Certification of Need (CON) for Level I Facilities:

[*A CON must be completed at the time of admission or date and time admission*]

FAX to Mercy Care Inpatient Notification:

855-825-3165

Date Completed:	**TIME**: AM ☐ PM☐

Type of Service Requested:

☐Psychiatric Acute Hospital **☐Sub-acute Facility** **☐IMD**

Client Information	**AHCCCS ID:**
Name:	**Provider:**
Date of Birth:	**Provider Phone #: ( )**
Address:	**Facility:**

Diagnosis (Must be numeric value per ICD 10 criteria):

- 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 services 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_____

Date: / /

Proposed Placement:

Level I Provider Name: **Facility:**

Requested Date of Admission:

Requested Service Dates:

From: **To:** **Discharge:**

Completed By (Name): Contact Info (phone):