Policy Form 1101.1
Certification of Need (CON) for Inpatient Facilities
For T/RBHAs and their Contracted Providers

A CON must be completed:
Prior to admission or at the time of admission, or
For an emergency admission, within 72 hours, or
If an individual applies for Medicaid Assistance while in the hospital, before Medicaid funding is authorized.

Date and Time of CON: / / : ☐ AM ☐ PM

Type of Service Requested:
☐ Psychiatric Acute Hospital ☐ Behavioral Health Inpatient Facility ☐ Sub-acute Facility

Client Information
Name: Date of Birth: / /
Address:
AHCCCS ID: Social Security Number: - -
Provider Provider Phone Number: ( ) -

DSM-IV Diagnostic Codes
Axis 1: Axis II: Axis III: Axis IV: Axis V:

- Please indicate why proper treatment of the person's behavioral health condition requires services on an inpatient basis under the direction of a physician.
- Please indicate why the requested service can reasonably be expected to improve the person's condition or prevent further regression so this level of service will no longer be needed.
- Please indicate why outpatient resources available in the community do not meet the treatment needs of this person.

I am aware of the client's condition and have been provided sufficient information to determine this level of care is appropriate.

Physician's Signature_____ Print Name_____

Dated: / /

Proposed Placement:
Inpatient Facility Provider Name:
Requested Date of Admission: / /
Requested Service Dates: From: / / To: / / Discharge: / /

RBHA Providers - when complete the CON must be faxed or emailed to **[the RBHA]** at **[Enter RBHA Fax Number and RBHA Email]**
TRBHA Providers - when complete the CON must be faxed or emailed to **[the TRBHA]** at **[Enter TRBHA Fax Number and TRBHA Email]**