CERTIFICATION OF NEED

Child and Adolescent Behavioral Health Inpatient Facility

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 Treatment (Must meet specifications in at least one of <u>a - g</u> below - circle all that apply):**

As a direct result of the individual's psychiatric disorder:

a. Individual is not actively suicidal but has within the past 30 days attempted or gestured serious self-harm and has failed less restrictive treatment interventions.
b. Individual has engaged in serious self-mutilation within the past 30 days and continues to manifest this behavior which has not responded to less restrictive treatment interventions.
c. Individual has exhibited psychotic symptoms that are not currently dangerous but is not sufficiently reality-based to be safe without continuous behavioral health professional monitoring and treatment interventions.
d. Individual has a significant psychiatric disorder and as a result of it has and continues to run away within the past 30 days, and all less restrictive treatment efforts have failed.
e. Individual is not actively homicidal but has with less restrictive treatment interventions continued to assault family, peers and/or staff.
f. Individual demonstrates marked difficulty accepting personal responsibility for their behaviors/consequences of their behaviors, necessitating continuous behavioral health professional monitoring and treatment interventions.
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 Behavioral Health Inpatient Facility treatment and that all of the below accurately describes the situation for treatment 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.

_____ _____ _____

Behavioral Health Inpatient Facility 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

FAX to MAGELLAN at 1-866 568-6147

Last Revision Date: 2/5/2014

CON for person 20 yo or under : Max is 30 days