CERTIFICATE OF NEED

Community Mental Health Program: Adapt Integrated Health Care

UMPQUA HEALTH ALLIANCE MEMBER INFORMATION

Legal Name :

Pronouns :

Preferred Name :

Date Of Birth :

A complete referral packet for a Psychiatric Residential Treatment Facility (PRTF) includes all of the following <u>signed and dated</u> documents:

- ☐ **Statement** from the local Community Mental Health Program (CMHP) attesting to the following:
  - ☐ Youth has recently received outpatient treatment and is **not** benefiting from this level of care **and**
  - ☐ Placement in a PRTF is recommended and necessary to meet the needs of the youth
- ☐ **Evaluation or progress note** recommending PRTF (face-to-face evaluation having taken place within 60 days of potential placement date) from any of the following provider types:
  - Psychologist
  - Psychiatrist
  - Psychiatric Mental Health Nurse Practitioner (PMHNP)
- ☐ **Current Mental Health Assessment** completed within the last **45** days, prior to referral.
  - ☐ The Mental Health Diagnosis must be primary and above the funded line on the prioritized list from the Oregon Health Plan.
- ☐ **Documentation of failed attempts at lower levels of treatment and/or community interventions.** Examples include: most recent therapy notes, crisis notes, PMHNP notes, ED notes, psychiatric inpatient notes, etc.
- ☐ **Certificate of Need Statement** (page 2)

Please return documents to Umpqua Health Alliance (Fax # 541-229-8180)

CERTIFICATE OF NEED STATEMENT

Community Mental Health Program: Adapt Integrated Health Care

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There is clear documentation that this level of care is clinically appropriate, in the best interest of the youth, and that less restrictive community based care has been tried and did not meet the treatment needs of the youth. Additionally, that the PRTF can be reasonably expected to improve the youth’s condition or prevent further regression.

Narrative:

OR: Documentation does **not** support that this level of care is clinically appropriate or in the best interest of the youth, and/or that less restrictive community based care has been tried and did not meet the treatment needs of the youth, and/or that the PRTF can't be reasonably expected to improve the youth’s condition or prevent further regression.

Narrative:

UMPQUA HEALTH ALLIANCE BOARD-ELIGIBLE OR BOARD-CERTIFIED PSYCHIATRIST

SIGNATURE:

DATE:

PRINTED NAME: