

# CERTIFICATION OF NEED FOR ADMISSION TO COMMUNITY-BASED RESIDENTIAL SERVICES FOR CHILDREN

Resident Name: \_\_\_\_\_ Placing Agency: \_\_\_\_\_

- 1. Explain how ambulatory/outpatient care does not meet the specific treatment needs of the recipient.**
  
- 2. Explain how proper treatment of the recipient's psychiatric condition requires services in a community-based residential program.**
  
- 3. Explain how the services can reasonably be expected to improve the recipient's condition or prevent regression so that the services will no longer be needed.**

- ❖ *Billing eligibility may only be determined by the most recent date on this form.*
- ❖ *For CSA children who are Medicaid recipients, this form must be completed and signed by the local CSA interdisciplinary team or FAPT (3 signatures) and signed by a physician.*
- ❖ *For Non-CSA children who are Medicaid recipients, this form must be completed and signed by the LMHP and a physician.*
- ❖ *The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON.*
- ❖ *For a recipient who applies for Medicaid while a resident at the facility, the certification must be made by the LMHP and a physician.*

Team Signatures:

1. \_\_\_\_\_ Date \_\_\_\_\_ 3. \_\_\_\_\_ Date \_\_\_\_\_

2. \_\_\_\_\_ Date \_\_\_\_\_ 4. \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

LMHP Signature (if applicable): \_\_\_\_\_ Date \_\_\_\_\_