RAMSEY COUNTY
Social Services

Adult Mental Health Case Management Referral
Statement of Need

Note: The first step to request case management services is to submit the Statement of Need form and attach a current Diagnostic Assessment **completed within the past 180 days**. Fax documents to 651-266-7989.

SECTION I. CLIENT INFORMATION: Required fields are marked with an asterisk.

***Client Name:** _____ _____ _____
(first name) (middle initial – opt) (last name)

***Date of Birth:** _____

***Race:**

- ☐ American Indian or Alaska Native
- ☐ Asian or Asian American
- ☐ Black or African American
- ☐ Hispanic or Latino/a
- ☐ Middle Eastern or North African
- ☐ Native Hawai`ian or Pacific Islander
- ☐ White or European
- ☐ Bi-racial
- ☐ Other

My race or ethnicity is best described as: _____

Does the client need an interpreter? ☐ Yes ☐ No If yes, specify the language _____

***Gender identity:**

☐ Gender nonconforming	☐ Questioning
☐ Genderqueer	☐ Woman
☐ Man	☐ Transgender
☐ Nonbinary	

My gender or gender identity is best described as: _____

***Client's address:**

Street _____ Apt # _____

City _____ Zip _____ County _____

***Client's email: _____ *Client's phone: _____**

***How would the client be contacted: ☐ Email ☐ Phone ☐ Text**

Provider, please provide detailed directions for contacting clients. (e.g., call a family member and ask for client).

***Is the client currently in a facility?** If yes, provide the following details:

Facility Name: _____ Contact Person: _____

Facility phone: _____

Facility Address: Street _____ City _____ Zip _____

Admission Date:_____ Anticipated Discharge Date: _____

SECTION II. DETERMINES ELIGIBILITY FOR TARGETED CASE MANAGEMENT: Required fields are marked with an asterisk. Serious and persistent mental illness (SPMI) diagnoses include: Major Depressive Disorders, Schizoaffective Disorders, Bipolar Disorders, Schizophrenia, and Borderline Personality Disorder.

***Current Diagnosis – DSM 5 TR**

1. _____	ICD 10 Codes _____
2. _____	ICD 10 Codes _____
3. _____	ICD 10 Codes _____

A. Hospitalizations: In the past 24 months, has the client had two or more episodes of inpatient hospitalizations for mental illness? If yes, please enter facility name and dates.

Facility 1	Dates:
Facility 2	Dates:
Facility 3	Dates:

B. In the past 12 months, has the client been in a psychiatric hospital or residential treatment for more than six months? If yes, please enter facility name and dates.

Facility 1	Dates:

C. Mental Health Crisis Services: In the past 24 months, has the client received help for a mental health crisis two or more times? This could include visits from a Crisis Team, assessments, trips to the Emergency Room, or stays at Crisis Residences/Urgent Care for Mental Health. If yes, please enter the facility name(s) and dates.

Facility 1	Dates:
Facility 2	Dates:

D. In the past 3 years, has the client been placed under civil commitment? ☐ Yes ☐ No . If Yes, provide information below:

County that filed for civil commitment: _____ Date of Order: _____

***Required Written Opinion for Case Management Services:** I am of the opinion that Case management services are medically necessary to reduce further episodes of inpatient or residential treatment services. The factors contributing to this opinion are the following:

_____
_____
_____
_____

SECTION III. FUNCTIONAL ASSESSMENT: The client has a functional need in the following area(s):

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

COMMENTS: _____

SECTION IV. Consent: *Has the client been fully informed about the referral and given their consent to receive case management services? ☐ Yes ☐ No

REFERRAL SOURCE: Required fields are marked with an asterisk. A Licensed Mental Health Professional Co-signature is ALSO required for Mental Health Practitioners and PA-Cs.

This Statement of Need completed by:
*Printed Name: _____
*Signature: _____ *Date: _____ *License Type: _____
*Name of Agency, Clinic, or Hospital: _____ *Phone _____
*Email _____
Co-signer's Printed Name: _____
Co-signature _____ Date: _____Co-signer's license type: _____
Name of Agency, Clinic, or Hospital: _____Phone: _____

Qualified Licensed Mental Health Professionals:
☐ Advanced Practice Nurse ☐ Licensed Professional Clinical Counselor ☐ Licensed Psychologist
☐ Licensed Marriage and Family Therapist ☐ Licensed Independent Clinical Social Worker ☐ Psychiatrist

There is an optional Consent to Share Information Personal Representative on next page.

(Optional) Consent to Share Information with Personal Representative

You may designate a personal representative to be involved in your case management. With your consent below, Ramsey County will share private data about you with your Personal Representative.

I, _____, agree that _____
(Print Client's Name) (Print Personal Representative's Name)
may be receive information about my care for case management services.

Client Signature: _____ Date: _____

Explanation of Your Rights and Permission to Release

If you have a question about anything regarding this consent, or would like more explanation before you sign it, please contact: Adult Mental Health Intake Department, Phone 651-266-4401, Email: SSD.AdultMentalHealth.TargetedCaseManagementFullAccess@CO.RAMSEY.MN.US

I, _____, am voluntarily giving my permission for Ramsey County Social
(Print Client's Name)
Services to release data about me to _____ as described in this
(Print Personal Representative's Name)
consent.

1. The specific data I want Ramsey County Social Services to release includes information regarding scheduling of appointments, reminders of appointments, and information pertaining to my case management.
2. I understand that I have voluntarily asked Ramsey County Social Services to release this data.
3. I understand that although the data are classified as private at Ramsey County Social Services, the classification/treatment of the data with my Personal Representative may not be the same and is dependent on laws or policies that apply to my Personal Representative.
4. I understand that, due to my decision to release this data, Ramsey County Social Services will be unable to control or monitor how my Personal Representative uses my data after it has been released to them, and that there may be consequences associated with the release of this data to my Personal Representative as a result of this decision.
5. I understand that I may cancel this consent to release my data at any time by writing to Ramsey County Social Services.

This consent will end one year from the date the form is signed unless I cancel my consent at an earlier time.

Client/Data Subject Signature: _____ Date: _____