MAP-569
(Rev. 5/90)

CERTIFICATION OF NEED BY INDEPENDENT TEAM
PSYCHIATRIC PREADMISSION REVIEW OF ELECTIVE ADMISSIONS FOR KENTUCKY MEDICAID RECIPIENTS UNDER AGE 21

PATIENT INFORMATION

NAME _____ MAID # _____
Last First MI

DOB _____ COUNTY OF RESIDENCE _____ RACE/SEX _____

FACILITY NAME _____ PLANNED ADMISSION DATE _____

PHYSICIAN INFORMATION

NAME _____ TELEPHONE # (_____)_____
Please type or print

ADDRESS _____

CERTIFICATION

I hereby certify the following:

1. I do not have an employment or consultant relationship with the admitting facility.
2. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
3. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
4. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
5. I have knowledge of the patient's situation and competence in diagnosis and treatment of mental illness.

_____ _____
Signature Date
Independent Team Physician

_____ _____
Signature Date
Other Independent Team Member

_____ _____
Signature Date
Other Independent Team Member

COMPLETE ON ALL ELECTIVE ADMISSIONS OF INDIVIDUALS WHO ARE MEDICAID ELIGIBLE AT TIME OF ADMISSION