



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 DIVISION OF FAMILY SERVICES  
**CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES**

NAME OF PATIENT		CASE NUMBER
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DATE OF ADMITTANCE	NAME OF JCAH CERTIFIED FACILITY
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I hereby certify that the above named individual, who is under 21 years of age, is currently a resident of the above named JCAH certified facility.

It has been determined: Ambulatory care resources available in the community do not meet the treatment needs of this individual, proper treatment of the claimant's psychiatric condition requires services on an inpatient basis under the direction of a physician, and said services can reasonably be expected to improve the claimant's condition or prevent further regression so that the services will no longer be needed.

The certification of need has been determined by an independent team or an interdisciplinary team as set forth in 13 CSR 70-15.070.

PHYSICIAN TEAM MEMBER	DATE	TEAM MEMBER/TITLE	DATE
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**AUTHORIZATION**

I, THE UNDERSIGNED, ON BEHALF OF	CLAIMANT'S NAME OR "MYSELF"
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**AUTHORIZE**

To release to the Division of Family Services Office sufficient medical information including, but not limited to my diagnosis and ability to function from my medical records or from the results of the examination(s) or test(s) which can be used to determine whether or not I meet the Division of Family Services definitions of: an inpatient in a psychiatric facility, permanently and totally disabled, or inability to work because of a physical or mental disability.

I understand that I may withdraw this consent at anytime. However, if the Division of Family Services has already requested medical information based on this consent, before I withdrew it, that request must be honored.

This consent (unless expressly withdrawn) expires on

MONTH/DAY/YEAR
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CLAIMANT, PARENT OR GUARDIAN	DATE	RELATIONSHIP
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WITNESS	DATE
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ADDRESS
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WITNESS	DATE
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ADDRESS
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