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STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING



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CHILD PLACING AGENCY LETTER 2008- 02

To: Child Placing Agencies and Family Courts that Certify Foster Homes
All Foster Family Homes and Foster Family Group Homes

From: James B. Gale, Director *James B. Gale*
Bureau of Children and Adult Licensing

Subject: Assessing an Applicant's Mental Health Condition

Assessing an Applicant's Mental Health Condition

Child Placing Agencies (CPA) that conduct either foster family or adoptive evaluations are required by administrative rule to assess “**the** physical, mental, and emotional health of each member of the household.” [See R400.12310(3)(a)(iv) and R400.12605(3)(a)(iv)] When an applicant has a history of treatment for a mental health condition, the agency must approach the applicant's treating practitioner for specific information related to whether the mental health condition would impair their ability to care for foster/adoptive children without risk.

Several federal statutes influence how an agency must approach the assessment of psychiatric impairments. Specifically, both Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 prohibit an entity that conducts services, programs and activities for which federal financial assistance is paid, from discriminating against a person based on a psychiatric or cognitive impairment. These programs include foster home licensure and adoptive evaluations, both of which qualify for payment of foster care maintenance funds under Title IV-E of the Social Security Act.

In order to assure agencies approach this type of assessment with consistency and a lack of bias, the Bureau of Children and Adult Licensing has created the attached *Practitioner's Statement of Status of Mental Health Condition* form. Effective immediately, agencies are directed to use only this form when requesting this type of assessment information from an applicant's treating physician or therapist. We also provide a sample cover letter to the applicant's treating practitioner, which may be placed on individual agency letterhead. An agency may continue to use its current release of information form and is to specifically list this form, by name, in the request section of the document.

DATE

ADDRESSEE
ADDRESS
ADDRESS

The following individual

Name
Address
Address

has presented her/himself to our agency as an applicant for licensure to provide foster care for children/adults. This individual has indicated that she/he has been under your care for a defined mental health condition. She/he has authorized us to contact you concerning this condition in order to provide us with information that would assist our effort to determine whether she/he is able to carry out the duties and requirements of providing foster care. (See attached release of information authorization.)

Attached, therefore, is a form for providing needed information.

Thank you in advance for your assistance.

SIGNATURE

Return these materials to

NAME
ADDRESS
ADDRESS

or use the enclosed envelope.

STATEMENTS OF STATUS OF MENTAL HEALTH CONDITION

In re: NAME OF Applicant

Name of Practitioner: _____

Professional Address: _____

Telephone Number: _____

Field of practice: _____ Psychiatry _____ Psychology
_____ Social Work _____ General Practitioner
_____ Other: _____

Degree: _____ MD _____ MA or MS _____ PhD _____ MSW

In regard to the above named individual:

When did you first see this individual concerning mental health issues? _____

When did you last see this individual concerning mental health issues? _____

Are you currently treating this individual concerning mental health condition? ___Yes ___No

If you are currently treating this individual for a mental health condition, what is the current diagnosis?

Description: _____

DSM-IV Code(s): _____

If you are no longer treating this individual for a mental health condition, what was the diagnosis of the condition that you treated?

Description: _____

DSM-IV Code(s): _____

Were/are medications (being) used by this individual as part of treatments you provided/are providing?

___Yes ___No ___I don't know

If medications were used/are being used, have they been effective (partially or fully) in managing the condition? ___Yes ___No ___I don't know

What are the common side effects of this/these medications? _____

Has this individual ever been hospitalized for the condition for which you treated him/her?

___Yes ___No ___I don't know

If yes, when was the most recent hospitalization?

Date _____

Length of stay/Number of days _____

Location _____

STATEMENTS OF STATUS OF MENTAL HEALTH CONDITION

In re: NAME OF Application

Has the individual reported, or have you determined for this individual, any of the following:

- Hallucinations
- Delusional content
- Paranoid anxiety (e.g., anxieties concerning the motives of other, including specific individuals or public agencies)
- Situational anxiety (e.g. phobic anxieties, relationship anxieties)
- Problems in impulse control, including controlling verbal and physical aggression
- Problems with depression that interfere with, or prohibited, daily work productivity and/or consistency of performance (e.g., absenteeism; conflicts with coworkers, supervisors)
- Problems with anxiety that interfere with, or prohibited, daily work productivity and/or consistency of performance (e.g., absenteeism; conflicts with coworkers, supervisors)
- Problems with anger that interfere with, or prohibited, daily work productivity and/or consistency of performance (e.g., absenteeism; conflicts with coworkers, supervisors)
- Deficiencies of attention, alertness or cognition. If so, which of the following areas of attentional or cognitive functioning have been affected:
 - Individual has problems in focusing on routine activities
 - Individual has problems sustaining concentration on activities
 - Individual has problems remembering information essential to either routine or work-related tasks

For any area checked, is the problem managed with medication? Yes No

How well?

STATEMENTS OF STATUS OF MENTAL HEALTH CONDITION

In re: NAME OF Applicant

To the best of your knowledge of this individual, including considerations of what you may have indicated above, please rate the following capacities by degree of impairment:

	<u>Degree of Impairment</u>				
	<u>None</u>	<u>Slight</u>	<u>Moderate</u>	<u>Marked</u>	<u>Extreme</u>
Attend to a stream of conversational Activity that includes requests, instructions and elicitations of information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand, remember and carry out short, simple instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand, remember and carry out detailed instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make judgments on simple worked-related decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact appropriately with the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respond to children with empathy and objectivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact with and handle appropriately children who present					
unique problems of troubled history and adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
problems of impulse control (e.g., ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
problems at managing anger and aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
depression that is related to loss and family disruption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
unique medical needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact appropriately with public, social and health agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respond appropriately to pressures of providing foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to accept rejection from a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Practitioner

Date