CERTIFICATION OF SERIOUS AND PERSISTENT MENTAL ILLNESS REQUIRED FOR BCOW/SPMI/SMI FUNDING

In Regards to:_____

A. Professional Opinion:
In accordance with M.S. 245.462 supbpart.1 and Rule 9505.0480 subpart 1, it is my professional opinion, as a duly qualified mental health professional, that the person named above meets the definition of a person with serious and persistent mental illness. Further, in the absence of community support services, this person would likely have future episodes of mental health problems which would require inpatient mental health treatment.

B. Diagnostic Category (an individual must meet one or more of the following criteria- please check all that apply):

1._____ Have a diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder; evidences a significant impairment in functioning and has a written opinion from a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient of residential treatment.

2._____ Have undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months.

3._____ Have experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months.

4._____ Have been or is currently committed by a court as a mentally ill person under Chapter 253B, or the person's commitment has been stayed or continued within the last three years.

5._____ The adult was eligible under clause 2 and 4 but the specified time period has expired, or the adult was eligible as a child under section 245.4871, subdivision 6; 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 2 or 3, unless ongoing case management or community support services are provided.

C. Diagnosis:
Axis I _____ DSM Code:_____
_____ DSM Code:_____
Axis II_____ DSM Code:_____

D. Acknowledgement (to be completed by MH professional):
1. Signature: _____ Name: _____
2. Qualifications : _____ Phone: _____

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3. Address: _____
4. Date: _____