DHB-5045 (Rev. 01/19)

DIVISION OF HEALTH BENEFITS CERTIFICATION OF NEED FOR INSTITUTIONAL CARE FOR INDIVIDUAL UNDER AGE 21

The purpose of this form is to communicate between the county department of social services, attending physician, and Division of Health Benefits (DHB) about the anticipated duration of treatment for an individual under age 21. The information is required for a determination of financial eligibility for Medicaid.

SECTION A: REQUEST TO PHYSICIAN (Completed by County DSS)

Name of Individual _____ Date of Birth _____

Medicaid coverage has been requested for medical care and treatment in an institutional setting for the above-named individual. The place and the expected duration of care and treatment are required in order to establish financial eligibility for Medicaid.

PHYSICIAN: Please complete SECTION B and also SECTION C, if appropriate, and ATTACH REQUESTED MEDICAL RECORDS AND DOCUMENTATION. **Return as soon as possible to**:
_____ County DSS

Attention: _____(Caseworker)
Date of Request: _____

SECTION B: RECOMMENDED DURATION OF CARE AND TREATMENT

1. Based on primary diagnosis of _____

and secondary diagnosis of _____
continuous care and treatment are recommended as follows:

a) Medicaid Certified Facilities: (**Please indicate the specific number of months-Example: 6, 12, 15 etc**)

(1) _____ months, acute care general or psychiatric hospital
(2) _____ months, inpatient substance abuse hospital
(3) _____ months, nursing facility (skilled or intermediate care)
(4) _____ months, intermediate care/mentally retarded
(5) _____ months, psychiatric residential treatment facility

b) Non-Medicaid Facilities (not covered by Medicaid) (**Please indicate the specific number of months-Example: 6, 12, 15 etc**)
(1) _____ months, residential treatment
(2) _____ months, therapeutic group home
(3) _____ months, other (specify type):

2. Medical records/documentation are needed when continuous care and treatment in a Medicaid-certified medical institution is expected to exceed 12 months or more. The following records and/or documentation are enclosed:

a) _____ For skilled or intermediate nursing care, FL-2 only
b) _____ For intermediate care for the mentally retarded, MR-2only

c) _____For acute inpatient care in a general hospital, psychiatric hospital, substance abuse hospital, or psychiatric residential treatment facility, (submit all available records)

_____ History of current illness
_____ Official medical records for past 6 months
_____ Discharge summaries for all inpatient, residential, or group home placements for past 12 months or dates of same
_____ List of current medications
_____ Plan of care with goals and time frames

3. Care is to be provided at _____
(Name of institution or facility)
beginning on (date) _____

4. I (will / will not) be treating this individual in this institution/facility.

SECTION C: PHYSICIAN CERTIFICATION (Completed by attending physician)

I understand this certification form is for the purpose of establishing financial eligibility for Medicaid and not for the purpose of determining medical necessity for the recommended care and treatment stated in SECTION B.

I certify that the recommended care and treatment and the expected duration of such care and treatment are based on my best judgment and evaluation of the individual's current medical condition and needs and that a false certification or misleading statement which results in Medicaid payments for which the individual would not otherwise have qualified may subject me to civil and criminal penalties.

Physician's Name: _____ Phone No. _____

Physician's Signature: _____ Date: _____

Address: _____
_____

SECTION D: DHB APPROVAL FOR DETERMINATION OF FINANCIAL ELIGIBILITY (Completed by DHB)

This approval authorizes the county DSS to establish financial eligibility of the named individual without regard to the income and resources of the parents. Neither the county DSS nor DHB is making a determination that institutional services are medically necessary. DHB expressly reserves the right to review the medical necessity of institutional services reimbursed by the Medicaid program, to recover improper payments, and to prosecute any person suspected of knowingly and willfully making or causing to be made a false statement or representation of a material fact intended for use in determining entitlement to Medicaid coverage.

Name of authorized agent: _____

Title of authorized agent: _____

Signature of authorized agent: _____

Date: _____