State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

CERTIFICATE OF MEDICAL NECESSITY FOR ENCLOSED BEDS

Recipient Name: _____ DOB: _____ MID: _____

1. Recipient must have one of the following (check all that apply):
   - ☐ Traumatic Brain Injury
   - ☐ Cerebral Palsy
   - ☐ Seizure Disorder
   - ☐ Severe Behavioral Disorder

2. Is there documented Cognitive Impairment? YES NO

3. Is there documented Communication Impairment? YES NO

4. Recipient must have a documented medical history of one of the following (check all that apply):
   - ☐ Daily tonic-clonic seizure activity
   - ☐ Uncontrolled perpetual movement related to diagnosis
   - ☐ Self-injurious behavior

5. Please describe history of unsafe mobility and/or serious injury related to bedtime (required):

   _____
   _____
   _____
   _____

6. Less-restrictive strategies tried (check all that apply):
   - ☐ Padding around a regular or hospital bed
   - ☐ Placing the mattress on the floor
   - ☐ Medications to address seizures or behaviors
   - ☐ Behavior modification strategies
   - ☐ Helmets for head banging
   - ☐ Removing safety hazards from the member's bedroom and using a child protection device on the doorknob
   - ☐ Visual and/or auditory monitors to observe recipient's activity
   - ☐ Other: _____

Prescriber Name (printed): _____ NPI: _____

Prescriber Signature: _____ Date: _____

Proof of medical necessity is valid for 12 months from the date of issue.