RE-CERTIFICATION OF NEED

Adult Sub-Acute Facility

Date of RON: ________________________ Time of RON: _______

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 g below - circle all that apply):

a. Individual's presenting psychiatric signs/symptoms have not changed since admission, necessitating continued sub acute treatment.

b. Individual's presenting psychiatric signs/symptoms have worsened since admission, necessitating continued sub acute treatment.

c Individual's presenting psychiatric signs/symptoms have substantially improved; however, not sufficiently to safely function in a residential or outpatient setting.

d. Individual's presenting psychiatric signs/symptoms have substantially improved; however, is accepted and waiting placement to a dual diagnosis(enhanced or capable) treatment facility **and** does not exhibit sufficient impulse control around substance use triggers or acceptance of the need to abstain from substances to warrant sub acute discharge, pending admission to the dual diagnosis treatment facility. Attempts to identify and mitigate substance use triggers, and/or denial have, to this point proven unsuccessful.

e. Individual's presenting psychiatric signs/symptoms have substantially improved; however, is accepted and waiting placement to a residential treatment facility and cannot be safely maintained in the community pending residential placement.

f. Individual requires continued sub acute treatment in order to facilitate a sensitive psychiatric medication adjustment/change, which cannot be safely conducted in a residential or outpatient setting.

g. 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

RON Valid for person 21 yo or older: Max is 60days RON 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