**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

***CERTIFICATION OF NEED***

**Psychiatric Hospital Services for Children Under 21**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI or Medicaid Provider ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A review team has evaluated all of the information submitted by the physician and other professionals to justify the client's admission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and certifies that:

( ) Documentation of comprehensive psychological assessment conducted within one (1) week by a LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, risk assessment; and

( ) Ambulatory services available in the community do not meet the current treatment needs of the client; and

( ) Prior treatment addressing presenting concern/problem has not been successful; and

( ) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

( ) The inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.

**OR**

( ) According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate SCDHHS Eligibility Office.

**TEAM PHYSICIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Effective Date: \_\_\_\_\_\_\_ Check One**: Interdisciplinary Team \_\_\_ Independent Team \_\_\_

**OTHER TEAM MEMBERS' SIGNATURES, TITLES, AND DATE SIGNED:**

|  |  |
| --- | --- |
| Date | Signature |
|  |  |
|  |  |
|  |  |
|  |  |

 **A minimum of one signature must be present.**