HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

YOUTH'S INFORMATION	PROVIDER INFORMATION
Youth's Name: *(Please print)* ____________________ MS Medicaid #: ☐☐☐☐☐☐☐☐☐ Check if no active Medicaid #: ☐ Enter Soc. Sec. # below: ☐☐☐-☐☐-☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐ Sex: ☐ Age: ☐☐ Guardian/Representative Name: *(Please print)* ____________________ Guardian/Representative Address: *(Please print)* ____________________ ____________________	MYPAC Medicaid #: ☐☐☐☐☐☐☐☐ MYPAC Provider Name: *(Please print)* ____________________ Request Date: ☐☐/☐☐/☐☐ Requester's Name: (Please print.) ____________________ Phone #: (☐☐☐) ☐☐☐-☐☐☐☐ Ext. ☐☐☐☐☐ **NOTE:** Attestation Statement on last page of form must be signed and dated by the physician.

PHYSICIAN INFORMATION

Medical Director Name: *(Please print)* ____________________ Medical Director Address: (only if no MS Medicaid #) *(Please print)* ____________________ ____________________	Medical Director MS Medicaid #: ☐☐☐☐☐☐☐☐ Medical Director Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

MEDICAL INFORMATION

Planned Date of Admission: ☐☐/☐☐/☐☐ IQ: ☐☐☐

Diagnoses 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.	

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

Beneficiary Name:	**Medicaid#:**
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:** ☐☐☐ **Current GAF Score:** ☐☐☐

REQUESTED SERVICES

HCPCS Code	**Description**	**Dates of Service**		**Total Unit (s) Requested**	
		From	**Thru**		
H2022	Wrap around	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	Days: *(Maximum = 365)*	☐☐☐
T2022	Case Management	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	Months: *(Maximum = 12)*	☐☐
H0045	Respite	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	Days: *(Maximum = 29 at initial cert)*	☐☐

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

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PAST TREATMENTS

Did the youth receive other related health care services prior to being recommended for MYPAC services?

☐ Yes ☐ No ☐ Unknown If **yes**, complete the following **Treatment History** section.

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

		Latest Discharge date
# Psychiatric Inpatient Admits	☐ None ☐ 1 ☐ 2 ☐ 3-5 ☐ 6 or more	__ __ / __ __ / __ __
Other Care/Institution	☐ None ☐ NF ☐ ICF/MR ☐ PRTF	__ __ / __ __ / __ __

	Community Mental Health Center	Outpatient Hospital Provider	Private Practice	Discharge date *Leave blank if active care.*
☐ Day Treatment	☐	☐	☐	__ __ / __ __ / __ __
☐ Case Management Services	☐	☐	☐	__ __ / __ __ / __ __
☐ Psychosocial Rehab	☐	☐	☐	__ __ / __ __ / __ __
☐ Medication management	☐	☐	☐	__ __ / __ __ / __ __
☐ Individual therapy	☐	☐	☐	__ __ / __ __ / __ __
☐ Group therapy	☐	☐	☐	__ __ / __ __ / __ __
☐ Family therapy	☐	☐	☐	__ __ / __ __ / __ __
☐ Outpatient Substance Use treatment	☐	☐	☐	__ __ / __ __ / __ __
☐ NA or AA Support Groups	☐	☐	☐	__ __ / __ __ / __ __
☐ NAMI or Other Mental Health Support Groups	☐	☐	☐	__ __ / __ __ / __ __
☐ Other (specify Below)				__ __ / __ __ / __ __

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST 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	☐	☐	☐	☐	☐	☐
	Self-Injurious Behavior	☐	☐	☐	☐	☐	☐
	Current plan to kill / injure self, requiring medical Tx.	☐	☐	☐	☐	☐	☐
	Homicidal Thought / Behavior	☐	☐	☐	☐	☐	☐
	Recent attempt to kill or seriously injure another person	☐	☐	☐	☐	☐	☐
	Aggressiveness	☐	☐	☐	☐	☐	☐
	Uncontrolled Impulsiveness	☐	☐	☐	☐	☐	☐
	Sexual Trauma Perpetrator	☐	☐	☐	☐	☐	☐

Behavioral/Evidence *(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.)*

		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	☐	☐	☐	☐	☐	☐
	Hallucinations – Non-Acute	☐	☐	☐	☐	☐	☐
	Delusions	☐	☐	☐	☐	☐	☐
	Paranoia	☐	☐	☐	☐	☐	☐
	Disorganized / Disoriented	☐	☐	☐	☐	☐	☐
Mood	Gross psychomotor retardation from depression	☐	☐	☐	☐	☐	☐
	Depressed Mood	☐	☐	☐	☐	☐	☐
	Mood Swings	☐	☐	☐	☐	☐	☐
	Mania	☐	☐	☐	☐	☐	☐
	Crying / Tearful	☐	☐	☐	☐	☐	☐
Anxiety	Anxiety / Panic Attacks	☐	☐	☐	☐	☐	☐
	Phobia	☐	☐	☐	☐	☐	☐
	Obsessions/Compulsions	☐	☐	☐	☐	☐	☐
Behavior	Social Withdrawal	☐	☐	☐	☐	☐	☐
	Binging / Purging	☐	☐	☐	☐	☐	☐
	Fire Setting	☐	☐	☐	☐	☐	☐
	Cruelty to Animals	☐	☐	☐	☐	☐	☐
	Property Destruction	☐	☐	☐	☐	☐	☐
	Oppositional Behavior	☐	☐	☐	☐	☐	☐
	Sexual Acting Out	☐	☐	☐	☐	☐	☐
	Sexual Promiscuity	☐	☐	☐	☐	☐	☐
	Running Away	☐	☐	☐	☐	☐	☐

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST 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	☐	☐	☐	☐	☐	☐
	Truancy	☐	☐	☐	☐	☐	☐
	Distractibility	☐	☐	☐	☐	☐	☐
	Hyperactivity	☐	☐	☐	☐	☐	☐
	Lying / Manipulative	☐	☐	☐	☐	☐	☐
Addiction	Withdrawal	☐	☐	☐	☐	☐	☐
	Alcohol Use / Abuse	☐	☐	☐	☐	☐	☐
	Other Drug Use / Abuse	☐	☐	☐	☐	☐	☐
	Uncontrolled Gambling	☐	☐	☐	☐	☐	☐
	Sexual Addiction	☐	☐	☐	☐	☐	☐

Current Psychological Stressors/Events *(Check all that apply)*

- ☐ Recent Death
- ☐ Physical / Sexual / Emotional Abuse
- ☐ Recent Hospitalization
- ☐ Legal Issues
- ☐ Separation / Divorce
- ☐ Relapse / Decompensation
- ☐ Work / School Problems
- ☐ Custody / Placement
- ☐ Financial Difficulties
- ☐ Change in Living Situation
- ☐ Current Living Arrangement is Unstable
- ☐ 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	☐	☐	☐	☐	☐	☐
	Change in Energy Level	☐	☐	☐	☐	☐	☐
	Decreased Concentration	☐	☐	☐	☐	☐	☐
	Poor Self-Esteem	☐	☐	☐	☐	☐	☐
	Sleep Disturbance	☐	☐	☐	☐	☐	☐
Verbal Interaction	Argumentative	☐	☐	☐	☐	☐	☐
	Rapid / Pressured Speech	☐	☐	☐	☐	☐	☐
	Slurred / Incoherent Speech	☐	☐	☐	☐	☐	☐
	Mute	☐	☐	☐	☐	☐	☐

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

Beneficiary Name: **Medicaid#:**

Current Communication

	0 Unable to Assess	1 Yes	2 No
Verbal	☐	☐	☐
Expression Difficulty	☐	☐	☐
Sign Language	☐	☐	☐
Uses Communication Device	☐	☐	☐
Gestures	☐	☐	☐
Unable to Make Needs Known	☐	☐	☐

Current Drug Use

	0 Unable to Assess	1 None	2 Within Past 24 Hours	3 Within Past 30 Days
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crank	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Methamphetamine	☐	☐	☐	☐
PCP	☐	☐	☐	☐
Other	☐	☐	☐	☐

Current Skill/Ability Assessment

	0 Unable to Assess	1 Independe nt or N/A	2 Minimal Assistance	3 Moderate Assistance	4 Significant Assistance
Literacy / Basic Math	☐	☐	☐	☐	☐
Coping Skills / Emotional Mgmt.	☐	☐	☐	☐	☐
Personal Safety	☐	☐	☐	☐	☐
Medical / Medication Mgmt	☐	☐	☐	☐	☐
Social / Family Relations	☐	☐	☐	☐	☐
Personal Hygiene	☐	☐	☐	☐	☐
Childcare / Parenting	☐	☐	☐	☐	☐
Cooking / Nutrition	☐	☐	☐	☐	☐
Household Tasks / Chores	☐	☐	☐	☐	☐
Physical Mobility within Community	☐	☐	☐	☐	☐
Leisure / Recreational	☐	☐	☐	☐	☐
Financial Management	☐	☐	☐	☐	☐

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST FORM

Beneficiary Name: **Medicaid#:**

Current Work/School Schedule

Employment/School Hours Per Week	**Employment Type**	**Date of Last Employment:** ☐☐/☐☐/☐☐
☐ N/A	☐ School	
☐ None	☐ Employed by Company	
☐ 1-9 hours	☐ Self Employed	**Occupation:**
☐ 10-19 hours	☐ Sheltered Workshop	
☐ 20-39 hours	☐ Supported Employment	______________________
☐ 40 or more hours	☐ Volunteering	______________________
	☐ Unemployed	

Current Living Arrangement *(Select only one)*

☐ Alone	☐ Foster Home	☐ Shelter
☐ With Spouse	☐ Other Relative	☐ Assisted Living Facility
☐ Parent / Guardian	☐ Friend	☐ Personal Care Home
	☐ Group Residential Facility	☐ Other: *(Specify.)*
		______________________
		______________________

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	☐	☐	☐	☐	☐
Family/Social Support	☐	☐	☐	☐	☐
Community Individual Support	☐	☐	☐	☐	☐
Financial	☐	☐	☐	☐	☐
Healthcare	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐
Educational	☐	☐	☐	☐	☐
Vocational	☐	☐	☐	☐	☐

Studies/labs/x-rays *(List any diagnostic studies and tests and findings that are associated with the primary diagnosis)*

Date	**Study/Lab/X-Ray**	**Results/Findings**
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
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☐☐/☐☐/☐☐		

HealthSystems of Mississippi
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MEDICATIONS

Date Ordered	Medication, Dosage, Frequency & Route	Date Discontinued *(if applicable)*
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
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☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐

Is the beneficiary compliant with home medications? ☐ Yes ☐ No ☐ Unknown

If **no**, length of non-compliance:

☐ within in last month ☐ within past three months ☐ within past six months ☐ sporadically compliant

TREATMENT PLAN/FREQUENCY (***Include treatment related to the primary diagnosis. Include up to five of the most urgent goals.***)

HealthSystems of Mississippi
MYPAC ADMISSION CERTIFICATION REQUEST 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 MYPAC Waiver 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 or its equivalent and the potential for benefit from psychiatric residential treatment or its equivalent is attached to this form. This evaluation was performed within the last 60 days prior to the proposed admission date.

______________________________________ ______________________________

MYPAC Waiver Medical Director'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.