may refuse to sign the authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Unless revoked earlier, this authorization will expire one year form the date of signature.

APPLICATION MUST BE SIGNED AND DATED

Person completing the application:
Relationship:

Signature_____ Date _____

LAPEER COUNTY MEDICAL CARE FACILITY
PHYSICIAN REFERRAL FOR ADMISSION

RESIDENT NAME_____ BIRTHDATE_____

The above patient needs care at Lapeer County Medical Care Facility for the following reasons:

CURRENT STATUS

Respiratory
____ Trach
____ Oxygen ___ Liters
____ Suctioning

Ambulation
____ Independent ____ Cane
____ Assist ____ W/C
____ Walker ____ Bedridden

Orientation
____ Alert ____ Oriented
____ Cooperative ____ Comatose
____ Confused ____ Lethargic
____ Combative ____ Delusions
____ Agitated ____ Anxious
____ Wanders ____ Hallucinations

Speech
____ Adequate ____ Impaired

Hearing
____ Adequate ___ HOH __ R __ L
____ Hearing Aide __ R __ L
____ Deaf

ADL's
____ Independent ____ Assistance
____ Total Dependence on others

Elimination
____ Continent ____ Incontinent
____ Colostomy ____Foley
____ Intermittent Catheterization

Skin
____ Intact ____ Rash
____Pressure Areas, if yes what stages and where? _____
_____
Skin Treatments _____
_____

Diet
____ Feeds self ____ Needs Assist
____ Tube Feeding __ N/G __ TPN
____ Peg tube ___ G- tube
Current Diet _____

Vision
____ Glasses ____ Blind

Current Medications: _____
_____
_____
_____

Present Diagnosis: _____
_____
_____

Past Medical Hx: Surgeries_____
Allergies: _____ Pneumonia Vaccine given (date) _____
Flu Vaccine given (date) _____ Any Hx of Tuberculosis ___ Yes ___ No

PHYSICIAN SIGNATURE _____ DATE _____

Please return completed application to: Lapeer County Medical Care Facility
1455 Suncrest Dr. Lapeer MI 48446
or fax to 810-664-4392

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 (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

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

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.

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

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

SECTION I – 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 #)			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 and III 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.

Patient Name

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

1. The person has a current diagnosis of **Mental Illness** or **Dementia** (Circle one or both)	☐ No	☐ Yes
2. The person has received treatment for **Mental Illness** or **Dementia** (within the past 24 months) (Circle 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 check "Yes" to items 1 and/or 2, circle the word "**Mental Illness**" and/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, nurse practitioner or physician's assistant 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 (type or print)
Address (number, street, apt. number or suite number)			Degree/License
City	State	Zip Code	Telephone Number

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

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 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 provide a copy to the patient 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