Request for Medical Opinion:

Serious and Persistent Mental Illness *This form is to be completed by a mental health professional*

To the health care provider: This is a request for you to provide information to Ramsey County Workforce Solutions and their designated subcontractors, about any physical health and/or mental health conditions your patient may have that you believe, in your professional opinion as a health care provider, impact the ability of your patient (the County's MFIP or DWP client) to work. Your information will help an employment counselor working for Ramsey County, or a designated subcontracted agency, to provide or arrange appropriate support services for your patient; assist your patient in finding and securing employment that is appropriate given your patient's health status and; and determine what work expectations are not appropriate for the patient. Please be advised that Minnesota Statutes §13.03, subd. 3 allow a client of a public entity access to private data maintained by that public entity. The information you provide on this form is classified as private data on your patient. Upon request by your patient or the patient's representative, the County or its designated agency, is required by law to provide access to the information contained on this form.
NOTE: This request does not represent an offer of payment on the part of Ramsey County or its designated agency.

Patient name (MFIP/DWP client):____ Maxis #: ______________________
Former name (if any): ______________________________________ Date of Birth:____________ Gender:___________
Street Address: ____ City ________________________ Zip Code __________

Authorization for Release of Information: I give permission to ____ to release the requested health care information by completing and sending this form to Ramsey County Workforce Solutions and/or contracted MFIP-ES provider staff_____________________________. I understand this information about me is protected under state and /or federal privacy laws and cannot be disclosed without my written authorization unless otherwise provided for by state or federal law. I voluntarily and knowingly waive those protections of this information and consent to its release to the agency listed above. This information will be used, in part, to qualify me for public assistance and/or services. I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested. This authorization will end one year from the date I sign it, unless the law allows for a longer period.

Client signature: ____ Date: ____________________
(or authorized representative)

Please answer all questions regarding the above-identified patient.

I have no record of this patient or I have not been able to diagnose this patient.

Patient's primary diagnosis
Code: ___________________________ Diagnosis: ____
Date of Initial Diagnosis: ______________________________

Determination that a "Serious and Persistent Mental Illness" is present requires "yes" responses to any of the following. Please check all that apply:

1. The patient has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months.

2. The patient has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months.

3. The patient meets **all three** of the following criteria:
   - Has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; and
   - Has a significant impairment in functioning; and
   - Has a written opinion from a mental health professional, within the last three years, stating that the patient is reasonably likely to have future episodes requiring inpatient or residential treatment, unless ongoing case management or community support services are provided.

4. The patient (in the last three years) has been committed by a court as a mentally ill person under chapter 253B.

☐ 5. The patient meets **both** of the following criteria:
   - Was eligible under clauses 1 to 4 above, but the specified time period has expired; and
   - Has a written opinion form a mental health professional, within the last three years, stating that the patient is reasonably likely to have future episodes requiring inpatient or residential treatment, unless ongoing case management or community support services are provided.

☐ 6. The patient meets **both** of the following criteria:
   - Was eligible as a child under section 245.4871, subdivision 6 (as a "child with a severe emotional disturbance"); and
   - Has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause 1 or 2 above, unless ongoing case management or community support services are provided.

☐ 7. The diagnosis seriously limits the patient's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

It is important that you sign and date this form below. Thank you for your cooperation. Please mail or FAX this form to the agency named at the bottom of this page as soon as possible. You may call that agency with any questions.

Qualified Professional (name): ____ Credentials: ______________________
(Please print or type)
Clinic Name/Address ____
City/State ______________________________ Zip ___________ Clinic phone _______________________________________

Signature ____ **Date**______________________________

Please mail or FAX to: ____________________________________ Agency/Dept.: _________________________

Address: ____ City/State: ___________________ Zip: ______________

Fax number: _______________________________ Phone number: _____________________________________