

RE-CERTIFICATION OF NEED

Child and Adolescent Residential Treatment Center

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: _____ Residential Treatment Center: _____

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 Residential Treatment (Must meet specifications in at least one of a - h below - circle all that apply):
As a direct result of the individual's psychiatric disorder:

- 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.
- 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.
- 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.
- Individual is not actively homicidal but has with less restrictive treatment interventions continued to assault family, peers and/or staff.
- Individual demonstrates marked difficulty accepting personal responsibility for their behaviors/consequences of their behaviors, necessitating continuous behavioral health professional monitoring and treatment interventions.
- Individual's presenting psychiatric signs/symptoms have substantially stabilized, however an additional 30 days are necessary to solidify therapeutic gains and prevent relapse.
- 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.
- Other: (Specify) _____

4. Likely *therapeutic* discharge plan (circle all that apply): Therapeutic Group Home 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 inpatient psychiatric treatment and that all of the below accurately describes the situation for inpatient hospitalization 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.

RTC 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: 3/31/2010