

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"/> <input type="text"/> Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> Guardian/Representative Name: <i>(Please print)</i> _____ Guardian/Representative Address: <i>(Please print)</i> _____	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"/> <input type="text"/> MYPAC Provider Name: <i>(Please print)</i> _____ Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Requester's Name: <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"/> Medical Director 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"/> <input type="text"/> <input type="text"/> <input type="text"/>

New or Changed Diagnosis since Admission/Five Parts of Multi-Axial <i>(Please print)</i>	ICD-9-CM Codes
I.	
II.	
III.	
IV.	
V.	

REQUESTED SERVICES					
HCPCS Code	Description	Dates of Service		Additional 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 per cert)</i>	<input type="text"/> <input type="text"/>

Note: Respite – No more than 45 days total certified per DOM fiscal year.

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Beneficiary Name: _____ MS Medicaid #:

CLINICAL INFORMATION

Current Behavior: *Please provide a detailed explanation why the beneficiary continues to require this intensity of services:*

Treatment Plans and response to treatment for past review period *(please check one and indicate percentage):*

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

Explain: _____

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

Anticipated Discharge Date: <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"/>	
Anticipated Discharge To: <i>(Please check one)</i>	Follow Up/Step Down Care <i>(Check all that apply)</i>
<input type="checkbox"/> Acute Care Specify Facility: _____	<input type="checkbox"/> Case Management <input type="checkbox"/> Family Therapy
<input type="checkbox"/> Custody DHS Specify County: _____	<input type="checkbox"/> Day Treatment - CMHC <input type="checkbox"/> Group Therapy
<input type="checkbox"/> Custody DYS <input type="checkbox"/> Shelter	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Med Management
<input type="checkbox"/> Home with Family <input type="checkbox"/> Independent Living	<input type="checkbox"/> Vocational Rehab <input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Group Home <input type="checkbox"/> Left AMA	
<input type="checkbox"/> Foster Home	

Please attach copies of the following with this form:

- 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:

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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