Mental Health Targeted Case Management

Child/Adolescent Diagnostic Verification Form

This form is meant to facilitate the eligibility determination process for mental health targeted case management services. It can be sent by a mental health targeted case manager to a mental health professional for the purpose of verifying that a client meets criteria for Severe Emotional Disturbance (SED).

CLIENT NAME

DATE OF BIRTH

HealthPartners ID #

PARENT OR GUARDIAN NAME

CLIENT ADDRESS

CITY

STATE

ZIP CODE

TCM PROVIDER AND AGENCY

FAX NUMBER

SENT TO

Date Sent

Diagnoses (Please complete all 5 Axes)

DATE MOST RECENT DIAGNOSTIC ASSESSMENT COMPLETED

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V

Check and complete all that apply:

☐ Is severely emotionally disturbed as defined under the Children’s Mental Health Act and Rule 79 and meets the criteria for case management services as indicated below:

☐ A. The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance, or:

☐ B. The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact, or:

☐ C. The child has one of the following as determined by a mental health professional:

☐ 1. Psychosis or a clinical depression;

☐ 2. Risk of harming self or others as a result of an emotional disturbance;

☐ 3. Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or
D. The child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Residential Treatment

Is this client currently receiving care in a residential treatment facility or program?  □ No  □ Yes – fill out below

<table>
<thead>
<tr>
<th>NAME OF FACILITY</th>
<th>DATE OF ADMISSION</th>
</tr>
</thead>
</table>

Has this client previously received care in a residential treatment facility or program?  □ No  □ Yes – fill out below

<table>
<thead>
<tr>
<th>NAME OF FACILITY/PROGRAM</th>
<th>DATE OF ADMISSION</th>
<th>DATE OF DISCHARGE</th>
</tr>
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Recommendations for Initial Goals/other services including those issues identified for the client’s parents or guardians:

- □ Mental health symptoms
- □ Mental health service needs
- □ Use of drugs/alcohol
- □ Educational functioning
- □ Social functioning
- □ Interpersonal functioning
- □ Self-care/independent living capacity
- □ Physical health
- □ Medication concerns
- □ Dental health
- □ Obtain/maintain financial assistance
- □ Obtain/maintain housing
- □ Using transportation
- □ Other:______________

Note: This form is not intended to be a substitute for a comprehensive diagnostic assessment completed by a mental health professional. According to Minnesota Statute 245.4876 Subd.2, providers of outpatient and day treatment services for children must complete a diagnostic assessment within five days after the child’s second visit or 30 days after intake, whichever occurs first. The expectation of the Department of Human Services is that a full diagnostic assessment will be sent to the mental health targeted case management provider no later than 30 days after a diagnostic assessment is requested.

<table>
<thead>
<tr>
<th>SIGNATURE OF MENTAL HEALTH PROFESSIONAL</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRINTED NAME OF MENTAL HEALTH PROFESSIONAL</td>
<td>PHONE NUMBER</td>
</tr>
</tbody>
</table>

QUALIFICATIONS OF MENTAL HEALTH PROFESSIONAL

- □ LP
- □ LMFT
- □ LCSW
- □ LPCC
- □ CNS-MH
- □ Psychiatric NP
- □ Psychiatrist
- □ LPP