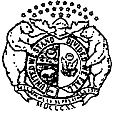

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

Certification of Need for Psychiatric Services

Name of Patient	Case Number (DCN)

Date of Admittance	Name of JCAHO Certified Facility

I hereby certify that the above named participant, who is under 21 years of age, is currently a resident of the above named Joint Commission facility.

It has been determined that ambulatory care resources available in the community do not meet the treatment needs of this individual. Proper treatment of the participant's psychiatric condition requires services on an inpatient basis under the direction of a physician, and said services can be reasonably expected to improve the participant's condition or prevent further regression so that the services will no longer be needed.

The certification of need has been determined by an independent team or an interdisciplinary team as set forth in 13 CSR 70-15.070.

Physician Team Member	Date	Team Member/Title	Date
▶			

AUTHORIZATION

I, the undersigned, on behalf of:	Participant's Name or "Myself"

Authorize:

To release to the Family Support Division (FSD) sufficient medical information, including, but not limited to, my diagnosis and ability to function from my medical records or from the results of test(s) or examinations(s) which can be used to determine whether or not I meet FSD's definitions of an inpatient in a psychiatric facility, permanently and totally disabled, or unable to work because of a physical or mental disability.

I understand that I may withdraw this consent at any time. However, if FSD requests medical information based on this consent before I withdraw my consent, this request must be honored.

This consent (unless expressly withdrawn) expires on:	Month/Day/Year

Participant, Parent, Guardian	Date	Relationship
▶		

Witness	Date
Address	
Witness	
Address	Date

MO 886-0741 IM-71 Certification of Need for Psychiatric Services 8/2019