Psychiatric medical institute for children (PMIC) admissions forms

There are two forms for PMIC admits:

1. Intake form: Please complete the intake form in its entirety and submit via the provider portal at https://providers.amerigroup.com/ia or fax the intake form to 1-877-434-7578. This form has to be submitted prior to approval for admission.
2. Clinical guide: Please complete the clinical guide in its entirety and submit via the provider portal at https://providers.amerigroup.com/ia or fax the clinical guide to 1-877-434-7578 if you are doing a written review for intake or concurrent review. If doing a verbal review, you do not need to submit this guide, but please have this information available to you when calling in to complete the review.

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

Psychiatric Medical Institute for Children Clinical Guide for Initial and Concurrent Reviews

Member name:		Member ID:		Eligibility date:
Current social activities (mentoring, sports, arts, music, groups, camps, etc.):				
First reason for PMIC level of care:			Where is behavior occurring?	
Frequency:		How long:		Current behavior: Y or N
Second reason for PMIC level of care:			Where is behavior occurring?	
Frequency:		How long:		Current behavior: Y or N
Third reason for PMIC level of care:			Where is behavior occurring?	
Frequency:		How long:		Current behavior: Y or N
Fourth reason for PMIC level of care:			Where is behavior occurring?	
Frequency:		How long:		Current behavior: Y or N
Fifth reason for PMIC level of care:			Where is behavior occurring?	
Frequency:		How long:		Current behavior: Y or N
Has child ever been in PMIC: Y or N	When:		Where:	Successful discharge: Y or N
Has child ever been hospitalized: Y or N		When (dates):		For what reason:
Has child ever been in shelter, group care, etc.: Y or N		When (dates):		For what reason:
Why PMIC now? What has changed that member can no longer be maintained outside of PMIC?:				
Current medications:				
Medication compliance issues:				
Previous medication(s):				
Additional medical concerns:				
Substance abuse: Y or N			What is child using?	
How frequent:			For how long:	
Are parents willing to be involved in weekly family therapy? Y or N				

What are the barriers to family involvement?		
If no parents, are there other family members/foster parents who can and will be involved in family therapy?: Y or N Who will be involved?		
Any other supports: Y or N What are they?		
What are the child's strengths?		
Family strengths:		
School concerns:		
Grades:		
Behaviors:		
Peer relationships:		
Initial enrollment period:		
504 plan:		
Full scale IQ:		
Legal concerns:		
History of detention:	Group care:	Juvenile Court Services involvement:
Individualized treatment goals	1.	
	2.	
	3.	
For concurrent review		
Please provide updates to identified reasons for admission and progress in meeting treatment goals:		
Transition/discharge planning:		
Where:		
With whom:		
What services:		

Barriers:	
Specific areas of focus for next review:	
Outcome:	
Days approved:	
Start date:	End date: