

ADMISSION

**Certificate of Need
for PHP**

Admission Date: _____

Requirements

1. I certify it is medically necessary that this patient receive **Outpatient Partial Hospitalization Services**. These services will be furnished under my care with a written plan of treatment identifying the therapeutic focus.

2. I estimate _____ days / _____ weeks of **Outpatient Services** are necessary for proper treatment of this patient.

3. **Outpatient Service** elements this patient will participate in:
 - Group and/or Individual Therapy
 - Multi Family Group Therapy
 - Training/Education Services
 - Other: _____

4. Diagnosis:

5. The therapeutic focus/goals to facilitate discharge from **Outpatient Services** are:

6. My plans for post **Outpatient Services** for this patient are:
 - Home
 - Home Health Agency
 - Office Care
 - Extended Care
 - Other: _____

Physician Signature: _____ Date: _____