Clear Form

Minnesota Department of **Human Services**

DHS-4905D-ENG 4-13

Minnesota Health Care Programs (MHCP)

Extended Psychiatric Inpatient Contract – Weekly Bed Review Form

CONTRACTING HOSPITAL	CONTACT NAME	PHONE NUMBER - -	FAX NUMBER - -
RECIPIENT NAME	PMI NUMBER (MA #)		

Review Day and Date	• **Goals** (document specific, measurable targets aimed at restoring previous level of functioning)	• **Attach treatment plan/objectives** (document specific efforts and progress towards accomplishing goals, as well as response to medication management	• **Discharge Plan:** 1. Provide the name and type of placements being considered. 2. Indicate why those placements are appropriate. 3. Provide a list of other plan specifics for return to the community. 4. Include the dates which contact was made with MH-TCM or ACT.
Day 14 DATE: _____			
Day 21 DATE: _____			
Day 28 DATE: _____			

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Day 35* *In addition to documentation, a phone call must be made to medical review agent to discuss possible extension of stay beyond 45 days DATE: _____			
Day 42 DATE: _____			

Fax (secure) weekly updates to medical review agent, MH-TCM, or ACT team. If voluntary admission and consent given/release signed, copies may be sent to Mental Health Case Manager or ACT team. Attach additional documentation if necessary.