

HealthSystems of Mississippi
Medicaid Admission Review Plan of Care Form: Hospital Outpatient Mental Health

Beneficiary Information		Provider Information	
Beneficiary Name: _____		Lead Clinician:	
Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Name: _____	
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Address: _____	
Sex: <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>		Address _____	
Beneficiary Account #: _____ <i>(if applicable)</i>		City/State _____	
		Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		License #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Hospital Information		<i>NOTE: Attestation Statement on last page of form must be signed and dated by the psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker.</i>	
Hospital #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Hospital Name: _____			
Requester's Information			
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Name: _____	
		Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
SERVICE DATES:			
Actual Admit/Service Start Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Proposed Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
MEDICAL INFORMATION - DIAGNOSIS AND PROCEDURES			
Axis I (ICD-9-CM Codes)	Narrative Description (Primary diagnosis cannot be substance abuse diagnosis.)		
1. Primary DX.:			
2.			
3.			
Axis II (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis III (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis IV (ICD-9-CM Codes)	Narrative Descriptions		
1.			
2.			
3.			
Axis V	Baseline GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	Current GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	

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REQUESTED SERVICES								
CPT® Code	Dates of Service		Total Unit(s) Requested	Performed by			Complete this section for each requested CPT® Code.	
	From	Thru		Psychiatrist / Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90801	<input type="text"/>	<input type="text"/>						
90804	<input type="text"/>	<input type="text"/>						
90805	<input type="text"/>	<input type="text"/>						
90806	<input type="text"/>	<input type="text"/>						
90807	<input type="text"/>	<input type="text"/>						
90808	<input type="text"/>	<input type="text"/>						
90809	<input type="text"/>	<input type="text"/>						
90810	<input type="text"/>	<input type="text"/>						
90811	<input type="text"/>	<input type="text"/>						
90812	<input type="text"/>	<input type="text"/>						
90813	<input type="text"/>	<input type="text"/>						
90814	<input type="text"/>	<input type="text"/>						
90815	<input type="text"/>	<input type="text"/>						
90846	<input type="text"/>	<input type="text"/>						
90847	<input type="text"/>	<input type="text"/>						
90849	<input type="text"/>	<input type="text"/>						
90853	<input type="text"/>	<input type="text"/>						

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CPT® Code	Dates of Service		Total Unit(s) Requested	Performed by			Complete this section for each requested CPT® Code.	
	From	Thru		Psychiatrist / Nurse Practitioner	Anesthesiologist / Nurse Anesthetist	Other	For each code requested, list the last and first name of the clinician who will be providing the service.	Provider Medicaid # or License #
90857	□□/□□/□□	□□/□□/□□						
90862	□□/□□/□□	□□/□□/□□						
90870	□□/□□/□□	□□/□□/□□						

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PAST TREATMENTS

Were outpatient mental health services provided by this hospital at the time of initial evaluation and/or prior to submission of this review request? Yes No *If yes, indicate why immediate intervention was required and therefore services could not be precertified.*

Did the beneficiary receive outpatient mental health services from this hospital prior to submission of this review request?

Yes No *If yes, provide the date on which those services were initiated.* //

Did the beneficiary receive other related health care services prior to initial evaluation? Yes No Unknown

If yes, complete the following Treatment History section.

Treatment History (Check all that apply within last year):

Psychiatric Inpatient Admits None 1 2 3-5 6 or more Latest Discharge Date //

Other care/Institution None NF ICF/MR PRTF //

	Community Mental Health Center	Outpatient Hospital Provider	Private Practice	Discharge Date <i>(Leave blank if active care)</i>
<input type="checkbox"/> Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Case Management Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Psychosocial Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Group Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Outpatient Substance Use Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> NA or AA Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> NAMI or Other Mental Health Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Other (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>

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Current Symptoms/Behavior		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Danger to Self/Others	Suicidal Thought / Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Current plan to kill / injure self, requiring medical Tx.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Homicidal Thought / Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recent attempt to kill or seriously injure another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Aggressiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Impulsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral/Evidence <i>(Includes presence of ideations and/or intentions, previous attempts/gestures, presence of plan, access to and lethality of intended means, ability to contract for safety and other social supports such as family.)</i>							
		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Psychosis	Command auditory hallucinations to kill / injure self, requiring medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hallucinations – Non-Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Disorganized/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	Gross psychomotor retardation from depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crying / Tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	Anxiety / Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Binging / Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Property Destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Behavioral/Evidence, Continued		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
Behavior, con't.	Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lying / Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction	Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Alcohol Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Drug Use / Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Uncontrolled Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sexual Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Psychological Stressors/Events (Check all that apply)

<input type="checkbox"/> Recent Death	<input type="checkbox"/> Separation / Divorce	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Physical / Sexual / Emotional Abuse	<input type="checkbox"/> Relapse / Decompensation	<input type="checkbox"/> Change in Living Situation
<input type="checkbox"/> Recent Hospitalization	<input type="checkbox"/> Work / School Problems	<input type="checkbox"/> Current Living Arrangement is Unstable
<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Custody / Placement	<input type="checkbox"/> Beneficiary is Unable to Return to Current Living Arrangement

Other: (Describe) _____

Current Functioning		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Care
Physical/ Cognitive	Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Change in Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Verbal Interaction	Argumentative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rapid / Pressured Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Slurred / Incoherent Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Current Communication	0 Unable to Assess	1 Yes	2 No
Verbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Communication Device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Make Needs Known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Drug Use	0 Unable to Assess	1 None	2 Within Past 24 Hours	3 Within Past 30 Days
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Skill/Ability Assessment	0 Unable to Assess	1 Independent or N/A	2 Minimal Assistance	3 Moderate Assistance	4 Significant Assistance
Literacy / Basic Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coping Skills / Emotional Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical / Medication Mgmt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social / Family Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare / Parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking / Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household Tasks / Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Mobility within Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure / Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Current Work/School Schedule		
Employment/School Hours Per Week <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> 1-9 hours <input type="checkbox"/> 10-19 hours <input type="checkbox"/> 20-39 hours <input type="checkbox"/> 40 or more hours	Employment Type <input type="checkbox"/> School <input type="checkbox"/> Employed by Company <input type="checkbox"/> Self Employed <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Supported Employment <input type="checkbox"/> Volunteering <input type="checkbox"/> Unemployed	Date of Last Employment: <input type="text"/> / <input type="text"/> / <input type="text"/> Occupation: _____ _____ _____

Current Living Arrangement <i>(Select only one)</i>		
<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Parent / Guardian	<input type="checkbox"/> Foster Home <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Group Residential Facility	<input type="checkbox"/> Shelter <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Other: <i>(Specify.)</i> _____ _____

Resource/Needs Assessment	0 Unknown	1 Has Resource	2 Has Resource that Needs Enhancement	3 Needs Assistance to Obtain and Use	4 Resource Not Available
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Social Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Individual Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Annual History and Physical Exam	
Date of last physical exam: <input type="text"/> / <input type="text"/> / <input type="text"/>	Next exam due: <input type="text"/> / <input type="text"/> / <input type="text"/>

Studies/labs/x-rays <i>(List any diagnostic studies and tests and findings that are associated with the primary diagnosis)</i>		
Date	Study/Lab/X-Ray	Results/Findings
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		

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DISCHARGE PLANS

Will/can the beneficiary return to current living arrangement? Yes No

Anticipated Discharge Date: / /

Anticipated Discharge to: *(Check one)*

- Acute Care Facility: _____
- Custody DHS County: _____
- Custody DYS
- Home with family
- Group home
- Foster home
- Shelter
- Independent living
- Left AMA
- Other: *(Specify.)*

Anticipated Follow-Up Care: *(Check all that apply)*

- Case Management
- Day Treatment - CMHC
- DME
- Family Therapy
- Follow-Up w/PCP /Specialist
- Follow-Up w/Pharmacy
- Group Therapy
- Home Health
- Individual Therapy
- Other: *(Specify.)*
- Med Management
- PDN
- OT/PT/ST Outpatient Therapy
- SNF/NH
- Substance Abuse Counseling
- Vocational Rehab

Clinician Attestation, Signature and Date

A psychiatrist, psychiatric nurse practitioner, psychologist, or licensed certified social worker who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to monetary penalties and/or fines. I hereby approve the information submitted on behalf of the beneficiary listed on this Plan of Care form for outpatient mental health services and I deem this request medically necessary. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Signature:

**Psychiatrist, psychiatric nurse practitioner, psychologist, or
 licensed certified social worker**

Date

Check One:

- Psychiatrist Psychiatric Nurse Practitioner
- Psychologist Licensed Certified Social Worker

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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