

**HealthSystems of Mississippi**  
**Instructions for Completing the MYPAC Admission Certification Request Form**

**Section I Beneficiary Information**

1. **Youth's Name** - Enter the youth's last and first name. If the youth has an active Medicaid number record the name as it appears on the Mississippi Medicaid ID card.
2. **MS Medicaid #** - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.
3. **Check If no active Medicaid #** - Check the box if the youth does not have an active Mississippi Medicaid ID.
4. **Soc. Sec. #** - If Mississippi Medicaid has been applied for, enter the youth's social security number.
5. **Date of Birth** - Enter the month, date, and year of the youth's birth.
6. **Sex** - Indicate the sex of the youth.
7. **Age** - Enter the age of the youth at the time service is to be rendered.
8. **Guardian/Representative Name** - Enter the name of the youth's legal guardian/representative.
9. **Guardian/Representative Address** - Enter the mailing address of the youth's legal guardian/representative.

**Section II Provider Information**

1. **MYPAC MS Medicaid Number** - Enter the MYPAC Waiver Medicaid provider number.
2. **MYPAC Provider Name** - Enter the name of the MYPAC Waiver provider.
3. **Request Date** - Enter the date of the request in month, day, and year format.
4. **Requester's Name** - Enter the name of the individual who is primary contact for this case.
5. **Phone # and Ext.** - Enter the requester's telephone number, including area code and extension, if applicable.

**Section III Physician Information**

1. **Medical Director Name** - Enter the name of MYPAC Waiver provider's medical director.
2. **Medical Director Address** - Enter this information only if the MYPAC Waiver provider's medical director's Ms Medicaid ID number is unavailable.
3. **Medical Director MS Medicaid #** - Enter the MS Medicaid ID number of the medical director.
4. **Medical Director Phone #** - Enter the phone number of the MYPAC Waiver provider's medical director.

**Section IV Medical Information**

1. **Planned date of Admission** - Enter the month, date and year of the planned admission.
2. **IQ** - Enter the youth's IQ score.
3. **ICD-9-CM Codes/Diagnoses/GAF Score** - Enter the ICD-9-CM code and narrative description for the beneficiary's diagnoses for Axis I, Axis II, Axis III, and Axis IV. For Axis V, record the beneficiary's baseline and current Global Assessment of Functioning (GAF) scores.

**Section V Requested Services**

1. The following information must be submitted for each type of service requested. Please note that once a Treatment Authorization Number has been issued by HSM, request for respite services must be submitted via the Web.
  - A. **Dates of Service** - Indicate date service will start and the date thru which the service is requested.
  - B. **Units** - Record the total number of units requested. Please do not exceed the maximum units allowed.

**Section VIII Treatment History**

1. **Past Treatments:**
  - A. **Did the youth receive other related health care services prior to being recommended for MYPAC services?** - Indicate whether the beneficiary received other health care services related to the current primary diagnosis prior to this admission. If **yes**, complete the **Treatment History** section.
2. **Treatment History:**
  - A. **Psychiatric Inpatient Admits/Latest Discharge Date** - Indicate the number of psychiatric inpatient hospitalizations within the last year. Record the discharge date for the most recent psychiatric inpatient hospitalization.
  - B. **Other Care/Institution/Latest Discharge Date** - Indicate whether the beneficiary received other care and type of institution, if applicable. Record the date of most recent discharge from that care, if applicable.
  - C. **Other Treatment and Settings: Community Mental Health Center, Outpatient Hospital Provider, Private Practice and Discharge Date** - Complete the grid, indicating all types of care and applicable setting in which the beneficiary received care within the last year. Indicate the discharge date or leave the date blank if the beneficiary is receiving active care.

**Section IX Current Symptoms/Behavior**

Complete the grid by indicating the beneficiary's current symptoms/behavior regarding danger to him or herself and/or to others. Select a valid value (0-5) for each listed area.

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**Section X Behavioral/Evidence**

The behavior/evidence section includes presence of ideations and/or intension, 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. Complete the grid by indicating the behavior or evidence demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

**Section XI Current Psychological Stressors/Events**

Complete the grid by indicating all applicable current psychological stressors/events. If none of the listed options are selected, check "other" and specify the stressors/events in the space provided.

**Section XII Current Functioning**

Current physical/cognitive function and verbal interactions are recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

**Section XIII Current Communication**

Current ability to communicate with others is recorded in this section. Complete the grid by indicating the current functioning demonstrated by the beneficiary. Select a valid value (0-2) for each listed area.

**Section XIV Current Drug Use**

Current drug use is recorded in this section. Complete the grid by indicating the whether the beneficiary is currently using illegal drugs and whether use occurred within the past 24 hours or within the past 30 days. Select a valid value (0-3) for each drug listed.

**Section XV Current Skill/Ability Assessment**

Complete the grid by indicating the results of the beneficiary's current skills and ability assessment. Select a valid value (0-4) for each listed area.

**Section XVI Current Work/School Schedule**

1. **Employment/School Hours per Week** – Indicate whether the beneficiary is employed or in school and the numbers of hours per week. Check only one option.
2. **Employment Type** – Indicate whether the beneficiary is in school or the employment type. Check only one option.
3. **Date of Last Employment and Occupation**– If the patient is no longer employed; indicate the date of last employment and the beneficiary's occupation.

**Section XVII Current Living Arrangement**

Complete the grid by indicating the beneficiary's current living arrangements. Select only one option.

**Section XVIII Resource/Needs Assessment**

Complete the grid by indicating the results of the beneficiary's resource/needs assessment. Select a valid value (0-4) for each listed area.

**Section XX Studies/Labs/X-rays**

Record the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses. Be sure to include pertinent abnormal results.

**Section XXI Medications**

1. **Medication List** – Complete the medication grid by recording the date of order, the medication's name, dosage, frequency, and route. If the medication was discontinued prior to submission of the review request, record the date of discontinuation. Include oral "stat" medications and adjustments to routine medications.
2. **Is the beneficiary compliant with home medications?** Indicate whether the beneficiary has been compliant with home medications.
  - A. If **yes**, this section is complete.
  - B. If **no**, indicate the length of time of the non-compliance.

**Section XXII Treatment Plan/Frequency**

List all planned treatment beginning with those related to the current diagnosis/diagnoses. Include up to five of the most urgent goals that will address specifically the diagnosis/diagnoses and specific reason for this service level.

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**Section XXIII Discharge Plans**

1. **Will/can the beneficiary return to current living arrangements?** Indicate whether the beneficiary will/can return to his or her current living arrangements.
2. **Anticipated Discharge Date** – Record the anticipated discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to an acute care hospital, record the hospital's name in the space provided. If the beneficiary is released to custody of DHS or DYS, record the county. If none of the listed options are appropriate, check "Other" and specify the location in the space provided.
4. **Anticipated Follow-Up Care** - Indicate the anticipated follow-up care for the beneficiary. If none of the listed options are selected, check "Other" and specify the anticipated follow-up plans in the space provided.

**Section XXIV Clinician Attestation, Signature and Date**

1. **Signature of MYPAC Medical Director and Date** - When submitting certification requests by fax or mail the MYPAC Waiver provider's medical director must sign this form. Although the form can be completed by any MYPAC staff responsible for supporting certifications for proposed services to Medicaid beneficiaries, the medical director must validate that the information documented on this form is correct to the best of their knowledge and that the information to be submitted to HSM is medically necessary.

**Note:** 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, must be attached to this form. This evaluation must be performed with in the last 60 days prior to the proposed admission date.