Select Health of South Carolina

Healthy Connections

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 the information submitted by the physical and other professionals to justify the client's admission to _____ and certifies that:

☐ Documentation of comprehensive diagnostic assessment conducted within 10 business days by the LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, and risk assessment.

☐ Ambulatory services available in the community do not meet the current treatment needs of the client.

☐ Prior treatment addressing presenting concern/problem has not been successful.

☐ Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician.

☐ 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 print name:	
Team physician's signature:	Date:
Physician's NPI:	
Effective date:	Check one: ☐ Interdisciplinary team ☐ Independent team

Other team members' signatures, titles, and date signed: (A minimum of one signature must be present.)

Date	Print name	Signature