# CERTIFICATION OF NEED
## Adult Sub-Acute Facility

Date of CON: ________________________ Time of CON: _______

Individual's Name:___________________________________ Individual D.O.B. & Age:__________________ - _______

Treating Facility: ___________________________________ Date of Admission__________________________

Title 19/21: Yes/No Emergency Admission: Yes No

**1. DSM – IV Diagnostic Codes** **AXIS I** _____________________; _________________________

**AXIS II** _____________________ **AXIS III** _______________________ **AXIS IV** _____________________ **AXIS V** ____

**2. Reason for Hospitalization (Must meet specifications in at least one of a through el below - circle all that apply):**

a. A clinical evaluation of the Individual's condition indicates sudden de-compensation with a strong potential for danger to self or others and the Individual has no available or appropriate to provide continuous monitoring.
b. A clinical evaluation suggests that the Individual can be effectively treated with short term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame.
c. A clinical evaluation indicates the onset of a serious psychiatric condition, but there is insufficient information to determine the appropriate level of care.
d. The Individual has had their Court Ordered Treatment Amended and requires a short period of stabilization prior to returning to a less intensive level of care.
e. Other: (Specify) ______________________________________________________________________________

**3. Likely *therapeutic* discharge plan (Circle all that apply:**

Residential Mental Health Rx. Residential Chemical Dependency Rx. Residential Dual Diagnosis Rx. Supervised Day Program Therapeutic Day Program Medical Day Program Partial Hospital Program Outpatient Case Management Outpatient Medication Management Dialectical Behavioral Therapy Outpatient Counseling Personal Assistance ALTCS Services DDD Services

**4. Estimated length of stay (Specify number):** _____________________ Days (required)

**5. Based upon physical, mental and social evaluations, I certify the above named individual requires sub acute psychiatric treatment and that all of the below accurately describes the situation for inpatient hospitalization according to 42 CFR Part 456 subpart C; under 21 42 CFR subpart D:**

- Above circled items are fully documented in the individual's clinical record.
- Ambulatory care resources available in the community do not meet the treatment needs of the individual; and
- Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- Sub acute psychiatric services can reasonably be expected to improve the Individual's condition or prevent further regression so that the services will no longer be needed.

_____________________________________ _____________________________________ ________________

**Sub Acute Physician's Name (Print)** **Physician's Signature** **Date**

**If above physician signature is from the Hospital treatment Team, then a physician independent of the Hospital treatment team must certify this admission below on all Title 19/21 Individuals under the age of 21**

________________________________ ________________________________ _____________ _____________

Outpatient Physician's Name (Print) Independent Physician's Signature Date Agency

**CON Valid for person 21 yo or older: Max is 60days** **CON for person 20 yo or under : Max is 30 days**

Call Magellan Care Management @ 1-800-564-5465 FAX CON to: 1-888-290-1285 Revised: 2/5/2014