CERTIFICATION OF NEED

Child and Adolescent Behavioral Health Inpatient Facility– Chemical Dependency

Date and Time This CON is Effective: _____ / _____ / _____ Date of Admission:_____

Individual's Name: _____ Individual's D.O.B.: _____

Individual's Age: _____ Title 19/21: Yes No **Assumption of Funding**: Yes No

PNO/QSP Case Manager: _____ Behavioral Health Inpatient Facility Name:

_____

1. **DSM IV TR Diagnostic Codes** AXIS I _____ AXIS I _____

   AXIS II _____ AXIS III _____ AXIS IV _____

   AXIS V _____

2. **Current Medications: _____**

   _____

3. **Reason for Behavioral Health Inpatient Treatment (Must meet specifications in at least one of a through g below - circle all that apply):**

   As a direct result of active and significant use of dangerous drugs/chemicals:

   a. The individual is at moderate but stable risk of imminent harm to self or others and does not require inpatient psychiatric care.
   b. The individual's recovery efforts are negatively affected by their emotional, behavioral, or cognitive problems in significant and distracting ways and less restrictive treatment interventions have failed.
   c. The individual has not yet related their problems to substance use or has not accepted the need to change and thus is in need of intensive motivating strategies, activities, and processes only available within a 24 hour therapeutic residential setting.
   d. Despite serious consequences the individual continues to deny there is any problem with substance use.
   e. The individual requires active treatment in a 24 hour therapeutic milieu to further develop recovery skills that are not yet sufficient to overcome environmental triggers (such as peer substance use or family stressors) or internal triggers, and less restrictive treatment interventions have failed.
   f. The individual's treatment plan involves their return to an environment determined by clinical standards to not yet be capable of supporting recovery. Clinical evidence supports return to this environment is appropriate once sufficient community based services are in place and/or the individual has developed adequate coping skills.
   g. Other: (Specify) _____

4. **_____ Likely *therapeutic* discharge plan (circle all that apply):** Behavioral Health Residential Facility Intensive Outpatient Services HCTC Outpatient Medication Monitoring Outpatient Case Management Family Therapy Family Support CDIOP MST FFT Other:

   _____

5. **Estimated length of stay (Specify number): _____** Days (required)

6. **Based upon physical, mental and social evaluations, I certify the above named individual requires Level I residential treatment center and that all of the below accurately describes the situation for residential treatment center according to 42 CFR Part 441 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
   - Inpatient 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.

_____ _____ _____

Treating Physician's Name (Print) Physician's Signature Date

If above physician signature is from the Behavioral Health Inpatient Facility Team, then a physician independent of the Behavioral Health Inpatient Facility 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 for person 20 yo or under : Max is 30 days FAX to MAGELLAN at (866) 568-6147 Last Revision Date: 2/5/2014