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Psychiatric medical institutions for children intake form

Date and time of request:		
Requested date of admit to PMIC:	PMIC provider:	PMIC provider's phone number:
Name of person completing the form:		
Contact person:	Contact person's phone number:	Contact person's fax number:
NPI number:	Tax ID number:	
Attending physician:	Attending physician's NPI number:	
Referral contact:	Referral contact's phone number:	Referral contact's fax number:
Certificate of Need (CON) signed by child physician within past 45 days? Y or N	Name of doctor who signed CON:	Date of child's last visit to doctor:
Child's ID number:	State ID number:	
Child's name:		
Child's DOB:	Child's age:	Child's phone number:
Child's address (including state and ZIP code):		
Name of parent/guardian:	Parent/guardian's phone number:	
Parent/guardian's ethnicity:	Parent/guardian's primary language:	
Who has custody of child (DHS, JCS, parents, other family, other agency, foster care, etc.)?	Custodian name:	
Custodian's relationship to the child:	Custodian's phone number:	
Custodian's address (including state and ZIP code):		
Is child court ordered to PMIC? Y or N If yes, please attach court order.		
Member admitting diagnosis: (please include ICD-10 codes) Primary: Secondary: Tertiary: Other:		
Integrated Health Home involvement? Y or N	Name of agency:	Care coordinator name and phone number:

Is child on any waiver? Y or N			Type of waiver:
Was the guardian informed the waiver slot would close upon admission to the PMIC and the child would have to reapply for the waiver if the inpatient stay exceeds 120 days? Y or N			
Has child had any recent psychological testing? Y or N			Date of assessment:
Provider name:			Provider phone number:
Current outpatient providers:			
Individual therapist:	Individual therapist's phone number:		Frequency of sessions:
Family therapist:	Family therapist's phone number:		Frequency of sessions:
BHIS provider:	BHIS provider's phone number:	Frequency of sessions:	Type of sessions (individual/family):
Psychiatrist/medical provider:	Psychiatrist/medical provider's phone number:		Frequency of visits:
Primary care physician (PCP):	PCP's phone number:		Date of last appointment:
Other:			Phone number:
Other:			Phone number:
By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse rules and regulations and to remain in compliance with IA Health Link Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit. I further acknowledge that an authorization is not a guarantee of payment.			
Name and credentials of referring person/PMIC:			Date:
Signature:			

Supporting documentation required with each request for services:

- Court order for treatment (if applicable)
- Most recent psychiatric and/or psychosocial evaluation
- Independent assessment (required to be completed within 45 days before admission)
- Most recent individualized education plan
- *Certificate of Need* prior to admission