ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
Certification of Need
Medicaid Inpatient Psychiatric Services for Under Age 21

Beneficiary's Name _____

Empower ID Number_____

Facility: _____

DSM/ICD-10 Diagnosis Codes:
Behavioral:
1. _____2. _____ 3. _____ 4._____

Medical:
1. _____None_____ 2. _____

Social Elements: 1. Primary support 2. Social

Functional Assessment Tier: _____

1. Ambulatory care resources available in the community do not meet the treatment needs of this beneficiary.

2. Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician.

3. The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that services will no longer be needed.

☐ Certification of Need is approved.

☐ Certification of Need is denied.
Reason for denial:_____

_____ _____
Signature of Certification Team Physician Date

_____ _____
Signature of Certification Team Professional Date