

RE-CERTIFICATION OF NEED

Child and Adolescent Behavioral Health Inpatient Facility

Date and Time of RON: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 Continued Treatment (Must meet specifications in at least one of a - i 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. Individual's presenting psychiatric signs/symptoms have substantially stabilized, however an additional 30 days are necessary to solidify therapeutic gains and prevent relapse.
h. Individual's presenting psychiatric signs/symptoms have substantially stabilized and can safely be transitioned to a lower level of care, however an alternative level of care is not available.
i. 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

Facility must submit subsequent Re-Certification of Need document for each successive thirty (30) days.

FAX to MAGELLAN at (866) 568-6147

Last Revision Date: 2/5/2014