# Montana Medicaid Youth Certificate of Need
# Psychiatric Residential Treatment Facility (PRTF)

**Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.**

| *Youth Information* | | | | | |
|---|---|---|---|---|---|
| NAME: | | | DOB: | SSN: | |
| ADDRESS: | | CITY: | | STATE: | ZIP: |
| ADMITTING FACILITY: | | | | MEDICAID NUMBER: | |
| PROPOSED ADMIT DATE: | EXPECTED DISCHARGE DATE: | PROVIDER NUMBER: | NPI NUMBER: | TAXONOMY: | |

**At the time of admission, the interdisciplinary team certifies the following:**

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| **( 1 ) Ambulatory care resources available in the community do not meet the treatment needs of the youth (include documentation):** |
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| **( 2 ) Proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician (include documentation):** |
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| **( 3 ) The services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed (include documentation):** |
| |

| | | |
|---|---|---|
| PRINT/TYPE NAME OF PHYSICIAN TEAM MEMBER | TITLE | DATE |
| SIGNATURE OF PHYSICIAN TEAM MEMBER | PHONE NUMBER | |
| PRINT/TYPE NAME OF MENTAL HEALTH PROFESSIONAL | TITLE | DATE |
| SIGNATURE OF MENTAL HEALTH PROFESSIONAL | PHONE NUMBER | |
| PRINT/TYPE NAME OF INDIVIDUAL COMPLETING FORM | TITLE | DATE |
| SIGNATURE OF INDIVIDUAL COMPLETING FORM | PHONE NUMBER | |

*** Complies with the Code of Federal Regulations**

To transmit request information:
Fax: 1-800-639-8982
Phone: 1-800-770-3084