NYC Health

Office of Mental Health

# SPOA CARE COORDINATION /ASSERTIVE COMMUNITY TREATMENT (ACT) AUTHORIZATION FOR RE-RELEASE OF INFORMATION

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. No HIV or HIV related information will be re-released.

## PART 1: Authorization to Re-Release Information

**Description of Information to be Used/Disclosed:**

You have been referred for Mental Health Care Coordination or Assertive Community Treatment (ACT) services. In order to review your referral, NYC Department of Health and Mental Hygiene (DOHMH) New York City's Adult Single Point of Access (SPOA) program must review information from your referral source (including your psychiatric and psychosocial evaluations) to discuss this application so that the right services may be provided for you.

If you are found eligible for Care Coordination or ACT services, DOHMH will then need to share information with the assigned Care Coordination or ACT agency that is contracted through the New York State Office of Mental Health and/or New York City's Department of Health and Mental Hygiene. The assigned program would be one of the following types of services: Health Home Care Coordination, Non-Health Home Care Coordination, or Assertive Community Treatment (ACT). The information that will need to be shared with the assigned program includes your educational, medical and mental health assessments, including: psychiatric evaluations, psychosocial assessments, medical exams, TB test results and discharge reports. All of this information is included in your "Universal Referral Form" (URF).

On this authorization form, you are being asked to consent to have your psychiatric and psychosocial evaluations released by your referral source to DOHMH. You are also being asked to consent to have DOHMH re-release the information included in your "Universal Referral Form" to the Care Coordination or ACT agency that will be assigned to provide you with services.

You are also being asked to consent to have the assigned Care Coordination or ACT provider check the Health Home Portal for the purpose of determining if you are already enrolled in a Health Home and/or Care Coordination Program.

**Purpose or Need for Information:**

1. This information is being requested:
   - ☐ by the individual or his/her personal representative; or
   - ☐ Other (please describe) _____
2. The purpose of the disclosure is (please describe):

It is understood that the psychosocial and psychiatric evaluations provided by my referral source, _____ will be used by DOHMH to evaluate me for possible referral to Adult Mental Health Care Coordination or Assertive Community Treatment (ACT). If deemed eligible, I will be referred for the appropriate level of service, the information in my Universal Referral Form (URF) will be provided to the respective Care Coordination or ACT provider, and I will be enrolled in their program.

**A.** I authorize DOHMH the New York City's Adult SPOA program to review the URF application, psychosocial and psychiatric information ("Confidential Information") provided by my referral source, and if I am determined to be eligible, I authorize DOHMH as the New York City's Adult SPOA program to make recommendations for an appropriate program for my possible enrollment. If I am eligible, I also authorize DOHMHto use and disclose my Confidential Information to the Assigned Care Coordination/ACT Program. I also authorize the assigned Care Coordination or ACT provider to check the Health Home Portal to determine if I am already enrolled in a Health Home and/or Care Coordination or ACT program. I understand that:

1. Only the Confidential Information described above may be used and/or disclosed as a result of this authorization.
2. My Confidential Information i cannot legally be disclosed without my permission.
3. If my Confidential Information is disclosed to someone who is not required to comply with privacy laws, rules, or regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time, by writing to DOHMH as the New York City Adult Single Point of Access. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my Confidential Information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from NYC DOHMH and New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own Confidential Information and ensure that it is used and/or disclosed in accordance with the requirements of the applicable privacy laws, such as HIPAA.

Health

Office of Mental Health

# CARE COORDINATION /ASSERTIVE COMMUNITY TREATMENT (ACT)
# AUTHORIZATION FOR RE-RELEASE OF INFORMATION

**B. Patient Signature:** I have been given the opportunity to ask questions if I do not understand any of the information on this form. I certify that I authorize the use of my Confidential Information (including my medical and mental health information) as set forth in this document.

**X** _____

Signature of Patient or Personal Representative — Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

## CONSENT TO RELEASE INFORMATION

(Please keep original on file)

I authorize the disclosure of the Care Coordination/ ACT Application and all related supporting documents, including confidential medical and mental health information, to NYC Department of Health and Mental Hygiene 42-09 28th St. Queens NY 11101 for the purposes of Care Coordination/ACT assessment and placement assistance for a period of one hundred and twenty. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

I authorize Department of Health and Mental Hygiene to check the Health Home Portal and PSYCKES for the purpose of determining if I am already enrolled in a Health Home and/or to inform assignment to Care Coordination/ACT Program.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

| Applicant's name (printed) | Signature of Applicant | Date |
|---|---|---|
| Witness' name (printed) | Signature of Witness | Date |

Revised 07-2014

# NYS OMH Single Point of Access (SPOA)
## Care Coordination /ACT Program Application Cover Sheet

Send this cover sheet to DOHMH along with the complete Universal Referral Form packet for all SPOA applicants

Date of Submission: _____ For CC/ACT Consultation Assistance call 347-396-7258

TO:
NYC DOHMH
SPOA Care Coordination /ACT Program
42-09 28th Street 20th Fl. Queens, NY 11101
Fax: 347-396-8910 Ph# 347-396-7258
Email: SPOA@Health.NYC.Gov

ALL COMPLETE SPOA PACKETS must include:
- ☐ This Cover Sheet with Signed Consent
- ☐ The Universal Referral Form (URF)
- ☐ CC/ACT Referral Summary
- ☐ A Comprehensive Psychosocial Summary
- ☐ A Comprehensive Psychiatric Evaluation

FROM:
Referring Agency/Program: _____

Referring Worker's Name: _____

Contact Phone: _____ Fax: _____

Referring Worker E-mail: _____

Other Case Managers _____ Contact Info _____

Borough Where Applicant Is/Will Reside (circle one): Brooklyn Manhattan Queens Bronx Staten Island

Regarding:
Applicant's Last Name: _____ First Name: _____

Applicant's D.O.B.:

Level of Service Requested (Check one): ○ Non-Medicaid Care Coordination ○ ACT ○ Medicaid Health Home Care Coordination

TYPE OF REFERRAL (Check all that apply):

**Priority Referral:** ☐ AOT ☐ Potential AOT ☐ State PC ☐ Acute Inpatient Unit ☐ CPEP/ER ☐ Correctional Health ☐ Mobile Crisis Teams ☐ Mental Health Courts ☐ OMH Residential Treatment Facilities ☐ OMH Links

**Community Referral:** ☐ Transfer ☐ PROS ☐ DHS ☐ Psychiatric Outpatient Residential ☐ Other _____

**Coordination /ACT Program & Health Home Requested** (If applicable): _____

### CONSENT TO RELEASE INFORMATION

(Please keep original on file)

I authorize the disclosure of the Care Coordination/ ACT Application and all related supporting documents, including confidential medical and mental health information, to NYC Department of Health and Mental Hygiene 42-09 28th St. Queens NY 11101 for the purposes of Care Coordination/ACT assessment and placement assistance for a period of one hundred and twenty. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

I authorize Department of Health and Mental Hygiene to check the Health Home Portal and PSYCKES for the purpose of determining if I am already enrolled in a Health Home and/or to inform assignment to Care Coordination/ACT Program.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

| Applicant's name (printed) | Signature of Applicant | Date |
|---|---|---|
| Witness' name (printed) | Signature of Witness | Date |

Revised 07-2014

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
*Commissioner*

# Adult Care Coordination and ACT Services
# UNIVERSAL REFERRAL FORM

**Fax Complete URF Packet to: 347-396-8910 or Email (Encrypted) to SPOA@Health.NYC.Gov**

## URF Application Must Include the Following:

- ☐ The Universal Referral Form (URF) including SPOA Coversheet. **Please answer all questions**; type answers when possible or write legibly. Indicate if information is Unknown (U/K) or Not Applicable (N/A),
- ☐ A Comprehensive Psychosocial Summary completed or updated within the last 6 months.
- ☐ A Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner and completed within the last 30 days for inpatient referrals.
- ☐ Authorization for Re-release of URF application to assigned Care Coordination or ACT Program
- ☐ Do not include any HIV or HIV related information (diagnosis/medications) in this application

**Note: The Applicant's social security number (SSN) is voluntary**
**For Questions about the Universal Referral Form: Call DOHMH at 347-396-7258**

## Service Being Requested:

O Non-Medicaid Care Coordination O Assertive Community Treatment (ACT)
O Health Home Care Coordination (Medicaid)

## Section A: Demographics

1. Name:
First: _____ Last: _____

2. DOB: 3. Sex: O Male O Female

4. Medicaid # (if applicable): Seq. #: O None O Unknown

HMO (if ineligible/inactive the date when insurance was last active):_____

Health Home Assignment: Select Agency:_____Care Coordination Agency: _____
(*Please contact your Lead Health Home in order to run all applicant's names through the Health Home portal to determine if referring applicant has already received assignment to a Health Home for Care Coordination or to make referrals for Medicaid Health Home Care Coordination*)

5. Primary Language:

| | | | | |
|---|---|---|---|---|
| O 1. American Sign Language | O 6. French | O 11. Italian | O 16. Russian | O 21. No Language |
| O 2. Cantonese | O 7. German | O 12. Japanese | O 17. Spanish | O 22. Unknown |
| O 3. Chinese | O 8. Greek | O 13. Mandarin | O 18. Urdu | O 23. Other (specify): |
| O 4. Creole | O 9. Hindi | O 14. Polish | O 19. Vietnamese | |
| O 5. English | O 10. Indic | O 15. Portuguese | O 20. Yiddish | _____ |

6. English Proficiency: O Does not speak English O Poor O Fair O Good O Excellent

7. Social Security Number:
If not provided, indicate reason: O Applicant declines to provide O Applicant does not have a SSN

Applicant's Last Name:_____

8. Applicant Address (If applicant is homeless note the shelter/drop in center or place he/she may be contacted):

Tel # :

If applicant is hospitalized and being discharged to a different address; or if the applicant is homeless and moving into housing, please indicate new address/contact information:

Tel # :

9. What is the applicant's Race/Ethnicity? (Check all that apply)

- ☐ 1. White, European American
- ☐ 2. Black, African American
- ☐ 3. American Indian or Alaskan Native
- ☐ 4. Asian Indian
- ☐ 5. Chinese
- ☐ 6. Filipino
- ☐ 7. Vietnamese
- ☐ 8. Other Asian
- ☐ 9. Native Hawaiian
- ☐ 10. Guamanion/Chamorro
- ☐ 11. Samoan
- ☐ 12. Japanese
- ☐ 13. Latino/Latina
- ☐ 14. Korean
- ☐ 15. Unknown
- ☐ 16. Other Pacific Islander
- ☐ 17. Other (specify):

## Section B: Family Contacts

1. Marital Status: (Check one)

O Single, never married O Cohabiting with significant other or domestic partner O Currently married
O Divorced / Separated O Widowed O Unknown O Other: _____

2. Family/Friend/Emergency contact(s): (Include name, address, telephone number and relationship)

| | | | |
|---|---|---|---|
| Name: | Address: | Tel # | Relationship: |
| Name: | Address: | Tel # | Relationship: |
| Name: | Address: | Tel # | Relationship: |
| Name: | Address: | Tel # | Relationship: |
| Name: | Address: | Tel # | Relationship: |

## Section C: AOT

1. AOT: O Yes O No **If Yes:** Effective Date: Expiration Date: ☐ Voluntary or ☐ Involuntary

AOT Contact Person: _____ Phone #: _____

* 2. If applying for AOT, has the AOT team been notified? : o Yes o No o Not Applicable

AOT Office Contact Person: _____ AOT Contact Phone #: _____

*Please note: The AOT office must be aware of the potential application for AOT.

## Section D: Characteristics

1. Current Living Situation: (Check one)

- O 1. Private residence alone
- O 2. Private residence with spouse or domestic partner
- O 3. Private residence with parent, child, other family
- O 4. Private residence with others
- O 5. MH Supported Housing (Supported Housing or Supported SRO)
- O 6. MH Housing Support Program (Congregate Support or Service Enriched SRO)
- O 7. MH Apartment Treatment program
- O 8. MH Congregate Treatment program
- O 9. MH crisis residence
- O 10. Inpatient state psychiatric hospital
- O 11. Inpatient, general hospital or private psychiatric
- O 12. DOH adult home
- O 13. Drug or alcohol abuse residence or inpatient setting
- O 14. Correctional Facility
- O 15. Homeless, street, parks, drop in center, or undomiciled
- O 16. Shelter or emergency housing
- O 17. Unknown
- O 18. Other (specify): _____

2. Has the applicant ever been homeless? O Yes O No

Applicant's Last Name:_____

3. Has an HRA Supportive Housing application (HRA 2010e) been submitted within the last 6 months for this applicant?

O Yes O No O Not Applicable O Unknown

4. Does the applicant have a current housing determination/approval? O Yes O No

5a. If you answered "Yes" to Question 2, complete the following. (Include dates of present episode of homelessness, provide name of shelter, drop-in center, street, etc., under "Location". List most recent locations first)

Date: Location:

Date: Location:

Date: Location:

Date: Location:

5b. Where did applicant reside prior to current episode of homelessness? (Indicate name of facility if applicable)

O 1. Own apartment/house
O 2. Single room occupancy
O 3. With family
O 4. Community residence
O 5. With friends
O 6. Jail/Prison
O 7. Adult home
O 8. Inpatient psychiatric facility
O 9. Unknown
O 10. Other (specify) _____

Facility Name: _____

Address: _____

5c. Length of occupancy (in months): ☐

5d. Reason for leaving: _____

6. Current Employment Status: (Check one)

O 1. No employment of any kind
O 2. Competitive employment (employer paid) with no formal supports
O 3. Other _____
O 4. Unknown

7a. Income or benefits currently receiving: (Check all that apply)

☐ 1. Wages, salary or self employed
☐ 2. Supplemental Security Income (SSI)
☐ 3. Social Security Disability Income (SSD)
☐ 4. Soc. Sec. retirement, survivor's, dependents (SSA)
☐ 5. Veteran benefits
☐ 6. Worker's Compensation or disability insurance
☐ 7. Medicaid
☐ 8. Hospital-based Medicaid
☐ 9. Medicaid Pending
☐ 10. Family Planning Medicaid
☐ 11. Medicare
☐ 12. Public assistance cash program, TANF, Safety, temporary disability
☐ 13. Private insurance, employer coverage, no fault or third party insurance
☐ 14. None
☐ 15. Ineligible (Reason)
☐ Other: _____

7b. For any current benefits checked in Question 7, indicate the type and amount per month:

| Type of benefit: | Amount per month: | Type of benefit: | Amount per month: |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

7c. Describe any special payee arrangements and the name and address of Representative Payee:

Applicant's Last Name:_____

8. Current Criminal Justice Status: (Check all that apply)

- ☐ 1. Applicant is not under Criminal Justice Supervision
- ☐ 2. CPL 330.20 order of conditions and order of release
- ☐ 3. In NYS Dept. of Correctional Services (State Prison)
- ☐ 4. On bail, released on own recognizance (ROR) conditional discharge, or other alternative to incarceration
- ☐ 5. Under probation supervision (PO/Contact)_____
- ☐ 6. Under parole supervision (PO/Contact)_____
- ☐ 7. Under arrest in jail, lockup or court detention
- ☐ 8. Released from jail or prison within the last 30 days
- ☐ 9. Unknown
- ☐ 10. Other (specify): _____

## Section E: Clinical

Clinical Disorders and other conditions that may be focus of clinical attention (do not include any HIV or HIV related information in this application)

| Diagnosis (if none, please indicate) | DSM Code |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

General Medical Disorders, as well as any Chronic Disorders. If none, please indicate with N/A. Do not include any HIV or HIV related information in this application

4. Psychosocial and Environmental Problems: (Check all that apply)

- ☐ 1. Problems with primary support group
- ☐ 2. Problems related to the social environment
- ☐ 3. Educational/Occupational problems
- ☐ 4. Insurance or Benefit problems
- ☐ 5. Housing problems
- ☐ 6. Economic problems
- ☐ 7. Problems with access to health care facilities/referrals
- ☐ 8. Problems related to legal system/crime
- ☐ 9. Unknown
- ☐ 10. Other (specify) _____

5. Current Psychotropic Medications: If none prescribed, please check ○

| Name | Dosage | Schedule |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Applicant's Last Name:_____

7. Current Medications for Physical Illness: If none prescribed, please check ○

(Do not include any medications specifically used in the treatment of HIV)

| Name | Dosage | Schedule |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

8. Applicant Adherence to Medication Regimen: (Check one)
   - ○ 1. Takes medication as prescribed
   - ○ 2. Takes medication as prescribed most of the time
   - ○ 3. Sometimes takes medication as prescribed
   - ○ 4. Rarely or never takes medication as prescribed
   - ○ 5. Applicant refuses medication
   - ○ 6. Medication not prescribed
   - ○ 7. Unknown
   - ○ 8. Other (specify) _____

9. What level of support is required for compliance with medication regimen? (Check one)
   ○ None, Independent ○ Reminders ○ Supervision ○ Dispensing ○ Not applicable ○ Unknown

10. Does applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support and/or a therapeutic diet?
    ○ Yes ○ No If Yes, please describe: _____

11. Name of Treating Medical MD or facility: _____ Phone #:_____

12. Medical Tests:
    Has applicant been tested for TB in the past year? ○ Yes ○ No

13. Physical Functioning Level:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Fully ambulatory | ○ | ○ | Can bathe self | ○ | ○ |
| Needs help with toileting | ○ | ○ | Can feed self | ○ | ○ |
| Climbs one flight of stairs | ○ | ○ | Can dress self | ○ | ○ |

## Section F: Utilization

1. Applicant Services within the last 12 months: (Check all that apply)
   - ☐ 1. None
   - ☐ 2. State psychiatric center inpatient unit
   - ☐ 3. General hospital unit or certified psychiatric hospital
   - ☐ 4. Mental health housing and housing support
   - ☐ 5. MH outpatient clinic, PROS, IPRT
   - ☐ 6. Alcohol / Drug abuse inpatient treatment (e.g. clubhouse, vocational services)
   - ☐ 7. Alcohol / Drug abuse outpatient treatment
   - ☐ 8. ACT, Care Coordination or other case management

   Name of Program:_____
   - ☐ 9. Emergency mental health (non-residential)
   - ☐ 10. Prison, jail or other court mental health service
   - ☐ 11. Local MH practitioner
   - ☐ 12. Assisted Outpatient Treatment (AOT)
   - ☐ 13. Self help / Peer support services
   - ☐ 14. Community Support Program non-residential mental health program
   - ☐ 15. Unknown
   - ☐ 16. Other (specify) _____

2. Psychiatric Services utilization including current hospitalization if applicable.
   (Indicate the number of utilizations for each. Include "O" if none. "UK" if unknown.)

   Psychiatric hospitalizations in the last 12 months: ☐
   Psychiatric hospitalizations in the last 24 months: ☐
   Arrests in the last 12 months: ☐
   Emergency room/mobile crisis visits for psychiatric conditions in the last 12 months*: ☐
   Emergency room/mobile crisis visits for psychiatric conditions in the last 24 months: ☐

   **Note only those ER/Mobile Crisis visits that did **NOT** result in a psychiatric admission.*

Applicant's Last Name:_____

3. To degree known, list all psychiatric hospitalizations (including current), psychiatric emergency room visits and mobile crisis visits within the last two years. OMH Residential Treatment Facilities are considered inpatient. (This information is required to determine eligibility for service).

| **Hospital/ER/Mobile Crisis** | **Admission Date** | **Discharge Date** (If currently hospitalized, expected Discharge Date) | **Source of Data** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

4a. Indicate any mental health or substance abuse program the applicant attends, had previously attended in the last 24 months, and/or if program is part of the discharge plan: (e.g., mental health clinic, substance abuse treatment program, day treatment, vocational services program). Indicate whether program is: **C** = **C**urrently attending or **P** = **P**reviously attended

| Dates | Program Name | Contact Name | Telephone Number | C or P |
|---|---|---|---|---|
| | | | | Currently |
| | | | | Currently |
| | | | | Currently |

4b. For inpatient and RTF (Residential Treatment Facility) referrals, the discharge plan for outpatient **medical** and **mental health** services must be listed below:

| Purpose | Program/Clinic Name | Contact Name | Telephone Number | Appointment Date |
|---|---|---|---|---|
| | | | | |
| | | | | |

Applicant's Last Name:_____

## Section G: Well Being

1. **High Risk Behavior**: (Check one response for each)

0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, but not in the past 3 months
3=one or more times in the past 3 months but not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
U=unknown

| | 0 | 1 | 2 | 3 | 4 | 5 | U |
|---|---|---|---|---|---|---|---|
| a. How often did applicant do physical harm to self? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| b. How often did applicant attempt suicide? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| c. How frequently did applicant physically abuse another? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| d. How frequently did applicant assault another? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| e. How frequently was applicant a victim of sexual abuse? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| f. How frequently was applicant a victim of physical abuse? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| g. How frequently did applicant engage in arson? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| h. How frequently did applicant engage in accidental fire-setting? | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| i. How often did applicant exhibit the following symptoms?: | | | | | | | |
| j. Please comment below on any above selections: Homicidal attempts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Delusions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Hallucinations | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Disruptive behavior | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Severe thought disorder | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other (specify below): | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

_____

2. **Does applicant have current or history of substance abuse?** ○ Yes ○ No

**If yes,** complete the questions below.

0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, but not in the past 3 months
3=one or more times in the past 3 months but not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
6=daily
U=unknown

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | U |
|---|---|---|---|---|---|---|---|---|
| a. Alcohol | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| b. Cocaine | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| c. Amphetamines | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| d. Crack | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| e. PCP | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| f. Inhalants | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| g. Heroin/Opiates | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| h. Marijuana/Cannabis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| i. Hallucinogens | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| j. Sedatives/hypnotics/anxiolytics | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| k. Other prescription drug abuse | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| l. Tobacco | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| m.Other (specify)_____ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

Applicant's Last Name:_____

**3. Co-occurring disabilities: (Check all that apply)**

- ☐ 1. None
- ☐ 2. Drug or alcohol abuse
- ☐ 2. Cognitive disorder
- ☐ 3. Mental retardation or developmental disorder
- ☐ 4. Blindness
- ☐ 5. Impaired ability to walk
- ☐ 6. Tobacco
- ☐ 7. Wheelchair required
- ☐ 8. Hearing impairment
- ☐ 9. Speech impairment
- ☐ 10. Visual impairment
- ☐ 11. Deaf
- ☐ 12. Bedridden
- ☐ 13. Amputee
- ☐ 14. Incontinence
- ☐ 15. Other (specify): _____

## Section H: Referral Source

**1. Referral Source:**

- ○ 1. Family/legal guardian
- ○ 2. Self
- ○ 3. School/education system
- ○ 4. State-operated inpatient program
- ○ 5. Local hospital acute inpatient program
- ○ 6. Criminal justice system
- ○ 7. Social services
- ○ 8. PROS
- ○ 9. Physician
- ○ 10. Emergency room (psychiatric & general hospital)
- ○ 11. Hospital medical unit
- ○ 12. Outpatient mental health service
- ○ 13. Private psychiatric inpatient hospital
- ○ 14. Residential treatment facility
- ○ 15. Community residence
- ○ 16. ACT
- ○ 17. Mobile Crisis Team
- ○ 18. AOT
- ○ 19. Non-Medicaid Care Coordination
- ○ 20. Health Home Care Coordination
- ○ 21. Child BCM/ICM/SCM
- ○ 22. OPWDD
- ○ 23. Shelter
- ○ 24. Other (specify) _____

**2. Referring Agency Information:**

Agency Name:_____

Program/Unit Name:_____

Primary Contact: _____

Primary Contact phone number: _____ Fax number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date: _____

NOTICE REGARDING DISCLOSURE OF CONFIDENTIAL INFORMATION

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

Applicant's Last Name:_____

## Referral Summary for Care Coordination/ACT

To be completed for an application for all referrals. Use additional pages if necessary.

1. Reason for the referral :

2. Community Mental Health Services tried in the past 2 years: *Type of services* (Outpatient Clinic, PROS, Assertive Community Treatment, Care Coordination, etc.) *and outcome,* i.e. rarely attended, never attended, refused services.

3. What community based supports and interventions/strategies (e.g. Care Coordination, ACT, Mobile Crisis Team, AOT, etc.) have been attempted within the last 12 months to engage and/or link applicant to community mental health services?

4. Medication compliance/non-compliance and consequences:

5. Brief statement regarding applicant's current level of functioning including mental status, relationship with family, community supports, etc.:

6. Health/Medical Status, including impact on applicant's overall functioning (Do not include HIV related information):

**Worker:** _____ _____ _____

**Print Name** **Signature** **Date**

**Title:** _____ **Phone #:** _____

Applicant's Last Name:_____

## NEW YORK STATE OFFICE OF MENTAL HEALTH
## CRITERIA FOR SEVERE MENTAL ILLNESS AMONG ADULTS

**To be considered an adult diagnosed with severe and persistent mental illness, Criteria A must be met. In addition, Criteria B or C or D must be met.**

A. **Designated Mental Illness Diagnosis**

The individual is 18 years of age or older and currently meets the criteria for a DSM IV psychiatric diagnosis other than alcohol or drug disorders (291.xx-292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx-294.xx), developmental disabilities (299.xx, 315.xx-319.xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent in DSM IV are also not included as designated mental illness diagnoses.

**AND**

B. **SSI or SSDI Enrollment due to Mental Illness**

The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

**OR**

C. **Extended Impairment in Functioning due to Mental Illness**

The individual must meet 1 or 2 below:

1. The individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:

   a. Marked difficulties in self-care (personal hygiene; diet; clothing. avoiding injuries; securing health care or complying with medical advice).
   b. Marked restriction of activities of daily living (maintaining a residence; using transportation; day-to-day money management; accessing community services).
   c. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time.)
   d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

2. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM IV) due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

**OR**

D. **Reliance on Psychiatric Treatment, Rehabilitation, and Supports**

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.