Long Term Care Consultation Program

Screening for Mental Retardation or Mental Illness

This form must be completed for a person seeking admission to a Medical Assistance (MA) certified nursing or boarding care facility OR as part of a community assessment.

PERSON'S NAME	DATE OF BIRTH *(mm/dd/yyyy)*
PMI # (IF APPLICABLE)	DOCTOR/PHONE #

Mental Illness: In order to refer a person for further evaluation and determination of need for specialized mental health services, the person must meet **all** of the following criteria on diagnosis, level of impairment and duration of illness.

1. Does the person have a major mental disorder diagnosable as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition excluding a primary diagnoisis of dementia, Alzheimer's disease, or other related cognitive conditions? ☐ YES ☐ NO

and

2. Has the major mental disorder resulted in significantly impaired functioning in major life activities that would be appropriate for the person's developmental stage within the past 3 to 6 months? ☐ YES ☐ NO

and

3. Does the person's treatment history indicate at least one of the following: ☐ YES ☐ NO

- Psychiatric treatment more intensive than outpatient care (partial hospitalization or inpatient hospitalization) more than once in the last two years? OR
- Within the past two years and due to the mental disorder, the person has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment center, or which resulted in intervention by housing or law enforcement officials?

If your answer is **yes** to **all** of the questions above and the person is seeking admission to a MA certified nursing facility a boarding care facility, refer the person to the county local mental health authority for completion of a Level II evaluation and determination of need for specialized services. If the person is seeking a community placement, retain the form in person's record and refer the client to others (county social services, county mental health office, physician, health plan) to receive necessary mental health services.

If your answer is **no** to **any** of the questions above:

- And the person is seeking admission to a MA certified nursing facility or boarding care facility, send the form to the admitting facility for inclusion in the person's records.
- And the person is seeking community placement, retain the form in the person's file. If in the future the person is admitted to a nursing facility, review the form for accuracy and send to the facility.

Reassessment ☐ CHANGE ☐ NO CHANGE

SIGNATURE OF SCREENER	DATE *(mm/dd/yyyy)*
SIGNATURE OF SCREENER *(upon review)*	DATE *(mm/dd/yyyy)*
REASSESSMENT SIGNATURE OF SCREENER	DATE *(mm/dd/yyyy)*