

PM FORM 3.14.1
CERTIFICATE OF NEED/RECERTIFICATION OF NEED

NARBHA Member Name: _____ **INPT/RTC FACILITY:** _____

Member ID No.: _____ **AHCCCS ID** _____

(9 DIGITS from Medifax. If not on AHCCCS, then "N/A")

Time Period Covered: **From:** _____ (Date of Admit or Recert date for RON) **through:** _____

(CON or RON must include
all dates of services)

For person 21 yo or older: Max is 60 days;

For person 20 yo or under: Max is 30 days;

Level of Care (circle): **Inpatient-Hospital** **Subacute** **Level I** **RTC** **ASH**

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient. Explain: (MUST CHOOSE AT LEAST ONE)

- Imminent, recent, recurring or frequently intermittent episodes of risk of danger to self or other as a result of a treatable mental disorder or its treatment;
- Disturbance of mood, thought or behavior which renders the patient incapable of developmentally appropriate self-care or self-regulation as a result of a treatable mental disorder;
- Requires multi-specialty services only available in an inpatient setting at this frequency or intensity;
- Outpatient services have failed to provide adequate treatment;
- Other: _____

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. Explain: (MUST CHOOSE AT LEAST ONE)

- Has known medical risk factors or side effects which complicate treatment;
- Needs physician or nursing observation and control of behavioral/functioning for diagnostic evaluation and treatment planning;
- Needs ongoing physical assessments, medication administration and/or laboratory monitoring which can not be reasonably provided at a lower level of care;
- Care is complicated and requires integration of multi-specialty services to form cohesive treatment;
- Other: _____

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed. Explain: (MUST CHOOSE AT LEAST ONE)

- Individual is suffering from an acute incident or exacerbation of a treatable mental disorder that can be expected to resolve with proper diagnosis and management.
- Other: _____

CON-Signature of Certification Team MD/DO
RON-Signature of MD/DO/CNP/PA

Date*

DAYS (REQUIRED)

Estimated Total Length of Stay at Facility
(Doesn't have to match "Time Period Covered")

(* For emergency admits: dated within 72 hours for persons age 21 or older; or within 14 days of admission if person age 20 or under, for non-emergency admits: dated prior to admission. For RON: dated before expiration of prior CON/RON.)

For translation or alternative format requests, call 1-800-640-2123
Para recibir esta forma en espanol, llame a 1-800-640-2123
NORTHERN ARIZONA REGIONAL BEHAVIORAL HEALTH AUTHORITY (NARBHA)
1300 South Yale Street, Flagstaff, AZ 86001 (928) 774-7128

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