Calhoun County Medical Care Facility
Marian E. Burch Adult Day Care
Sharing and caring through the years

CCMCF Admissions Packet

Jenny Collins, LMSW, Social Worker/Admissions jcollins@ccmcf.com

Phone (269) 962-5458 Ext. 300 Fax (269) 963-4580

Thank you for your interest in Calhoun County Medical Care Facility. In order for us to consider you for admission, we require the following information from you and your doctor. You may fax, mail, or email information to us. Contact me any time, and I will be happy to help you, because this process can be confusing. I can give you an in-person or virtual tour of CCMCF.

From the Physician:

-History and Physical, including height and weight, within the last 60 days

-List of current medications, with dosages

-Mental Health Screening - (see attached information and forms)

-Any recent labs

From you or your family:

-Photo identification if you have it, Social Security card, and insurance cards

-DPOA, Patient Advocate, or Guardianship paperwork

-Name and phone number of one or two main contact people

-Covid vaccination card showing all vaccinations and boosters

If you are a resident in another nursing facility:

Copy of the current Minimum Data Set (MDS) (in addition to all of the above)

Our nurse case manager and admission director will review the information, request other information as needed, and determine if you meet criteria for care in our skilled nursing facility. We prefer to have an in person assessment meeting where we can answer your questions, review your medical condition and care needs. We also will have you speak with our billing department about paying for long-term care.

PLEASE LIST PRIMARY CONTACT NAME AND PHONE NUMBER

PRIMARY CONTACT

PHONE NUMBER

PLEASE LIST SECONDARY CONTACT NAME AND PHONE NUMBER

SECONDARY CONTACT

PHONE NUMBER

CALHOUN COUNTY MEDICAL CARE FACILITIY
Physician's History & Physical Examination

Resident: _____ **Birthdate** _____

Date _____

CHIEF COMPLAINT & CURRENT DIAGNOSIS :

Other current diagnoses are listed on today's Order Summary.

MEDICAL HISTORY:

ROS >	Unable to obtain complaints d/t Dementia
General:	Fever, chill, appetite (good, poor) Wt. Los Sleep (good, poor)
HEENT:	Headache, sore throat, choking, red eye otalgia dizziness, runny nose
Cardio:	Chest pain, SOB, DOE, PND, Palpitation
Respiratory:	Cough, Sputum, Cyanosis, Wheezing
GI:	Abd. Pain, N,V,C,D. Melena Heartburn
GU:	Incontinence (Urine, Bowel), dysuria Frequency: Polyuria
MuscSkel	Backache, knee pain, neck pain, Myalgia, Shoulder pain, Swelling
Neuro:	Headache, Dizziness, Fall Seizure, Numbness, Tingling, Anesthesia
Skin:	Ulcer, Rash, Bruise, Itching, Redness, Gangrene

PHYSICAL EXAMINATION:

Vital Signs:	BP ____ / ____ PR: ____ /min
	RR: ____ /min. Temp: ____ F
Weight	_____ (Change _____)
General:	Distress, Wasted, Obese, Contracted
HEENT:	NC, Sym, PERRLA with EOMI, Supple Enlarged lymph node, JVD, Carotid Bruit Thyromegaly, Denture, Cataract OP, Red eye
Cardio:	NSR, Irregular Rhythm, SEM(_____/IV), Gallop, Rubs, CABG scar, Tachycardia
Respiratory:	Good air entry W/O wheezing or rales, Wheezing, Rales, Rhonchi Stridor, Dullness
GI:	BS(+), soft, non-tender, PEG tube in place Distension, Rebound tenderness Hepatomegaly, Splenomegaly
GU:	CVA tenderness, Discharge, Rash, LNE

PHYSICAL EXAMINATION CONT'D:

Extremities:	Pulse (Palpable, weak), cold, gangrene Decubitus Ulcer: Pedal Edema (/) Erythema, Ulcer (Stage _____, size_____) Rash, Dry skin, bruise, pigmentation
Rectal:	Not Done, Sphincter tone, Guaiac ( ), Mass Prostate
Pelvic	Not Done, discharge, tenderness, bleeding, mass
Neuro:	Alert, oriented x__, bed-ridden, W/C bound Cranial N: WNL, Asym, Blind, Deaf Motor: No deficit, Hemiparesis, Paralysis Atrophy Sensory: No deficit, others Tremor: Rigidity, Unsteady gait DTR:_____/_____

LABS - X-RAY:

Date:	Test & Findings:

MEDICATIONS: See current Physician's Orders

ASSESSMENT - PLAN:

MEDICAL CONDITION & PLANS DISCUSSED WITH RESIDENT:

____ Yes ____ No

If no, explain: _____

_____

___ **REPORT DICTATED**

SIGNATURE _____

DATE _____

Mental Health Screening Information

Michigan OBRA Pre-Admission Process for

Skilled Nursing Facility Admission

Every person admitted to a skilled nursing facility in Michigan must have a pre-admission screening. This mental health screening reviews issues including dementia, depression, or psychosis. The physician office making the referral for skilled nursing facility care must complete the paperwork for this process using the attached forms.

Dana Quinn, LMSW, is the Calhoun County OBRA Coordinator. She is available to answer questions.

Dana Quinn LMSW

OBRA Coordinator

Summit Pointe

Desk Phone DID: 269-441-6462

Cell Phone: 269-275-2873

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.

DCH-3878, MENTAL ILLNESS/INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

(For Use in Claiming Exemption Only)

Michigan Department of Health and Human Services

Level II Screening

(Revised 3-22)

SECTION 1 - 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.

SECTION 2 – GENERAL INFORMATION

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

SECTION 3 – 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.
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

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.

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

CALHOUN COUNTY MEDICAL CARE FACILITY
SCHEDULE OF CHARGES

ROOM RATE

$ 355.00 /DAY (EFF 3/01/2022)
$194.50 /DAY. MEDICARE A COINSURANCE.(EFF. 1/01/2022)
$ 355.00 /DAY HOLD BED (EFF 3/01/2022)

BARBER/BEAUTY

PERMANENT	$	40.00
HAIR CUT FACILITY	$	15.00
HAIR COLOR	$	35.00
PERMANENT (ADC)	$	40.00
HAIR CUT (ADC)	$	15.00
HAIR COLOR (ADC)	$	35.00
WASH & SET (ADC)	$	15.00

LAUNDRY

CURRENTLY NO CHARGE-INCLUDED IN ROOM RATE

SKILLED THERAPY SERVICE

PHYSICAL THERAPY	$	160.00	/HOUR
OCCUPATIONAL THERAPY	$	160.00	/HOUR
SPEECH THERAPY	$	160.00	/HOUR
PT EVALUATION	$	160.00	/HOUR
OT EVALUATION	$	160.00	/HOUR
SPEECH EVALUATION	$	160.00	/HOUR

ADULT DAY CARE SERVICE

WHOLE DAY	$	97.00	
HALF DAY	$	47.00	
CANCELLATION AT THE DOOR	$	14.00	
BATH	$	20.00	
SATURDAY ADULT DAY CARE	$	15.00	/HOUR
RESPITE CARE DAILY RATE	$	275.00	
RESPITE CARE PER HOUR	$	15.00	EACH ADDITIONAL HOUR TO A MAXIMUM OF $275.00
LATE PICK UP FEE	$	5.00	PER EACH 5 MINUTES BEYOND SCHEDULED TIME
ASSESSMENT FEE	$	30.00	
ENEMA/BOWEL PROGRAM	$	15.00	
EXTENDED HOURS	$	15.00	
GUEST TRAY	$	3.00	
SKILLED NURSING	$	15.00	/DAY. SUPPLIES NOT INCLUDED.

MEDICAL SUPPLIES

LEG BAGS	$	8.82
DRAIN BAGS	$	14.55
FOLEY TRAY	$	11.58
FOLEY CATHETER	$	18.39
FOLEY CATHETER CDE	$	40.49
OSTOMY POUCH	$	9.93
OSTOMY DEODORENT	$	3.87
TRACHEOSTOMY	$	81.95
TRACH. CARE SET	$	6.95
TRACH. INNER CANULA	$	9.83
URINARY POUCH W/BARRIER	$	9.02
WAFER	$	7.40

OXYGEN

PORTABLE TANK	$	10.00
CONCENTRATOR/ MONTHLY FEE	$	75.00

LATE FEE

$25.00 LATE FEE IS APPLIED FOR ANY PAYMENT RECEIVED AFTER THE 15TH OF EACH MONTH.

CHARGEABLE TRANSPORTATION

$ .25 per mile round trip plus
$ 25.00 per hour driver time, with a minimum of $25.00.
Nights, Weekends and Holidays will have to be negotiated separately.

Room rate includes laundry, hair care, and all personal need items (e.g. briefs, tissues, toothpaste, lotion). A separate bill from pharmacy for all prescription drugs is sent monthly directly to your home. The physician will also bill separately for his visits. Podiatry, X-ray, Lab, Dentist, Psychiatrist, and Optometrist are available and are billed directly to you by their office.

ITEMS IN GRAY HAVE BEEN REVISED FOR PRICING

Effective 1/01/2022
Revised 02/21/2022