# 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 _____