

HealthSystems of Mississippi Psychiatric Residential Treatment Facility Continued Stay Plan of Care

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"/>
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.

Continued Stay Information

Request Date: / / Treatment Authorization Number (TAN):

Admit Date: / / Last Day Certified: / / Additional Days Requested:

New Diagnosis Since Last Review

New Axis I (ICD-9-CM)	New Diagnosis Narrative Description	Date Identified
1.		
2.		
3.		
New Axis II (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
New Axis III (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
New Axis IV (ICD-9-CM)	New Diagnosis Narrative Descriptions	Date Identified
1.		
2.		
3.		
Axis V	Base line GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>	Current GAF Score: <input type="text"/> <input type="text"/> <input type="text"/>

Date of Procedure	ICD-9-CM Codes	Procedure Description <i>(If Applicable)</i>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

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Specifically, why does the beneficiary need continued PRTF services? Please describe what will be the focus of continued PRTF Services. _____

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 treatment	<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"/>

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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, cont.	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"/>
	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

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"/>

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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 Skill/Ability Assessment					
	0 Unable to Assess	1 None	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"/>
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"/>

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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
□□/□□/□□		
□□/□□/□□		
□□/□□/□□		
□□/□□/□□		
□□/□□/□□		
□□/□□/□□		
□□/□□/□□		

MEDICATIONS

Date Ordered	Medication, Dosage, Frequency & Route	Date Discontinued <i>(if applicable)</i>
□□/□□/□□		□□/□□/□□
□□/□□/□□		□□/□□/□□
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RESPONSE TO TREATMENT PLAN FOR PREVIOUS REVIEW PERIOD (please check one and indicate percentage):

- Successfully met all goals and objectives for this treatment intervention and care setting. _____ % (80 – 100)
- Partially met goals and objectives for this treatment intervention and care setting. _____ % (51 – 79)
- Minimally met goals and objectives for this treatment intervention and care setting. _____ % (11 - 50)
- No progress evident. *Explain below.* _____ % (0 - 10)

FAMILY THERAPY: Please list the date(s) family therapy was provided during the prior review period.

Therapy Dates	Check one of the following			Therapy Dates	Check one of the following		
	Face to Face	Phone	Waiver		Face to Face	Phone	Waiver

CURRENT TREATMENT PLAN/FREQUENCY

(Include treatment related to the current diagnosis. Include up to five of the most urgent goals.)

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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)*

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Acute Care
<input type="checkbox"/> Custody DHS
<input type="checkbox"/> Custody DYS
<input type="checkbox"/> Home with family
<input type="checkbox"/> Group home
<input type="checkbox"/> Foster home
<input type="checkbox"/> Shelter
<input type="checkbox"/> Independent living
<input type="checkbox"/> Left AMA
<input type="checkbox"/> Other: <i>(Specify.)</i> | Facility: _____
County: _____

<input type="checkbox"/> Case Management
<input type="checkbox"/> Day Treatment - CMHC
<input type="checkbox"/> DME
<input type="checkbox"/> Family Therapy
<input type="checkbox"/> Follow-Up w/PCP /Specialist
<input type="checkbox"/> Follow-Up w/Pharmacy
<input type="checkbox"/> Group Therapy
<input type="checkbox"/> Home Health
<input type="checkbox"/> Individual Therapy
<input type="checkbox"/> Other: <i>(Specify.)</i> | <input type="checkbox"/> Med Management
<input type="checkbox"/> PDN
<input type="checkbox"/> OT/PT/ST Outpatient Therapy
<input type="checkbox"/> SNF/NH
<input type="checkbox"/> Substance Abuse Counseling
<input type="checkbox"/> 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.