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:

| ( 1 ) | Ambulatory care resources available in the community do not meet the treatment needs of the youth (include documentation): |
| --- | --- |
|  | |

| ( 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): |
| --- | --- |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| 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**