REMOVAL OF DESIGNATION ATTESTATION

MEMBER CONTACT INFORMATION:

Name:	______________________________	Guardian:	______________________________
Address:	______________________________	Address:	______________________________
	______________________________		______________________________
Phone:	______________________________	Phone:	______________________________

REMOVAL OF DESIGNATION IS REQUESTED BY (CHECK ALL THAT ARE APPLICABLE – IF AN SMI MEMBER OR SED MEMBER'S GUARDIAN IS REQUESTING REMOVAL OF DESIGNATION, THEY MUST SIGN THIS FORM)

❑ SMI/SED Member

Signature of SMI Member/SED Member's Guardian: ________________________________

❑ Guardian

❑ Provider / Treating Clinician

REASON FOR REQUEST FOR REMOVAL OF DESIGNATION: ______________________________

____

Was this 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 this 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 or serious emotional disturbance designation (see attached criteria)? ❑ Yes ❑ No

Please provide facts which support your opinion:_____________________________________

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If a member's designation is removed, 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/SED removal of designation:

Plan to address changes in ***Mental Healthcare*** access as a result of ineligible status:________________

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____

Plan to address changes in ***Physical Healthcare*** access as a result of ineligible status:_______________

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Plan to address changes in ***Housing*** as a result of ineligible status:______________________________

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Plan to address changes/absence of ***Case Management*** support as a result of ineligible status:________

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Plan to address changes in ***Transportation*** as a result of ineligible status:________________________

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____

Plan to address changes in ***Treatment options*** (med formulary, etc.) as a result of ineligible status:_____

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DOCUMENTATION INCLUDED IN SUBMISSION

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

______________________________ ____________

Your Signature Date

____

Printed Name

SMI/SED Removal of Designation Notice

Please read/review with all members seeking removal of designation

This process involves a neutral, independent party, Solari reviewing your records and determining if you still meet criteria for Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation.

Your clinic will provide Solari with any/ all relevant information to help Solari determine if SMI/SED criteria are met or not.

Solari will make a decision as soon as there is sufficient information to do so.

Removal of Designation is criteria- based ***only*** (having a qualifying diagnosis and a functional impairment as a result of that diagnosis)

Removal of Designation is not influenced by preference, choice, or access to providers or care issues.

Removal of Designation 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.

Removal of Designation means your SMI/SED designation will end, and therefore any/all services that came from SMI/SED 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:____________

Solari
1275 W. Washington, Suite 201
Tempe, AZ 85288
Toll Free: 1-855-832-2866
community.solari-inc.org/eligibility-and-care-services

Crisis Lines
Statewide: 1-844-534-4673
National: 9-8-8

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 designation

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)