RAMSEY COUNTY
Working with you to enhance our quality of life

Adult Mental Health Case Management Referral
Statement of Need

COMPLETION OF THIS FORM AND A CURRENT (6 months or less) DIAGNOSTIC ASSESSMENT ARE NECESSARY TO DETERMINE/ MAINTAIN SERVICE ELIGIBILITY.

THE ATTACHED DIAGNOSTIC ASSESSMENT MUST MEET THE DHS REQUIREMENTS IN MINNESOTA RULE 9505.0372 SUPPART 1

Client Name:_____ DOB:___/___/___ Race: _____

Client Phone: _____ Social Security Number: _____

Client's Permanent Address: (*non Ramsey County residents should be referred to their County of Residence*)

Street _____ Apt # _____

City: _____ County: _____ Zip:_____

Language if other than English: _____ Does client need interpreter: _____

Is the client currently at the above address or are they in a facility? ☐ *at address* ☐ *in facility*

If in a facility: Name: _____ Station: _____ Phone: _____

Admit Date: _____ Anticipated Discharge Date: _____ Treating MD: _____

Current Diagnosis - DSM 5

1._____ ICD 10 Codes _____

2._____ ICD 10 Codes_____

3._____ ICD 10 Codes_____

****Rule outs and unspecified diagnoses will not be accepted for Adult Mental Health Case management***

IN MY OPINION AS A LICENSED MENTAL HEALTH PROFESSIONAL THE ABOVE NAMED ADULT:

1. ____ **IS NOT** seriously and persistently mentally ill as defined in MN Statute
2. ____ **IS** seriously and persistently mentally ill and **meets the criteria for case management services** as indicated below (Please check A, B, C, D or E to identify how this adult meets the criteria).

A. ____ The adult has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months (specify):

Facility: _____ Dates: _____
Facility: _____ Dates: _____

B. ___The adult has experienced continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months (specify facility and dates):

_____

_____

_____

C. ___The adult has been treated by a crisis team two or more times within the preceding 24 months (specify crisis agency and dates):

Crisis Agency: _____ Dates: _____
Crisis Agency _____ Dates: _____

D. ___The adult caries an eligible diagnosis (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, or borderline personality disorder), indicates a significant impairment in functioning, and has a written opinion **(below)** of need from a mental health professional.

WRITTEN OPINION: I am of the opinion that the above named adult is reasonably likely to have further episodes requiring inpatient or residential treatment of a frequency described in item A or B (above). The factors forming my belief that case management services are needed to prevent hospitalization are the following: _____

_____

_____

_____

_____

_____

E. ____ The adult has, in the last three years, been committed by a court as a mentally ill person under Minnesota Statutes, Chapter 253B or the person's commitment has been stayed or continued for reason related to the person's mental illness **AND** has a written opinion (may check above). Please specify:

1. Committing Court Location: _____
2. Date of Court Commitment Order: _____

E. (i)The adult was eligible under A, B, C or D, but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional (see above), in the last three years, stating that the adult is reasonably likely to have future episode requiring inpatient or residential treatment, of a frequency described in A or B, unless ongoing case management or community support services are provided

****** Please list specific **SERVICE OBJECTIVES** for Case Management to address *****

1)_____

2)_____

3)_____

Unless under civil commitment, case management is a voluntary service. Has the mental health professional discussed this referral with individual being referred? Y / N

Is the person in agreement with receiving case management services? Y / N

This person has a functional impairment in the following area(s):

☐ Mental Health Symptoms	☐ Mental Health Service Needs	☐ Use of Drugs and/or Alcohol	☐ Vocational Functioning
☐ Social Functioning	☐ Interpersonal Skills	☐ Self Care/ILS	☐ Medical Health
☐ Obtaining/Maintaining Financial Assistance	☐ Obtaining/Maintaining Housing	☐ Using Transportation	☐ Other: _____

Please explain any boxes checked above: _____

_____

_____

_____

Completed By:
Signature: _____

Printed Name: _____

Phone: _____ Name of Agency, Clinic or Hospital: _____
Fax: _____ Date: _____

I qualify as a Mental Health Professional in the following field:
___ Advanced Practice Nurse ___ Psychiatrist ___ Psychology (LP, LPCC)
___ LICSW ___ LMFT

Please send this completed form and a Current Diagnostic Assessment to:
Ramsey County Case Management Intake
1919 University Avenue W #200. Saint Paul, MN 55104-3453
Phone: 651-266-7890 Fax: 651-266-7989

Please Note – completion of this process does not guarantee case management services