



Verification of Meeting Serious Emotional Disturbance Criteria for OMH Youth ACT, CCRs, and RTFs

Instructions:

A child or adolescent (under the age of 21) has Serious Emotional Disturbance (SED) if they have a designated mental illness diagnosis in the Diagnostic and Statistical Manual (DSM) categories below as defined by the most recent version of the DSM of Mental Health Disorders AND have experienced functional limitations listed below due to emotional disturbance over the past 12 months from the date of assessment on a continuous or intermittent basis as determined by the treating or assessing Licensed Practitioner of the Healing Arts (LPHA.) A child with verified SED may be eligible for intensive services offered by Youth Assertive Community Treatment (ACT), Children’s Community Residence (CCR) and Residential Treatment Facility (RTF.)

This verification form is to be filled-out by a LPHA who has the ability to diagnose within their scope of practice under New York State law. The LPHA must verify that the applicant meets SED criteria based on primary diagnosis and functional impairments. The form should be completed by a LPHA who has diagnosed or is actively treating the child. The LPHA verification is required component of a referral for access to Youth ACT, CCR, and RTF.

NOTE: This form is not required if verification of SED by an LPHA is present in the youth’s clinical documentation.

Child’s Information			
Last Name	First Name	MI	Date of birth

Verification of Meeting Serious Emotional Disturbance Criteria				
Diagnostic Criteria				
As a Licensed Practitioner of the Healing Arts I verify that the child/youth has at least one primary DSM diagnosis in the following Qualifying Mental Health Categories				
Select at least one DSM Qualifying Mental Health Category	Current Diagnosis	Select Primary Diagnosis	Select Severity Indicator	Date of Diagnosis
Anxiety Disorders			Low Medium High	
Bipolar and Related Disorders			Low Medium High	
Depressive Disorders			Low Medium High	
Disruptive, Impulse-Control, and Conduct Disorders			Low Medium High	
Dissociative Disorders			Low Medium High	
Obsessive-Compulsive and Related Disorders			Low Medium High	
Feeding and Eating Disorders			Low Medium High	
Gender Dysphoria			Low Medium High	
Paraphilic Disorders			Low Medium High	
Personality Disorders			Low Medium High	
Schizophrenia Spectrum and Other Psychotic Disorders			Low Medium High	
Somatic Symptom and Related Disorders			Low Medium High	
Trauma- and Stressor-Related Disorders			Low Medium High	
Attention Deficit/Hyperactivity Disorder			Low Medium High	



Functional Criteria

As a Licensed Practitioner of the Healing Arts I verify that the child/youth has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations have been moderate in at least two of the following areas or severe in at least one of the following areas:

Moderate	Severe	
		<p>Ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or</p> <p>Family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or</p> <p>Social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or</p> <p>Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or</p> <p>Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).</p>

Supporting documentation (psychosocial, psychological, psychiatric and education documentation) supports this verification.

I hereby verify, as a Licensed Practitioner of the Healing Arts that this child/youth meets the clinical standards for SED determination as indicated above.

LPHA Name	LPHA Signature	Date

Credentials Of LPHA:

- | | |
|-------------------------------|--------------------------------------|
| Registered Professional Nurse | Licensed Master Social Worker |
| Nurse Practitioner | Licensed Clinical Social Worker |
| Physician | Licensed Marriage & Family Therapist |
| Psychiatrist | Licensed Mental Health Counselor |
| Licensed Psychologist | Licensed Creative Arts Therapist |
| Licensed Psychoanalyst | |