DECERTIFICATION ATTESTATION

MEMBER CONTACT INFORMATION:

Name: _____ Guardian: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

DECERTIFICATION IS REQUESTED BY (CHECK ALL THAT ARE APPLICABLE – IF AN SMI MEMBER IS REQUESTING DECERTIFICATION THEY MUST SIGN THIS FORM)

- ❑ SMI Member

  Signature of SMI Member: _____

- ❑ Guardian
- ❑ Provider / Treating Clinician

REASON FOR DECERTIFICATION REQUEST: _____

_____

Was this decertification request prompted by a change in your provider(s) related to your integrated health plan?

❑ Yes; Describe_____ ❑ No

If yes, has an Opt- out or single case agreement been attempted before decertification request?

❑ Yes; Outcome_____

❑ No; If not, why? _____

CLINICAL RECOMMENDATION:

Name and title of physician/nurse practitioner attesting to this form:_____

Date you last saw the member:_____

The number of times you personally met with member: _____

Is it your opinion that the member meets the criteria for a serious mental illness designation (see attached criteria)? ❑ Yes ❑ No

Please provide facts which support your opinion:_____

_____

_____

_____

_____

_____

_____

_____

_____

If a member is decertified, multiple benefits and services may be impacted, leading to possible risk of deterioration. Please comment on each of the items below in the case of SMI decertification:

Plan to address changes in ***Mental Healthcare*** access as a result of NON- SMI status:_____

_____

_____

Plan to address changes in ***Physical Healthcare*** access as a result of NON- SMI status:_____

_____

_____

Plan to address changes in ***Housing*** as a result of NON- SMI status:_____

_____

_____

Plan to address changes/absence of ***Case Management*** support as a result of NON- SMI status:_____

_____

_____

Plan to address changes in ***Transportation*** as a result of NON- SMI status:_____

_____

_____

Plan to address changes in ***Treatment options*** (med formulary, etc.) as a result of NON- SMI status:___

_____

_____

DOCUMENTATION INCLUDED IN SUBMISSION

- ❑ Decertification notice signed by provider and member (Required)
- ❑ Assessment/SMI form (Required)
- ❑ Most recent year of treatment records
- ❑ Original SMI determination
- ❑ Annual Reviews

_____ _____

Your Signature Date

_____

Printed Name

SMI Decertification Notice

Please read/review with all members seeking decertification

The decertification process involves a neutral, independent party, Solari reviewing your records and determining if you still meet criteria for Seriously Mentally Ill (SMI) designation.

Your clinic will provide Solari with any/ all relevant information to help Solari determine if SMI criteria are met or

not. Solari will make a decision as soon as there is sufficient information to do so.

Decertification is criteria- based ***only*** (having an SMI diagnosis and a functional impairment as a result of that diagnosis)

Decertification is not influenced by preference, choice, or access to providers or care issues.

Decertification is not a solution to access to care issues. Your clinic can help you address barriers to care.

SMI designation ***alone*** does not impact firearm ownership.

Decertification means your SMI designation will end, and therefore any/all services that came from SMI status may potentially be affected, including: case management, medical services, transportation, housing, etc.

Your clinical team will work with you to help ensure a safe transition.

FOR PROVIDER
I have read/reviewed this notice to the member

Print / Sign: _____Date:_____

FOR MEMBER

I understand the process and implications of decertification

Print / Sign: _____ Date:_____

Assessment:

Please select one:

- ❑ Comprehensive psych assessment dated from the last 6 months is **attached** **(**No further action needed on this form if attached):

---- OR ---

- ❑ If NOT submitting a comprehensive psych assessment from the last 6 months, please complete below (typed responses are ok):

1. Original diagnosis and functional impairments that resulted in SMI determination

2. Interval history over the past 12 months (hospitalizations, crisis services, relapses, diagnostic changes, legal issues, functioning, changes in supports, medication, medical or other treatment changes)

3. Comprehensive risk assessment (biopsychosocial risks, static and dynamic risk factors, protective factors)