

# PHYSICIAN CERTIFICATION OF ADULT WITH A SERIOUS MENTAL ILLNESS

CLIENT NAME First: \_\_\_\_\_ Last: \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_

GENDER: M F O RACE (Circle all that apply): WH AS BL AI/AN NH/OPI ETHNIC HISPANIC: Yes or No

PROVIDER \_\_\_\_\_ CLIENT ID NO. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

**Adults with a serious mental illness (SMI) are persons (All boxes must be checked for an adult to be certified as SMI):**

age eighteen (18) and over;

**AND**, who currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5)\*, **OTHER THAN** "V" codes, substance use disorders or developmental disorders (including intellectual disability and autism spectrum disorders) which are excluded unless they co-occur with another diagnosable serious mental illness.

**DSM Diagnoses (primary listed first):** \_\_\_\_\_

\_\_\_\_\_;

**AND**, this disorder has resulted in functional impairment which meets one of the criteria below for substantially interfering with or limiting one or more major life areas (Persons who would have met functional impairment criteria during the past year without the benefit of treatment or other support services are considered to meet the functional impairment criterion for serious mental illness).

**Check which apply. If A or B criterion set below is checked it is not necessary to check the C criterion set:**

- \_\_\_\_ (A) At any point in life have met the diagnostic criteria for Schizophrenia, Schizoaffective Disorder or Bipolar I Disorder, **or**  
\_\_\_\_ (B) During the past year have met diagnostic criteria for Major Depression, Panic Disorder or Obsessive-Compulsive Disorder, or at any point in life have met diagnostic criteria for Bipolar II Disorder; **AND**, during the past year meet at least one of the following severity criteria: inpatient psychiatric hospitalization, psychotic symptoms, use of antipsychotic medications, **or**  
\_\_\_\_ (C) During the past year met at least one of the criteria listed below (Check all that apply):
- \_\_\_\_ Either planned or attempted suicide during the past 12 months;
  - \_\_\_\_ Lacked any legitimate productive role;
  - \_\_\_\_ Had a serious role impairment in their main productive roles, for example consistently missing at least one full day of work per month as a direct result of their mental health;
  - \_\_\_\_ Had serious interpersonal impairment as a result of being totally socially isolated, lacking intimacy in social Relationships, showing inability to confide in others, and lacking social support;
  - \_\_\_\_ Had difficulties that substantially interfered with or limited role functioning in basic daily living skills (e.g. eating, bathing, dressing);
  - \_\_\_\_ Had difficulties that substantially interfered with or limited role functioning in instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and/or,
  - \_\_\_\_ Had difficulties that substantially interfered with or limited functioning in social, family or vocational/educational Contexts. **DESCRIBE:** \_\_\_\_\_

**I, the undersigned, do hereby certify that I have performed a medical review of the evaluation of this client and that he/she meets the above Division of Behavioral Health Services (DBHS) criteria for adults with a serious mental illness.**

- \_\_\_\_ **Evaluation based on my direct examination of client within last 45 days (Valid up to one calendar year).**  
\_\_\_\_ **Evaluation not based on my direct examination of client within last 45 days (Valid up to 45 days).**  
\_\_\_\_ **Evaluation based on my participation in ongoing treatment planning/review process (Valid for period covered by the current physician approved treatment plan).**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date of Medical Review**

**\*or the most current version of the DSM in use.**