

# HealthSystems



HealthSystems  
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the main title text.

# **MYPAC Provider Manual**

**Effective 01/01/09**

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# Of Mississippi

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## ***I. Introduction***

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform precertification for Mississippi Youth Programs Around the Clock (MYPAC) waiver services rendered to Mississippi Medicaid beneficiaries. We perform precertification review activities for case management, wraparound and respite services.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and process.

## **II. Getting Started – Helpful Tips**

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov/MYPAC.aspx>.

MYPAC waiver services are available for Mississippi Medicaid beneficiaries under the age of 21. In order to qualify for MYPAC, the youth must:

- Be diagnosed with a Serious Emotional Disturbance (SED).
- Meet the same level of care criteria for admission to a psychiatric residential treatment facility (PRTF).
- Be Medicaid eligible or has applied for Medicaid.

MYPAC services are not considered emergent in nature and must be precertified with HSM.

Request for precertification are submitted to HSM following:

- Completion of an independent evaluation performed within 60 days prior to the proposed admission date. The psychiatric evaluation must be performed by a psychiatrist or a licensed psychologist and must include IQ testing, **or**
- Addendum of an independent evaluation that is greater than 60 days prior to the proposed admission date. The addendum must include a clinical summation and recommendations for care, **or**
- A pre-discharge recommendation if the beneficiary is in an acute care setting prior to request for placement in the MYPAC provider, **and**
- Discussion between the assessing clinician and the youth's legal guardian, or representative/responsible party, **and**
- Agreement between the attending physician, the MYPAC provider and the youth's legal guardian, or representative/responsible party regarding the services.

The MYPAC Waiver Program is able to provide services to a predefined number of youth for each year of the waiver. HSM will verbally notify the requester if the maximum number of participants has been reached for the MYPAC program. When this occurs, HSM will not proceed with precertification review.

### **III. Information You Need to Know**

Required forms and instructions are included in this manual and can be downloaded from the HSM Web site at [www.hsom.org](http://www.hsom.org).

A dedicated MYPAC fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides the most expedient response to your request. The table below lists fax and phone numbers, and hours of operation.

<b>Purpose</b>	<b>Description</b>	<b>Hours of Operation and Number(s)</b>
MYPAC Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	Hours: 24 hours, 7-days a week.  Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next working day.  FAX: 1-888-204-0504  Mail: Attn: HSM – MYPAC 175 East Capitol Street Jackson, MS 39201
Helpline	Used by providers for questions regarding the precertification process and to obtain assistance.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)  Local: 601-360-4949  Toll Free: 1-866-740-2221
Hot Line	Number to use to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)  Toll Free: 1-888-204-0221

#### ***Electronic Helpline Inquiries***

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. One of the benefits to providers who are enrolled to use the electronic Web system is that you can check the status of your reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

If you do not have a HSM logon, contact HSM's Education Department at [education@hsom.org](mailto:education@hsom.org) or by phone at (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers.
- Color monitor.
- 28.8K modem connection or higher (phone line quality will determine speed of connection).
- Internet Explorer Version 4.0 or higher.

#### **IV. MYPAC Review Exclusions**

Medicaid policy exempts certain encounters from HSM review and the provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

<b>Reason</b>	<b>Description</b>
No Medicaid Eligibility	If the patient has applied for Medicaid and the <u>eligibility determination is pending</u> , HSM will review the request and follow the process described in the <i>Notification of Review Outcome</i> section of this manual.
Medicare Eligibility	No HSM review is allowed if the beneficiary has Medicare Part A and Part B coverage for the encounter timeframe and the Medicare benefits are not exhausted.
Adult Beneficiaries	No HSM review is required for beneficiaries who have attained age 21. MYPAC services are not available for <u>age 21 and over</u> .
Duplication of Services	No HSM review is allowed if a review determination has already been rendered for the requested services for a different provider.
Family Planning Waiver	No HSM review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.

**Notes:**

Certification should be obtained from HSM when the youth:

- Has Medicare Part A and Part B and benefits are exhausted and the beneficiary has private insurance.
- Has Medicaid eligibility and third party insurance.

### **V. MYPAC HCPCS Codes Requiring Precertification**

MYPAC Waiver providers must precertify services through HSM. Service codes, narrative descriptions and maximum units/days are listed in the following table.

<b>HCPCS Codes</b>	<b>Descriptions</b>	<b>Units/Days</b>	<b>Notes</b>
T2022	Case Management	12 months per fiscal year	One year must be requested when youth initially admitted to program.
H2022	Community Based Wraparound	365 days	One year must be requested when youth initially admitted to program.
H0045	Respite	Up to 29 days at a time	The beneficiary must be discharged from MYPAC if 29 consecutive days of respite have been used and the beneficiary cannot be safely discharged. DOM must be notified of the discharge.  No more than 45 days total certified per DOM fiscal year.

## **VI. Precertification Review Process**

### **A. Requests for Precertification Review**

Providers submit requests for review directly to HSM. Reviews may be submitted by fax or mail. Please refer to Forms and Instructions section of this manual for the approved forms or the forms may be downloaded from the HSM Web site at [www.hsom.org](http://www.hsom.org).

A review for initiation of a service(s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically indicated and appropriate. These are called continued stay reviews.

Case Management and community based wrap-around services are reviewed for medical necessity and appropriateness. Respite services are reported to HSM; this service must be entered via HSM's Web Utility when an HSM Treatment Authorization Number has previously been issued.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review. Required forms and instructions are included in the *Forms and Instructions* section of this for providers without web technology.

<b>Review Type</b>	<b>Timeframe</b>	<b>Required Documentation</b>
Preadmission Certification	At least 3 business days prior to initiation of MYPAC waiver services.	Fax or mail the following to HSM: <ul style="list-style-type: none"> <li>• Completed HealthSystems of Mississippi MYPAC Admission Certification Request Form.</li> <li>• A completed and signed freedom of choice form.</li> <li>• A copy of an independent evaluation performed within 60 days prior to proposed admission date. The psychiatric evaluation must be performed by a psychiatrist or a licensed psychologist.</li> <li>• If the evaluation is greater than 60 days, HSM will accept the evaluation with an update or addendum. The addendum must include the clinical summation and recommendation for the care.</li> </ul> <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> <li>• A pre-discharge recommendation in lieu of the independent evaluation if the youth is in an acute care setting prior to placement in the MYPAC Waiver.</li> </ul>
Once the beneficiary has been admitted:	At least 30 business days post admission to MYPAC waiver services.	Fax or mail the following to HSM: A copy of the Individualized Service Plan (ISP).
Continued Stay/Recertification request:	At least 30 days prior to the last date certified by HSM.	Fax or mail the following to HSM: <ul style="list-style-type: none"> <li>• Completed HealthSystems of Mississippi MYPAC Continued Stay/Recertification Request Form.</li> <li>• A copy of the most current Individualized Service Plan indicating the necessity of continuing the current level of care. Plan should be dated no more than 30 days from the date of the request.</li> <li>• A copy the most current CANS – MH, dated no more than 60 days from the date of the request.</li> <li>• A copy of the WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.</li> </ul>

## B. Processing of Review Requests

HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make certification review determinations for MYPAC Waiver services. The following table describes our staff's functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> <li>• Screen request for completeness. May request additional non-clinical information.</li> <li>• Perform verbal notification of review determination, as appropriate.</li> <li>• Support all review functions.</li> </ul>
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> <li>• Apply DOM policy.</li> <li>• Apply explicit DOM approved medical necessity clinical guidelines.</li> <li>• Apply quality of care triggers and screens.</li> <li>• May request additional information.</li> <li>• Approves services based on policy or criteria.</li> <li>• Refer requests that cannot be approved for physician determination.</li> </ul>
Physician Advisors (Reviewers)	<ul style="list-style-type: none"> <li>• Make certification, denial or reconsideration determinations. That decision is: <ul style="list-style-type: none"> <li>- Based on documentation that supports medical necessity and appropriateness of setting.*</li> <li>- Patient-centered and takes into consideration the unique factors associated with each patient care episode.</li> <li>- Sensitive to the local healthcare delivery system infrastructure</li> <li>- Based on his or her clinical experience, judgment and generally accepted standards of healthcare.</li> </ul> </li> <li>• May request additional information.</li> </ul> <p>*The physician reviewer may request additional information and attempt to contact the MYPAC Waiver Provider's medical director to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p><b>Note:</b> See the Reconsideration Process section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review can not proceed because ...	Then ...	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	<ul style="list-style-type: none"> <li>• Preadmission</li> <li>• Continued Stay</li> </ul>	One business day.

### C. Notification of Review Outcome

HSM provides written notification of review results to the MYPAC provider and to the youth's legal guardian or representative/responsible party when services are denied. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Providers also receive verbal notice of denials.

The MYPAC provider/medical director and youth's legal guardian/representative/responsible party may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the youth's legal guardian/representative/responsible party may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information.

The following table contains the details of the review outcome notification process based on review outcome.

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> <li>Written notification of approval review results is sent to the MYPAC provider.</li> <li>Verbal notification will only occur if the provider is unable to receive written auto-fax notification.</li> </ul>
Denial	<ul style="list-style-type: none"> <li>If HSM determines that services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply.</li> <li>Written notification of denial determination is sent to the MYPAC provider and the youth's legal guardian/representative/responsible party.</li> <li>The youth's legal guardian/representative/responsible party's notice does not contain the medical basis for the denial.</li> <li>Verbal notice is also given to the MYPAC provider.</li> </ul>
Suspended	<ul style="list-style-type: none"> <li>HSM will notify the requester (verbally and in writing) when additional information is required and the review will be pended. If the requested information is not submitted by the due date HSM issues a written notice of Review Suspended.</li> </ul>

Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> <li>Preadmission</li> <li>Continued Stay</li> </ul>	Within three business days of receipt of review request and necessary information.	Within one business day of review determination.

*Medicaid Ineligible Youth*

- If a youth is not Medicaid eligible when the review is initiated:
  - HSM will assign a pseudo number (Temporary ID).
  - The pseudo number will be used on all forms/documents/correspondence submitted to HSM until an active Medicaid number is assigned.
  - If HSM determines that services are medically necessary and appropriate, the Division of Medicaid will determine whether the youth meets Medicaid financial eligibility requirements. This may take up to 45 days.

If the youth is	Then
Determined to be financially eligible	<ul style="list-style-type: none"> <li>• DOM will notify HSM of the youth’s active Medicaid number.</li> <li>• HSM will update the pseudo number with the youth’s active Medicaid number on all correspondence.</li> <li>• HSM will notify the MYPAC waiver provider of the medical necessity review certification (approval).</li> </ul>
Determined not to be financially eligible	<ul style="list-style-type: none"> <li>• DOM will notify the provider.</li> <li>• HSM will end the review process.</li> </ul>

- If HSM determines that services are not medically necessary and appropriate we will issue a denial letter. Reconsideration rights will apply.

*Content of Written Notices of Review Outcome*

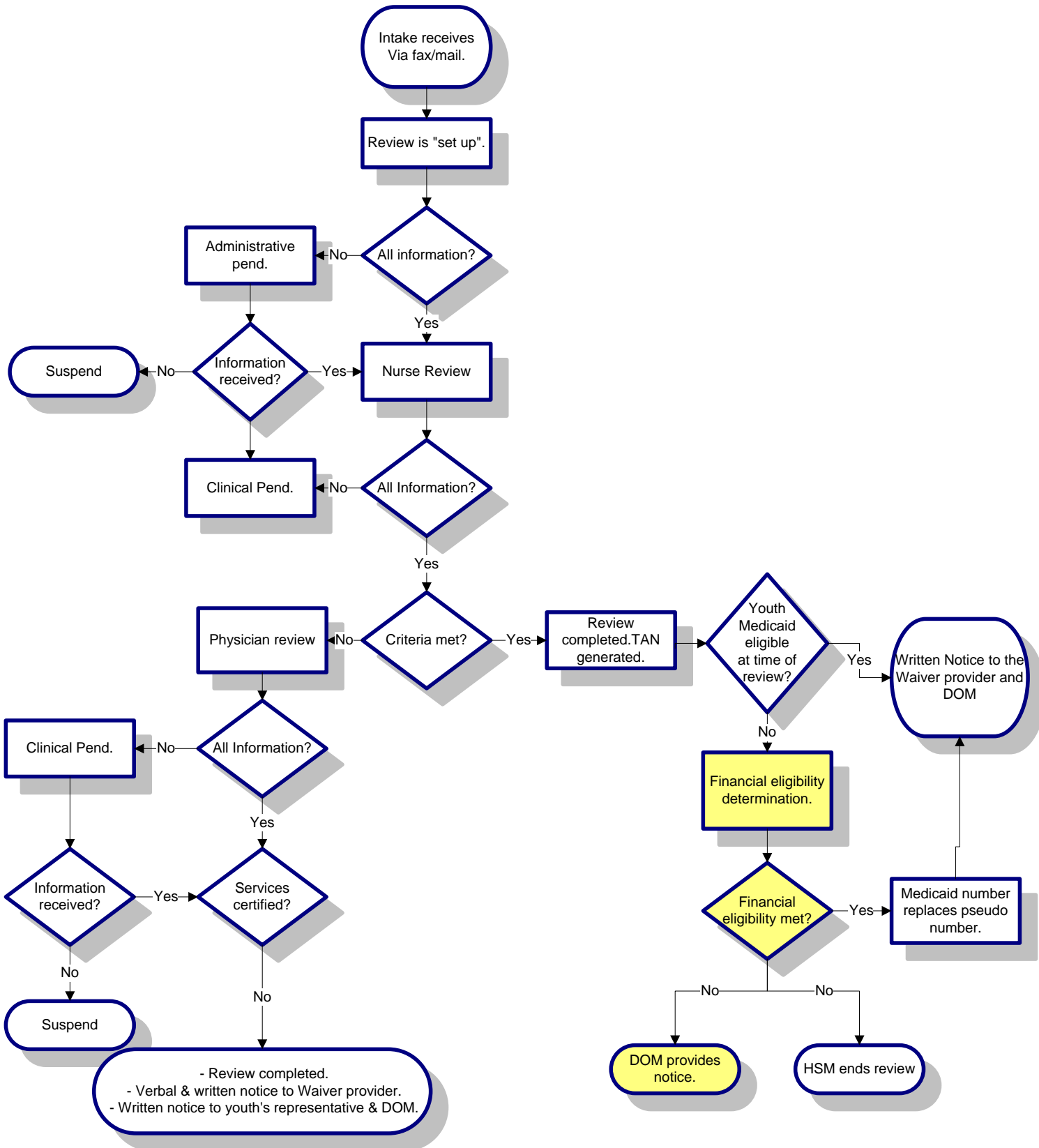
Written notifications of review certification (approval) and determinations involving denials are sent to the various parties as noted above.

Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Continued Stay/Recertification
Certification (Approval)	Date of notice	√	√
	Brief statement of HSM’s authority and responsibility for review	√	√
	Reason for determination	√	√
	Date(s) of service being approved	√	√
	Type service certified	√	√
	Number of units/days certified	√	√
	Total number & type services certified to date	√	√
	Total time span approved to date	√	√
	Treatment Authorization Number (TAN)	√	√
Denial	Date of notice.	√	√
	Brief statement of HSM’s authority and responsibility for review.	√	√
	Principal and clinical reason for denial.	√	√
	Type of services, number of units, and dates of services being denied.	√	√
	Total number and time span for previously certified procedures or services.		√
	Process for submitting a reconsideration request.	√	√
	Reconsideration timeframes.	√	√

**D. Review Process Flow Chart**

Key: Black by HSM  
Yellow by DOM



### ***VII. Reconsideration Review***

If any of the following parties disagrees with the determination made by HSM, a request for reconsideration may be requested.

- Youth's legal guardian/representative/responsible party
- MYPAC Waiver Provider
- MYPAC Medical Director

A second physician, one not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld, the youth's legal guardian or representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Manual*** for additional details.

### ***VIII. Quality Review Process***

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving MYPAC Waiver services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM.

HSM identifies aberrant patterns and/or trends by provider. Quality sampling may include health care services provided to all age groups.

Please see the *Quality Review Process Manual* for additional details.

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***IX. Utilization Analysis, Focused Studies, Outcome Reports and  
Proposals for Improving Health Care Delivery System***

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

***X. Forms and Instructions***

- Admission Certification Review Request
- Continued Stay Certification Review Request
- Additional Information

# HealthSystems of Mississippi

## MYPAC ADMISSION CERTIFICATION REQUEST FORM

YOUTH'S INFORMATION	PROVIDER INFORMATION
<p>Youth's Name: <i>(Please print)</i></p> <p>_____</p> <p>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"/> <input type="text"/> <input type="text"/></p> <p>Check if no active Medicaid #: <input type="checkbox"/> Enter Soc. Sec. # below:</p> <p><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"/></p> <p>Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/></p> <p>Guardian/Representative Name: <i>(Please print)</i></p> <p>_____</p> <p>Guardian/Representative Address: <i>(Please print)</i></p> <p>_____</p> <p>_____</p>	<p>MYPAC Medicaid #:</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>MYPAC Provider Name: <i>(Please print)</i></p> <p>_____</p> <p>Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Requester's Name: <i>(Please print.)</i></p> <p>_____</p> <p>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"/></p> <p>Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><b>NOTE:</b> Attestation Statement on last page of form must be signed and dated by the physician.</p>

### PHYSICIAN INFORMATION

<p>Medical Director Name: <i>(Please print)</i></p> <p>_____</p> <p>Medical Director Address: (only if no MS Medicaid #) <i>(Please print)</i></p> <p>_____</p> <p>_____</p>	<p>Medical Director MS Medicaid #:</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Medical Director Phone #:</p> <p>(<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"/></p>
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### MEDICAL INFORMATION

Planned Date of Admission:   /   /        IQ:

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.	

**HealthSystems of Mississippi  
MYPAC ADMISSION CERTIFICATION REQUEST FORM**

<b>Beneficiary Name:</b>		<b>Medicaid#:</b>			
<b>Axis III (ICD-9-CM Codes)</b>		<b>Narrative Descriptions</b>			
1.					
2.					
3.					
<b>Axis IV (ICD-9-CM Codes)</b>		<b>Narrative Descriptions</b>			
1.					
2.					
3.					
<b>Axis V</b>		<b>Baseline GAF Score:</b> <input type="text"/> <input type="text"/> <input type="text"/>		<b>Current GAF Score:</b> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>REQUESTED SERVICES</b>					
HCPCS Code	Description	Dates of Service		Total Unit (s) Requested	
		From	Thru		
H2022	Wrap around	<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"/>	Days: <i>(Maximum = 365)</i>	<input type="text"/> <input type="text"/> <input type="text"/>
T2022	Case Management	<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"/>	Months: <i>(Maximum = 12)</i>	<input type="text"/> <input type="text"/>
H0045	Respite	<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"/>	Days: <i>(Maximum = 29 at initial cert)</i>	<input type="text"/> <input type="text"/>

# HealthSystems of Mississippi

## MYPAC ADMISSION CERTIFICATION REQUEST FORM

<b>Beneficiary Name:</b>	<b>Medicaid#:</b>
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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.)

# 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"/> Case Management Services	<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"/> Medication management	<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"/> Group therapy	<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"/> Outpatient Substance Use treatment	<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"/> NAMI or Other Mental Health Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (specify Below)				

## HealthSystems of Mississippi MYPAC ADMISSION CERTIFICATION REQUEST FORM

Beneficiary Name:		Medicaid#:					
		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
<b>Current Symptoms/Behavior</b>							
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"/>
<b>Behavioral/Evidence</b> <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 MYPAC ADMISSION CERTIFICATION REQUEST FORM

<b>Beneficiary Name:</b>	<b>Medicaid#:</b>
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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
<input type="checkbox"/> Other: <i>(Describe)</i>		

**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

## MYPAC ADMISSION CERTIFICATION REQUEST FORM

<b>Beneficiary Name:</b>		<b>Medicaid#:</b>			
<b>Current Communication</b>					
	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"/>		
<b>Current Drug Use</b>					
	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"/>	
<b>Current Skill/Ability Assessment</b>					
	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

## MYPAC ADMISSION CERTIFICATION REQUEST FORM

<b>Beneficiary Name:</b>	<b>Medicaid#:</b>
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<b>Current Work/School Schedule</b>		
<b>Employment/School Hours Per Week</b>	<b>Employment Type</b>	<b>Date of Last Employment:</b> <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"/> 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	<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	<b>Occupation:</b> _____ _____

<b>Current Living Arrangement</b> <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> _____ _____

<b>Resource/Needs Assessment</b>					
	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"/>

<b>Studies/labs/x-rays</b> <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

## MYPAC ADMISSION CERTIFICATION REQUEST FORM

<b>Beneficiary Name:</b>	<b>Medicaid#:</b>
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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
- 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.**

**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.

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

**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.

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

**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.

# HealthSystems of Mississippi

## MYPAC Continued Stay/Recertification Request Form

YOUTH'S INFORMATION	PROVIDER INFORMATION
Youth's Name: <i>(Please print)</i> _____ 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"/> <input type="text"/> <input type="text"/>	MYPAC 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"/>
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	MYPAC Provider Name: <i>(Please print)</i> _____
Sex: <input type="text"/> Age: <input type="text"/> <input type="text"/>	Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Guardian/Representative Name: <i>(Please print)</i> _____	Requester's Name: <i>(Please print)</i> _____
Guardian/Representative Address: <i>(Please print)</i> _____ _____	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"/>

PHYSICIAN INFORMATION
Medical Director Name: <i>(Please print)</i> _____ Medical Director 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"/> <input type="text"/> <input type="text"/> 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"/>

MEDICAL INFORMATION
Date of admission: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Treatment Authorization Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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.		
<b>Axis V</b>	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

## MYPAC Continued Stay/Recertification Request Form

Beneficiary Name: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

REQUESTED SERVICES				
HCPCS Code	Description	Dates of Service		Total Unit (s) Requested
		From	Thru	
H2022	Wrap around	<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"/>	Days: <i>(Maximum = 365)</i> <input type="text"/> <input type="text"/> <input type="text"/>
T2022	Case Management	<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"/>	Months: <i>(Maximum = 12)</i> <input type="text"/> <input type="text"/>
H0045	Respite	<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"/>	Days: <i>(Maximum = 29 at initial cert)</i> <input type="text"/> <input type="text"/>

**Specifically, why does the beneficiary need continued MYPAC services? Please describe what will be the focus of continued MYPAC 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"/>

## HealthSystems of Mississippi MYPAC Continued Stay/Recertification Request Form

Beneficiary Name: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

<b>Behavioral/Evidence</b> <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"/>
		0 Unable to Assess	1 None	2 History (Now Stable)	3 Mild/ Infrequent	4 Moderate/ Frequent	5 Severe/ Acute Crisis
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"/>
	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"/>

# HealthSystems of Mississippi

## MYPAC Continued Stay/Recertification Request Form

Beneficiary Name: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

**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"/>	<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"/>

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"/>

## HealthSystems of Mississippi MYPAC Continued Stay/Recertification Request Form

Beneficiary Name: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

<b>Current Skill/Ability Assessment</b>					
	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"/>

<b>Resource/Needs Assessment</b>					
	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"/>

<b>Studies/labs/x-rays</b> <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="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"/> / <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"/> / <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"/>		
<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"/> / <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>		



# HealthSystems of Mississippi

## MYPAC Continued Stay/Recertification 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)*

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acute Care<br><input type="checkbox"/> Custody DHS<br><input type="checkbox"/> Custody DYS<br><input type="checkbox"/> Home with family<br><input type="checkbox"/> Group home<br><input type="checkbox"/> Foster home<br><input type="checkbox"/> Shelter<br><input type="checkbox"/> Independent living<br><input type="checkbox"/> Left AMA<br><input type="checkbox"/> Other: <i>(Specify.)</i> | Facility: _____<br>County: _____<br><br><input type="checkbox"/> Case Management<br><input type="checkbox"/> Day Treatment - CMHC<br><input type="checkbox"/> DME<br><input type="checkbox"/> Family Therapy<br><input type="checkbox"/> Follow-Up w/PCP /Specialist<br><input type="checkbox"/> Follow-Up w/Pharmacy<br><input type="checkbox"/> Group Therapy<br><input type="checkbox"/> Home Health<br><input type="checkbox"/> Individual Therapy<br><input type="checkbox"/> Other: <i>(Specify.)</i> | <input type="checkbox"/> Med Management<br><input type="checkbox"/> PDN<br><input type="checkbox"/> OT/PT/ST Outpatient Therapy<br><input type="checkbox"/> SNF/NH<br><input type="checkbox"/> Substance Abuse Counseling<br><input type="checkbox"/> 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.**

# HealthSystems of Mississippi

## Instructions for Completing the MYPAC Continued Stay/Recertification 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. **Date of Birth** - Enter the month, date, and year of the youth's birth.
4. **Sex** - Indicate the sex of the youth.
5. **Age** - Enter the age of the youth at the time service is to be rendered.
6. **Guardian/Representative Name** - Enter the name of the youth's legal guardian/representative.
7. **Guardian/Representative Address** - Enter the mailing address of the 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 MS Medicaid #** - Enter the MS Medicaid ID number of the medical director.
3. **Medical Director Phone #** - Enter the phone number of the MYPAC Waiver provider's medical director.

### Section IV Medical Information

1. **Date of Admission** - List the date services began for the admission for which continued services are requested and for which a treatment authorization number (TAN) was previously issued.
2. **Treatment Authorization Number** - This is the TAN number provided to you during the initial precertification review.

### Section V New Diagnoses Since Last Review

1. **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 VI 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.**
  - **Dates of Service** - Indicate date service will start and the date thru which the service is requested.
  - **Units** - Record the total number of units requested. Please do not exceed the maximum units allowed.
2. **Specifically, why does the beneficiary need continued MYPAC services? Please describe what will be the focus of continued MYPAC services.** Record a response in the space provided.

### Section VII 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.

### Section VIII Behavioral/Evidence

The behavior/evidence section 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.

Complete the grid by indicating the behavior or evidence demonstrated by the beneficiary. Select a valid value (0-5) for each listed area.

### Section IX 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.

**HealthSystems of Mississippi**  
**Instructions for Completing the MYPAC Continued Stay/Recertification Request Form**

**Section X 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 XI 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 XII 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 XIII 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 XIV 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 XV 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 XVI 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 XVII Response to Treatment Plan for Previous Review Period**

Please evaluate and provide the percentage of completion of the overall treatment plan as a whole in which treatment interventions were requested during the previous review period. Example: If all goals and objectives were met during the previous review period select option 1. If no progress was made and option 4 was selected, provide an explanation. Available options are listed below.

- Successfully met all goals and objectives
- Partially met goals and objectives
- Minimally met goals and objectives
- No progress evident

**Section XVIII Current 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.

**HealthSystems of Mississippi**  
**Instructions for Completing the MYPAC Continued Stay/Recertification Request Form**

**Section XIX 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. If the beneficiary was discharged prior to submission of the review request, indicate whether the beneficiary returned to his or her living arrangement in place at the time of inpatient admission.
2. **Anticipated Discharge Date** – Record the anticipated discharge date. If the patient has been discharged, record the actual discharge date.
3. **Anticipated discharge to:** - Indicate the anticipated discharge location or care arrangement. If the beneficiary is transferred to a different 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. If the beneficiary was discharged prior to submission of the review request, indicate the actual discharge location or care arrangement for the beneficiary.
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. If the beneficiary was discharged prior to submission of the review request, indicate the actual follow-up plans for the beneficiary.

**Section XX 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:**

Include a copy of the following:

- A current ISP indicating the necessity of continuing the current level of care. The ISP must be dated no more than 30 days prior to this request.
- Current CANS – MH, dated no more than 60 days prior to the date of this request.
- WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.

