SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATION OF NEED

Client's Name: _____ Date of Birth: _____

Social Security Number: _____

NPI or Medicaid Provider ID: _____

A review team has evaluated all of the information submitted by the physician and other professionals to justify the client's admission to _____ and certifies that:

( ) Documentation of comprehensive diagnostic assessment conducted within one (1) week by a LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, risk assessment; and

( ) Ambulatory services available in the community do not meet the current treatment needs of the client; and

( ) Prior treatment addressing presenting concern/problem has not been successful; and

( ) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

( ) The inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.

OR

( ) According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate SCDHHS Eligibility Office.

TEAM PHYSICIAN'S PRINT NAME: _____

TEAM PHYSICIAN'S SIGNATURE: _____ Date: _____

Physician's NPI: _____

Effective Date: _____ **Check One**: Interdisciplinary Team ___ Independent Team ___

OTHER TEAM MEMBERS' SIGNATURES, TITLES, AND DATE SIGNED: (A minimum of one signature must be present.)

Date	Print Name	Signature