TEAM CERTIFICATION OF NEED FOR PSYCHIATRIC MEDICAL INSTITUTIONS CHILDREN'S LEVEL OF CARE

Name: _____Birthdate: ____

YES NO (Please check one choice for each item.)

____ ____ 1. Available community resources for ambulatory care do not meet the treatment needs of this child.

____ ____ 2. Proper treatment of this child's psychiatric condition requires service on an inpatient basis, under the direction of a physician.

____ ____ 3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

TREATMENT TEAM

Physician _____Date _____

Facility Name_____

Name and Profession_____Date _____

Facility Name_____

Independent Certification _____
Facility Team Certification _____