Reset Form

RAMSEY COUNTY
Workforce Solutions

Request for Medical Opinion:

Criteria for Severe Emotional Disturbance

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 (child of MFIP or DWP client) may have that you believe, in your professional opinion as a health care provider, impact the availability of your patient's caregiver (the County's MFIP or DWP client) to work in another capacity. 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's caregiver; assist your patient's caregiver in finding and securing employment that is appropriate given your patient's health status and caregiver needs; and determine what work expectations are not appropriate for the patient's caregiver. 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.

Caregiver name (MFIP/DWP client):_____ Maxis #: _____
Former name (if any): _____ Date of Birth:_____ Gender:_____
Street Address: _____ City _____ Zip Code _____

Patient (child) name:_____
Date of Birth: _____ Gender: _____ Relationship to client/caregiver: _____

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 child or I have not been able to diagnose this child

Child's primary diagnosis
Code: _____ Diagnosis: _____
Date of Initial Diagnosis: _____
Determination that a "Severe Emotional Disturbance" is present requires "yes" responses to any of the following.

Please check all that apply:

☐ 1. 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.

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

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

- Psychosis or a clinical depression; or
- Risk of harming self or others as a result of emotional disturbance; or
- Psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the last year.

☐ 4. 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 the mental health professional, presents substantial risk of lasting at least one year.

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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: _____