

Certification of Need Form ~ Acute Inpatient Hospitalization for Individuals Under Age 21

Patient Information

Recipient's Name _____

Medicaid ID Number _____

Date of Birth _____ Age _____ Gender _____

The Team Responsible for the Plan of Care Certifies the Following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient due to:

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician due to:

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed based upon:

Signature of Physician Team Member

Signature of Other Team Member

Signature of Other Team Member

Print/Type Name

Print/Type Name

Print/Type Name

Date: _____

Date: _____

Date: _____

Title: _____

Title: _____

Title: _____