PHYSICIAN CERTIFICATION
STATE MENTAL HEALTH HOSPITAL SERVICES

To be completed by Comprehensive Assessment and Review for Long Term Care Services (CARES)

Name: _____ Date of Birth: _____ Medicaid #: _____
Race: _____ Sex: _____ Marital Status: _____
Current Location: _____ Telephone #: _____ Date of Admission: _____
Attending Physician (please print): _____
Last State Mental Health Hospital Stay: From _____ To _____ N/A _____

1. Diagnosis: _____
_____
2. Summary of Current Medical Findings: _____
_____
_____
3. Medical History and Current Medications: _____
_____
_____
_____
4. Mental and Physical Capacity: _____
_____
_____
5. Prognosis: _____

6. Meets the following clinical criteria: (42 CFR § 441.102, 42 CFR § 441.103, 409.906(22), Florida Statutes)
_____ A. Ambulatory care resources available in the community do not meet the treatment needs of the individual.
_____ B. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist.
_____ C. Services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

☐ Recommended to receive State Mental Health Hospital Services Effective Date: _____

Attending Physician Signature: _____ Date: _____

Consulting Psychiatrist Signature: _____ Date: _____
(Required if Attending Physician is not a Psychiatrist)

Comments: _____
_____
_____

PHYSICIAN CERTIFICATION STATE MENTAL HEALTH HOSPITAL SERVICES INSTRUCTIONS

Name, Date of Birth, and Medicaid Number: Should be filled out accurately and as completely as possible.

Race, Sex, and Marital Status: Should be filled out accurately and as completely as possible.

Current Location and Telephone Number: Where the individual is located during the time the level of care is requested and the contact telephone number.

Date of Admission: The date the individual was admitted into the current facility.

Attending Physician: The physician responsible for coordinating clinical care for the individual.

Last State Mental Health Hospital Stay: Dates the individual previously received state mental health hospital services, if known.

Diagnosis: All medical and psychiatric diagnoses for the individual.

Summary of Current Medical Findings: Any significant medical conditions that impact the individual (lab results, radiology reports, etc).

Medical History and Current Medications: All pertinent historical medical information and any medications currently prescribed for the individual. A copy of individual's medical history and current medications may be attached.

Mental and Physical Capacity: Current mental and physical capabilities and deficits of the individual.

Prognosis: Indicate poor, fair, or good.

Meets the following criteria: Individual meets each of the criteria as described in 42 CFR 441.152 (a), and detailed in the Florida Medicaid State Mental Health Hospital Services Coverage Policy.

Recommended to receive State Mental Health Hospital Services: By checking this box, the attending physician and or consulting psychiatrist certifies placement is recommended in a state mental health hospital.

Effective Date: The date the attending physician and/or consulting psychiatrist certifies the individual meets the medical and psychiatric criteria for state mental health hospital services.

Attending Physician Signature: The original signature of the medical doctor (MD) or doctor of osteopath (DO) that is providing medical care to the individual, is required.

Date: The date the physician signs the form.

Consulting Psychiatrist Signature: The original signature of the psychiatrist providing care to the individual is required if the attending physician is not a psychiatrist.

Date: The date the psychiatrist signs the form.

Comments: The attending physician or consulting psychiatrist may provide additional comments here relevant to the individual or level of care.