



Mental Health Targeted Case Management

Adult 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 Serious and Persistent Mental Illness. **This form does not meet diagnostic assessment requirements.**

CLIENT NAME		DATE OF BIRTH	PMI NUMBER
CLIENT ADDRESS	CITY	STATE	ZIP CODE
TCM PROVIDER AND AGENCY			FAX NUMBER
SENT TO	DATE SENT	DATE MOST RECENT DIAGNOSTIC ASSESSMENT COMPLETED	
List Diagnoses			

Check and complete all that apply:

- A. This person has undergone two or more episodes of inpatient care for a mental illness or treatment by a mental health crisis team within the preceding 24 months.
- B. This person has experienced a continuous psychiatric hospitalization or residential treatment exceeding 6 months within the preceding 12 months.
- C. This person has a diagnosis of schizophrenia, major depressive disorder, bipolar disorder, or borderline personality disorder and is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in A or B (above) unless case management services are provided.
- D. In the past 3 years, this person has been committed by a court as a mentally ill person under Minnesota Statutes, chapter 253B, or this person's commitment has been stayed or continued for reasons related to this person's mental illness.
- E. This person has been eligible for case management services under one of the above items (A, B, C or D) or was eligible as a child for such services and is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in item A or B without case management services.

Residential Treatment

Is this client currently receiving care in a residential treatment facility or program? No Yes

Has this client previously received care in a residential treatment facility or program? No Yes

Recommendations for initial goals or other services including those issues identified for the client's parents or guardians:

- | | | |
|---|---|--|
| <input type="checkbox"/> Mental health symptoms | <input type="checkbox"/> Mental health service needs | <input type="checkbox"/> Use of drugs or alcohol |
| <input type="checkbox"/> Educational functioning | <input type="checkbox"/> Vocational functioning | <input type="checkbox"/> Social functioning |
| <input type="checkbox"/> Interpersonal functioning | <input type="checkbox"/> Self-care or independent living capacity | <input type="checkbox"/> Physical health |
| <input type="checkbox"/> Medication concerns | <input type="checkbox"/> Dental health | <input type="checkbox"/> Obtain or maintain financial assistance |
| <input type="checkbox"/> Obtain or maintain housing | <input type="checkbox"/> Using transportation | <input type="checkbox"/> Other |

Note: This form is not intended to be a substitute for a comprehensive diagnostic assessment completed by a mental health professional. 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.

SIGNATURE OF MENTAL HEALTH PROFESSIONAL	DATE
PRINTED NAME OF MENTAL HEALTH PROFESSIONAL	PHONE NUMBER
QUALIFICATIONS OF MENTAL HEALTH PROFESSIONAL <input type="checkbox"/> LP <input type="checkbox"/> LMFT <input type="checkbox"/> LICSW <input type="checkbox"/> LPCC <input type="checkbox"/> CNS-MH <input type="checkbox"/> Psychiatric NP <input type="checkbox"/> Psychiatrist	