

Youth Certificate of Need Psychiatric Residential Treatment Facility (PRTF)

Youth Information		
*NOTE: All fields must be legible to avoid a delay in processing and admission.		
Name:	DOB:	Medicaid ID:
Address:		City:
State:	Zip code:	
Admitting Facility Information		
Name:	NPI Number:	
Admission Information		
Proposed Admit Date:	Anticipated Discharge Date:	
Is this form being submitted with a Continued Stay (CSR) or Prior Authorization (PA) form?		
<input type="checkbox"/> Yes, CSR <input type="checkbox"/> Yes, PA <input type="checkbox"/> No		
At the Time the Above Youth Is Admitted, the Admitting Facility Certifies:		
*NOTE: Supporting documentation for selected statements must be included, in accordance with 42 CFR 441.152 and 441.153.		
<input type="checkbox"/> Treatment needs cannot be met by existing community resources <input type="checkbox"/> Treatment needs include an inpatient program with physician oversight <input type="checkbox"/> This treatment plan is expected to help improve the patient's health and/or prevent further regression so the services can end at or around the expected discharge date listed above		
Health Care Team Information		
Physician Name/Title:		
Signature:	Date:	
Phone:	Email:	
Mental Health Profession Name/Title:		
Signature:	Date:	
Phone:	Email:	
Individual Completing Form Name/Title:		
Signature:	Date:	
Phone:	Email:	
Notes		
The provider must maintain original, signed copy of this form for their records.		