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.

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| 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:

| ( 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): |
| --- | --- |
|       |

| ( 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): |
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|       |

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|       |  |       |       |
| 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 |

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|       |  |       |       |
| Print/Type Name of individual completing form |  | title | date |

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|  |  |       |
| Signature of individual completing form |  | phone number |

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