D613 (12/09/2016)

**Hennepin County**
Human Services and Public Health Department
**Eligibility and Work Supports**
PO Box 107
Minneapolis, MN 55440-0107

Phone 612-596-1300
Fax 612-288-2981
www.hennepin.us

# MFIP MEDICAL FORM - NEEDED IN HOME / SED/ SPMI

This information is available in other forms to people with disabilities by calling the county worker on this form. For TDD users and those with speech difficulties, please contact your county worker through the Minnesota Relay at 711 or 1-800-627-3529 (TDD) or 1-877-627-3848 (Speech-to-Speech Relay).

## Case Information

| Client Name | Case Number | Date |
|---|---|---|
| | | 10/01/2018 |

**Dear Medical/Health Service Professional:**

has indicated that someone in his/her household has medical conditions that may affect his/her ability to work.

The State of Minnesota requires counties to assist participants in the Minnesota Family Investment Program (MFIP) and the Diversionary Work Program (DWP) to achieve family stability. One of the components of these programs to determine the level at which a participant can achieve self-sufficiency through employment.

Participants work with a job counselor or vocational counselor to develop a plan that best fits their circumstances. In some situations, they may need assistance in determining what type of employment best fits their physical and mental capacity and that of their child/children. We must consider physical and mental disabilities an the requirements of the Americans with Disabilities Act. Please fill out the parts I-IV of this form that are applicable to the participant's situation.

☐ The participant has indicated that a child in her/his home may meet the criteria for Severe Emotional Disturbance (SED). Please complete Part I and II of the form.

☐ The participant has indicated that an adult in her/his home may meet the criteria for Serious and Persistent Mental Illness (SPMI). Please complete Part I and III of the form.

☐ The participant has indicated she/he is needed in the home to care for another member of her/his household. Please complete Part I and IV of the form.

Please return this form this completed form to the agency listed above.

**Hennepin County**
Human Services and Public Health Department
**Eligibility and Work Supports**
PO Box 107
Minneapolis, MN 55440-0107

Phone 612-596-1300
Fax 612-288-2981
www.hennepin.us

D613 (12/09/2016)

**MFIP MEDICAL FORM - NEEDED IN HOME / SED/ SPMI**

# MFIP/DWP Request for Medical Examination and Exchange of Information

Participant Name

Patient Name if different from above

Address

City | State MN | ZIP Code

Social Security Number | Date of Birth | Sex ☐ Male ☐ Female

## Giving Permission

I give permission to any licensed physician and/or health care professional to give/exchange the information requested with the agency listed above. I understand that my job counselor may share this information with the county human services agency to determine eligibility for an extension of MFIP benefits. The exchange may include written and/or verbal follow-up.

## Consequences

I know that the State And Federal privacy laws protect my records. I know that I must give my prior written consent for agencies to give out information. I know why I am being asked for this information. I know I do have to consent to this release, but that this written notice will not affect information the agency has already requested. This consent will end one year from the date I sign it. Minnesota Data Privacy Act (MN Statute Ch. 13).

Participant's Signature | Date

Patient's Signature (Children at 13 and older must sign) | Date

Adult/Guardian/ Authorized Representative (if required) | Date

## Note to Physician/Health Care Professional

This information will be used to assess the severity of the patient's physical and/or mental impairment or combination of impairments, so that an evaluation of the participant's capacity to engage in work or work related activities can be made. Please complete the sections indicated on the first page. Sign and date the form and return to the agency listed above. Attach any pertinent information.

## Notice to Third Parties

MN Statutes 15.162 allows recipients access to recorded data. Be informed that upon request of the recipient or his or her legal representative, this Department is required by law to provide them the information contained on this form. Any statements included in the client's file may be open to his or her inspection.



Case No.

**Hennepin County**
Human Services and Public Health Department
**Eligibility and Work Supports**
PO Box 107
Minneapolis, MN 55440-0107

Phone 612-596-1300
Fax 612-288-2981
www.hennepin.us

D613 (12/09/2016)

# MFIP MEDICAL FORM - NEEDED IN HOME / SED/ SPMI

## Part I

| Name of Physician/Health Care Professional (Please Print) | | | Phone Number | |
|---|---|---|---|---|
| Signature of Physician/Health Care Professional | | | Date | |
| Address | City | | State MN | ZIP Code |

## Part II

☐ **SEVERE EMOTIONAL DISTURBANCE**: The MFIP/DWP participant requested a modification to her/his employment services participation requirement. Or, s/he requested an extension to the 60-month time limit because a child in her/his home may meet the criteria for Severe Emotional Disturbance (SED).

### Criteria for Severe Emotional Disturbance (SED)

**Requires 'Yes' responses to both parts of Section A and to any part of Section B. Please check all that apply.**

(This form is to be completed by a qualified professional.)

Patient Name

| **Section A** | Yes | No |
|---|---|---|
| Does this child have an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that: | | |
| 1. Is listed in the clinical manual ICD-10-CM, code rage 290.0 to 302.99 or 306.0 to 316.0, or the corresponding code in the DSM-MD, Axes I, II, or III? | ☐ | ☐ |
| 2. Seriously limits the child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation? | ☐ | ☐ |

**Please check all that apply.**

| **Section B** | Yes | No |
|---|---|---|
| 1. Has this child been admitted within the last three years to inpatient treatment or residential treatment for an emotional disturbance? | ☐ | ☐ |
| 2. Is this child at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance? | ☐ | ☐ |
| 3. Is this child a Minnesota resident who is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact? | ☐ | ☐ |
| 4. Does this child have: | | |
| (i) psychosis or a clinical depression? | ☐ | ☐ |
| (ii) risk of harming self or others as a result of an emotional disturbance? | ☐ | ☐ |
| (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year? | ☐ | ☐ |
| 5. Does this child, as a result of an emotional disturbance, have a significantly impaired home, school, or community functioning that: | | |

**Hennepin County**
Human Services and Public Health Department
**Eligibility and Work Supports**
PO Box 107
Minneapolis, MN 55440-0107

Phone 612-596-1300
Fax 612-288-2981
www.hennepin.us



| | | |
|---|---|---|
| (i) has lasted at least one year? | ☐ | ☐ |
| (ii) presents substantial risk of lasting at least one year? | ☐ | ☐ |

Date of onset ____________________

## Part III

☐ **SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)**: The participant has indicated that an adult in her/his home may meet the criteria for Serious and Persistent Mental Illness.

### Criteria for Serious and Persistent Mental Illness (SPMI)

**Requires 'Yes' responses to both parts of Section A and to any part of Section B. Please check all that apply.**

(This form is to be completed by a qualified professional.)

Patient Name

| **Section A** | Yes | No |
|---|---|---|
| Does this adult have an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that: | | |
| 1. Is listed in the ICD-10-CM, code rage 290.0 to 302.99 or 306.0 to 316.0, or the corresponding code in the DSM-MD, Aces I, II, or III? | ☐ | ☐ |
| 2. Seriously limits the person's capacity to function in primary aspects of daily living such as persona relations, living arrangements, work and recreation? | ☐ | ☐ |

**Please check all that apply.**

| **Section B** | Yes | No |
|---|---|---|
| 1. Has this adult undergone two or more episodes of inpatient care for a mental illness within the preceding 12 month? | ☐ | ☐ |
| 2. Has the adult experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months? | ☐ | ☐ |
| 3. Does this adult meet all three of the following criteria: | | |
| (i) have a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder?<br>(ii) diagnosis significantly impairs functioning<br>(iii) documentation from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring impatient or residential treatment, unless ongoing case management or community support services are provided? | ☐ | ☐ |
| 4. Has this adult, in the last three years: | | |
| (i) been committed by a court as a mentally ill person under chapter 253B? | ☐ | ☐ |
| (ii) had her/his commitment stayed or continued? | ☐ | ☐ |
| 5. Does this adult meet <u>both</u> of the following criteria: | | |
| (i) was eligible under numbers (1) or (4) above, but the specified time period has expired?<br>(ii) documentation from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring impatient or residential treatment, unless ongoing case management or community support services are provided? | ☐ | ☐ |

**Hennepin County**
Human Services and Public Health Department
**Eligibility and Work Supports**
PO Box 107
Minneapolis, MN 55440-0107

Phone 612-596-1300
Fax 612-288-2981
www.hennepin.us



## MFIP MEDICAL FORM - NEEDED IN HOME / SED/ SPMI

| | | |
|---|---|---|
| 6. Does this adult meet both of the following criteria:<br>(i) was eligible as a child under section 245.4871, subdivision 6 (as a "child with a severe emotional disturbance")?<br>(ii) documentation 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, unless ongoing case management or community support services are provided? | ☐ | ☐ |

Date of onset ______________________

## Part IV

☐ **NEEDED IN THE HOME**: The MFIP/DWP participant requested a modification to her/his employment services participation requirement OR s/he requested an extension to the 60-month time limit because s/he is needed in the home to care for a family member.

Name of disabled patient needing care ______________________ Social Security Number ______________________

Diagnosis or type of disorder ______________________

Prognosis ______________________

Date of onset ______________________ Date of last visit ______________________

Does this patient need the MFIP participant in the home to care for them? ☐ Yes ☐ No

What hours of the day is the MFIP participant required to be in the home with the participant?

From ______________________ To ______________________

Is this the only person who can care for this patient? ☐ Yes ☐ No

Does this patient have other daily activities? ☐ Yes ☐ No

Please explain (examples could be school, training, etc.)

______________________

When do you anticipate this patient may have a change in care needs? Please explain

______________________



Case No.