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

YOUTH'S INFORMATION

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.
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.
Check If no active Medicaid # – Check the box if the youth does not have an active Mississippi Medicaid ID.
Soc. Sec. # - If Mississippi Medicaid has been applied for, enter the youth's social security number.
Date of Birth – Enter the month, date, and year of the youth's birth.
Sex - Indicate the sex of the youth.
Age - Enter the age of the youth at the time service is to be rendered.
Guardian/Representative Name – Enter the name of the youth's legal guardian/representative.
Guardian/Representative Address – Enter the mailing address of the guardian/representative.

PROVIDER INFORMATION

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

PHYSICIAN INFORMATION

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

Medical Information

Date of Admission – Enter the month, date and year of the planned admission.
Last Date Certified – Enter the thru date of the Treatment Authorization Number for the admission.
Treatment Authorization Number – Enter the Treatment Authorization Number given for the admission.
Diagnosis/Multi- Axis – Enter the youth's current diagnoses (five parts of multi-axial).
ICD – 9-CM Codes - Enter the ICD-9-CM codes that correspond with each of the listed diagnosis.

REQUESTED SERVICES

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.

CLINICAL INFORMATION

Current Behavior - List a detailed explanation why the youth continues to require this intensity of services.
Treatment Plans and response to treatment - List the treatment plans and response to treatment from admission to present. Check the appropriate level of goals met; successfully is 80% - 100%; partially 51% - 79%; minimally 50% or less; none 10% or less.
Reason for continued services - List the specific goals to be met.
Anticipated Discharge Date - List the anticipated discharge date.
Anticipated Discharge Plans -

- Discharge To: List the place of discharge - Select one.
- Follow Up/Step Down Care: Check the box(es) that apply to what has been agreed upon with family and facility for the beneficiary.

Attachments - Include current ISP indicating the necessity of continuing the current level of care, dated no more than 30 days from the date of this request; current CANS – MH, dated no more than 60 days from the date of this request; WRAP meeting notes for the past two meetings, one of which must be within the last 30 days.
Comments – Any additional information HSM should know, that has not been previously provided.