

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

| Beneficiary Information | Provider Information |
|--|--|
| Beneficiary Name: _____ | Facility MS 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"/> |
| MS 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"/> | Facility Name: _____ |
| Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | Physician Name: _____ |
| Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/> | Physician MS 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"/> |
| Beneficiary Account #: _____ <i>(if applicable)</i> | Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician |
| | Requester 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"/> <input type="text"/> |
| | Note: Attestation Statement on last page of form must be signed and dated by the physician. |

Admission Information

Request Date: / /

Service Dates

Planned Date of Admission: / / Number of days requested:

Can the patient be managed in an outpatient or alternative level of care (if available)? Yes No IQ:

MEDICAL INFORMATION

Diagnoses and Procedures

| Axis I (ICD-9-CM Codes) | Narrative Description <i>(Primary diagnosis cannot be substance abuse diagnosis.)</i> |
|---------------------------|--|
| 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"/> |

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____

Medicaid#: _____

PAST TREATMENTS

Did the youth receive related health care services prior to being recommended for PRTF services? Yes No Unknown
If yes, complete the following **Treatment History** section.

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

| | | |
|--------------------------------|---|---|
| # Psychiatric Inpatient Admits | <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6 or more | Latest Discharge Date <input type="text"/> / <input type="text"/> / <input type="text"/> |
| Other Care/Institution | <input type="checkbox"/> None <input type="checkbox"/> NF <input type="checkbox"/> ICF/MR <input type="checkbox"/> PRTF | <input type="text"/> / <input type="text"/> / <input type="text"/> |

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

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

| 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"/> | |

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

| 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 |
| <input type="checkbox"/> 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"/> | <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"/> |

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

| 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"/> |

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

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

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

| 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"/> | | |
| <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"/> | | |
| <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | | |

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form

Beneficiary Name: _____ Medicaid#: _____

DISCHARGE PLANS

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

Anticipated Discharge Date: / /

Anticipated Discharge to: *(Check one)*

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

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

Physician Attestation, Signature and Date

A physician who attests to prescribed psychiatric residential treatment facility 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 civil monetary penalties and/or fines. I hereby certify that I am the ordering physician identified on this form and I deem the service medically necessary for the patient listed as the beneficiary. I certify that the medical necessity information on this form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

A copy of an independent evaluation completed by a psychiatrist or psychologist which indicates the need for psychiatric residential treatment and the potential for benefit from psychiatric residential treatment is attached to this form. This evaluation was performed within the last 60 days prior to the proposed admission date.

Physician's Signature

Date

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.