new directions
YOUTH AND FAMILY SERVICES
fostering good.

Medical Necessity – Admission Criteria
Community Psychiatric Supports and Treatment

Youth Name: _____

DOB:_____ **Medicaid CIN:**_____

All criteria (1-4) must be met:

☐ 1. *Check one of the following:*

☐ The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM.
Diagnosis:_____

OR

☐ the child/youth is at risk of development of a behavioral health diagnosis.
Describe:_____
_____

☐ 2. The child/youth is expected to achieve skill restoration in one of the following areas:
Check one or more of the following:
☐ participation in community activities and/or positive peer support networks
☐ personal relationships;
☐ personal safety and/or self-regulation
☐ independence/productivity;
☐ daily living skills
☐ symptom management
☐ coping strategies and effective functioning in the home, school, social or work environment
*Describe:*_____
_____
_____

☐ 3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms

☐ 4. The services are recommended by a Licensed Practictioner of the Healing Arts (LPHA) operating within the scope of their practice under State License*:

*Recommendation/Signature of LPHA:*_____
*Date:*_____
*License #:*_____
*NPI #:*_____

**LPHA includes the following: Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse or, Nurse Practitioner*