BAY COUNTY
MEDICAL
CARE FACILITY

564 W. Hampton Road Essexville, MI 48732
baycountymcf.com | 989.892.3591

Thank you for your interest in Bay County Medical Care Facility, your county's long term care and rehabilitation facility. Please complete the attached application for admission and return it with the following documents:

- **History & Physical dated within 30 days of admission**
- **DCH 3877 & 3878 forms completed by physician (in packet)**
- **Completed admission packet, including BOTH responsible party and physician sections**
- **Copies of Power of Attorney and/or Patient Advocate forms**
- **Copies of Insurance cards and picture ID**

If you need further assistance, please do not hesitate to call or email the Admissions Department. The completed packet should be returned via mail, email, fax or in person to:

Isabell Bond
Admission Coordinator
Bay County Medical Care Facility A198
Phone: 989-459-1044
Fax: 989-891-0144
ibond@bcmcf.com

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APPLICATION FOR ADMISSION

TO BE COMPLETED BY FAMILY/RESPONSIBLE PARTY

Please return completed application to Bay County Medical Care Facility.

Name_____ Nickname_____
Address_____
County of Residence_____
Date of Birth_____
Applicant is currently living at: _____ Home? _____With family member?_____ or other? Please specify.
If living elsewhere, with whom? _____ How long_____

Personal Information

Marital Status: ____Married _____Single _____Widowed ____Divorced
Birthplace _____ Occupation _____
Religion: _____Church/Synagogue_____
Primary Language _____

Dentures: ___Yes ___No
If yes: ___ Upper ___ Lower ___Partial
If no, date of last dental exam: _____

Glasses ___ Yes ___No
Date of last eye exam: _____ Eye Doctor _____

Hard of Hearing: ___Yes ___No
Hearing Aids: ___Yes___ No
If yes: ___Right ____Left
Date of last evaluation: _____

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Emergency Contact Information

Emergency Contact: _____
Relationship: _____ **Address:** _____
Phone# _____ **(Home)** _____ **(Work)** _____ **(Cell)**

Emergency Contact: _____
Relationship: _____ **Address:** _____
Phone#_____ **(Home)** _____ **(Work)** _____ **(Cell)**

Emergency Contact: _____
Relationship: _____ **Address:** _____
Phone# _____ **(Home)** _____ **(Work)** _____ **(Cell)**

Responsible Party Information

Person responsible for handling/assisting with financial matters:

Name: _____ **Relationship:** _____
Address: _____
Phone: _____ **(Home)** _____ **(Work)** _____ **(Cell)**

Legal Guardian: ___Yes ___No
If yes, name of legal guardian: _____
We must receive a copy of guardianship.

Conservator: ___Yes ___No
If yes, name of conservator: _____
Phone: _____
We must receive a copy of conservatorship.

Durable Power of Attorney for Finances: ___Yes ___No
If yes, name of financial DPOA: _____
We must receive a copy of the DPOA.

Medical Durable Power of Attorney/Patient Advocate: _____Yes _____ No
If yes, name of medical DPOA: _____
If no, would you like assistance in completing a MDPOA? ____Yes ____ No
We must receive a copy of the MDPOA.

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Insurance Information

We MUST receive copies of ALL insurance cards

Social Security #_____Medicare # _____Part A ___Part B ___
Medicaid # _____
If currently no Medicaid, will you be applying? ____Yes ____No
In what County? _____
Other Insurance: _____Supplemental: _____
Vision: _____Dental: _____Prescription: _____
Long Term Insurance Coverage: _____

Is this admission covered by workman's comp? ___Yes ___No
If yes, dates: _____
Company: _____

Is this admission covered by auto insurance? ___Yes ___No
If yes, dates: _____Company: _____
Agent Name: _____ Phone Numbers: _____

Has applicant been in another skilled nursing facility before? ___Yes ___No
If yes, where? _____
Dates of stay: _____
Reason for placement at that time? _____

Financial Information

A. MONTHLY INCOME
Monthly Social Security Income: _____
Monthly Pension: ____Yes _____No
If yes, what is the amount? _____

B. REALESTATE ASSETS
Does applicant own home? ____Yes ____No
If yes, where is the property located? _____
_____
Approximate value $ _____

Does applicant receive any "rental" income? ___Yes ___No
If yes, how much per month? _____Per year?_____

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Does applicant own any other property than home? _____Yes _____No
If yes, where is the property located?_____

C. LIFE INSURANCE CASH VALUE
Does applicant have life insurance policies with cash value?____Yes ____No
Approximate amount of cash value? _____
Company: _____
Agent's Name: _____ Phone Number: _____

D. SECURITIES
Does the applicant have stocks and bonds? ___Yes ___No

E. FUNERAL ARRANGEMENTS
Does the applicant have a pre-paid funeral? ___Yes ___No
If yes, with what funeral home? _____

PLEASE RETURN COMPLETED APPLICATION TO ADMISSION OFFICE.

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MEDICAL INFORMATION

TO BE COMPLETED BY PHYSICIAN

Patient Name: _____ **Date of Birth:**_____

Height: _____ **Weight:** _____ **Normal Weight:** _____

The patient listed above requires care at Bay County Medical Care Facility for the following reasons:

Current Diagnosis: _____

_____

Current Medications: _____

_____

Allergy to Medications: _____

_____

Cardiovascular History: _____

_____

Surgical History: _____

_____

Mental Health History:_____

_____

_____

Positive History for Tuberculosis? ____**Yes** ___**No**

Communicable Diseases? ___**Yes** ___**No**

If yes, please list: _____

Activities of Daily Living: _____**Independent** _____**Dependent**

Needs Assistance with:

_____

_____

_____

_____

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Ambulation: _____Independent _____Wheelchair _____Walker _____Cane

Bowel and Bladder: ____ Continent ____Incontinent ____Catheter ____Colostomy

Breathing: ___Oxygen ___Tracheostomy ___Suction ___N/CMask ___BI Pap/C Pap

Speech: ___Clear ___Aphasic

Mental Status

___Alert	___Lethargic	___Comatose	___Confused
___Forgetful	___Oriented	___Cooperative	___Uncooperative
___Pleasant	___Combative	___Restless	___Agitated

Current Diet: _____

Skin Condition: _____**Bruises:** _____
Decubiti: ___Yes ___No
If yes, location and stage: _____

Other pertinent information: _____
_____
_____
_____

Physician Signature: _____**Date:** _____

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

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

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.

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.