Minnesota Department of **Human Services**

DHS-6069B-ENG 6-16

*Mental Health Targeted Case Management*

# Child/Adolescent Diagnostic Verification Form

This form is meant to initiate the 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 | PMI # |
|---|---|---|---|
| PARENT OR GUARDIAN NAME | | | |
| CLIENT ADDRESS | CITY | STATE | ZIP CODE |
| TCM PROVIDER AND AGENCY | | | FAX NUMBER |
| SENT TO | | | DATE SENT |

| **Diagnoses** | DATE MOST RECENT DIAGNOSTIC ASSESSMENT COMPLETED |
|---|---|
| ICD CODE | PRIMARY DIAGNOSIS (narrative) |
| ICD CODE | SECONDARY DIAGNOSIS (narrative) |

## 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

| NAME OF FACILITY | DATE OF ADMISSION |
|---|---|
| | |

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

| NAME OF FACILITY/PROGRAM | DATE OF ADMISSION | DATE OF DISCHARGE |
|---|---|---|
| | | |

## Inpatient Treatment

Has this client previously received care in an inpatient treatment facility or program? No Yes – fill out below

| NAME OF FACILITY/PROGRAM | DATE OF ADMISSION | DATE OF DISCHARGE |
|---|---|---|
| | | |

## Recommendations for Initial Goals/other services including those issues identified for the client's parents or guardians:

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

| SIGNATURE OF MENTAL HEALTH PROFESSIONAL | DATE |
|---|---|
| | |
| PRINTED NAME OF MENTAL HEALTH PROFESSIONAL | PHONE NUMBER |
| | |

QUALIFICATIONS OF MENTAL HEALTH PROFESSIONAL

LP LMFT LICSW LPCC CNS-MH Psychiatric NP Psychiatrist