NYS OMH Single Point of Access (SPOA)
Case Management/ACT Program Application Cover Sheet

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

Date of Submission: _____ For CM/ACT Consultation Assistance call (212) 801-3343

TO:
SPOA Case Management/ACT Program
Center for Urban Community Services
198 East 121st Street, 6th Floor
New York, NY 10035
Fax: (212) 366-4095

ALL COMPLETE SPOA PACKETS must include:

- ☐ This Cover Sheet with Signed Consent
- ☐ The Universal Referral Form (URF)
- ☐ CM/ACT Referral Summary
- ☐ A Comprehensive Psychosocial Summary
- ☐ A Comprehensive Psychiatric Evaluation
- ☐ Physical Exam (required from inpatient referral)
- ☐ PPD Results (required from inpatient referral)

FROM:

Referring Agency/Program: _____

Referring Worker's Name: _____

Contact Phone: _____ **Fax:**_____

Referring Worker E-mail: _____

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

RE:

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

Applicant's D.O.B.: _____ / _____ / _____

Level of Service Requested (circle one): ACT ICM BCM SCM

TYPE OF REFERRAL (circle all that apply):

Priority Referral: AOT Potential AOT State PC Acute Inpatient Unit CPEP Unit Psychiatric Emergency Room Correctional Health/Prison Mental Health Unit Mobile Crisis Teams Mental Health Courts OMH Links OMH Residential Treatment Facilities

Community Referral: ACT/Case Management Transfer Continuing Day Treatment Program Psychiatric Outpatient Program Residential Program DHS/Section 8 Project
Other: _____

Specific ACT/Case Management Program Requested (If applicable): _____

CONSENT TO RELEASE INFORMATION

(Please keep original on file)

I authorize the disclosure of the New York City Case Management Application and all related supporting documents to the Center for Urban Community Services, 198 East 121st Street, 6th Floor, New York, NY 10035 for the purposes of case management assessment and placement assistance for a period of ninety (90) days. 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.

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

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

Adult Case Management and ACT Services
UNIVERSAL REFERRAL FORM

A Complete Application Must Include the Following:

- ☐ The Universal Referral Form (URF) including SPOA Coversheet. **Please answer all questions** and write legibly. If information is Unknown (U/K) or Not Applicable (N/A), please indicate.
- ☐ 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 and within 6 months for outpatient referrals.
- ☐ A Physical Exam is requested for referrals from out-patient programs and required for referrals from inpatient programs, including PPD results.
- ☐ Authorization for Release of Confidential HIV-Related Information, if any HIV-related information is disclosed.

Send or FAX Complete URF Packet to: CUCS, SPOA Case Management/ACT Program
198 East 121st Street, 6th Floor
New York, NY 10035
FAX: 212-366-4095

Note: The Applicant's social security number (SSN) may be used to verify identity. Disclosure of the SSN is voluntary.

For Questions about the Universal Referral Form: Call CUCS at 212-801-3343.

Service Being Requested:

○ Assertive Community Treatment (ACT)* ○ Intensive Case Management (ICM)
○ Blended Case Management (BCM) __SCM __ICM ○ Supportive Case Management (SCM)

Section A: Demographics

1. Name:
First: _____ Last: _____

2. DOB: ☐☐/☐☐/☐☐ 3. Sex: ○ Male ○ Female

4. Medicaid # (if applicable): ☐☐☐☐☐☐☐☐ Medicaid Sequence #: ☐☐
○ None ○ Unknown

5. Primary Language:

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

6. English Proficiency: (Check one)
○ Does not speak English ○ Poor ○ Fair ○ Good ○ Excellent

7. Social Security Number: ☐☐☐-☐☐-☐☐☐☐
If Not Provided, indicate reason: ○ Applicant declines to provide ○ 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	○ 5. Chinese	○ 9. Guamanion/Chamorro	○ 14. Unknown
○ 2. Black, African American	○ 6. Filipino	○ 10. Samoan	○ 15. Other Pacific Islander
○ 3. American Indian or Alaskan Native	○ 7. Vietnamese	○ 11. Japanese	○ 16. Other (specify): _____
○ 4. Asian Indian	○ 8. Other Asian	○ 12. Latino/Latina	
	○ 9. Native Hawaiian	○ 13. Korean	

10. If the applicant is Latino/Hispanic, please complete the following:

○ 1. Mexican, Mexican American or Chicano	○ 3. Dominican	○ 5. Unknown
○ 2. Puerto Rican	○ 4. Cuban	○ 6. Other: _____

Section B: Family Contacts

1. Marital Status: (Check one)

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

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

_____

_____

_____

Section C: AOT

1. AOT: ○ Yes ○ 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? : ○ Yes ○ No ○ 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)

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

Applicant's Last Name:_____

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

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

○ Yes ○ No ○ Not Applicable ○ Unknown

4. Does the applicant have a current housing determination/approval? ○ Yes ○ 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.)

Dates	**Location**

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

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

Facility Name: _____

Address: _____

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

5d. Reason for leaving: _____

6. Current Employment Status: (Check one)

○ 1. No employment of any kind
○ 2. Competitive employment (employer paid) with no formal supports
○ 3. Competitive employment (employer paid) with no ongoing supports
○ 4. Sporadic or casual employment for pay (includes odd jobs)
○ 5. Non-paid work experience (includes volunteer positions)
○ 6. Community-integrated employment run by a state, local or non- government agency or organization
○ 7. Employment in sheltered (non-integrated) workshop run by State or local agency
○ 8. Unknown
○ 9. Other_____

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. Medication Grant Program
○ 11. Unemployment or union benefits
○ 12. Railroad, retirement pension (excluding SSA)
○ 13. Medicare
○ 14. Public assistance cash program, TANF, Safety, temporary disability
○ 15. Private insurance, employer coverage, no fault or third party insurance
○ 16. None
○ 17. Other: _____

Applicant's Last Name:_____

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

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

_____

_____

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
   - ○ 6. Under parole supervision
   - ○ 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

1. Axis I: Clinical Disorders and other conditions that may be focus of clinical attention.

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

2. Axis II: Personality Disorders and/or Mental Retardation.

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

3. Axis III: General Medical Disorders, including Significant Communicable Diseases.

   Diagnosis (if none, please indicate)

   _____

   _____

   _____

4. Axis IV: Psychosocial and Environmental Problems. (Check all that apply)
   - ○ 1. Problems with primary support group
   - ○ 2. Problems related to the social environment
   - ○ 3. Educational problems
   - ○ 4. Occupational problems
   - ○ 5. Housing problems
   - ○ 6. Economic problems
   - ○ 7. Problems with access to health care facilities
   - ○ 8. Problems related to access with legal system/crime
   - ○ 9. Unknown
   - ○ 10. Other (specify) _____

5. Axis V: Global Assessment of Functioning (GAF), current :_____

Applicant's Last Name:_____

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

Name	Dosage	Schedule

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

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 **If Yes**, **attach results.**

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, continuing day treatment, partial hospital, IPRT
   - ○ 6. Alcohol / Drug abuse inpatient treatment (e.g. clubhouse, vocational services)
   - ○ 7. Alcohol / Drug abuse outpatient treatment
   - ○ 8. ACT, ICM, SCM 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) _____

Applicant's Last Name:_____

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.*	

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

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?:							
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	○ 5. Impaired ability to walk	○ 11. Deaf
○ 2. Drug or alcohol abuse	○ 6. Tobacco	○ 12. Bedridden
○ 2. Cognitive disorder	○ 7. Wheelchair required	○ 13. Amputee
○ 3. Mental retardation or developmental disorder	○ 8. Hearing impairment	○ 14. Incontinence
	○ 9. Speech impairment	○ 15. Other (specify): _____
○ 4. Blindness	○ 10. Visual impairment	

Section H: Referral Source

1. Referral Source:

○ 1. family/legal guardian	○ 13. private psychiatric inpatient hospital
○ 2. self	○ 14. residential treatment facility
○ 3. school/education system	○ 15. community residence
○ 4. state-operated inpatient program	○ 16. ACT
○ 5. local hospital acute inpatient program	○ 17. Mobile Crisis Team
○ 6. criminal justice system	○ 18. AOT
○ 7. social services	○ 19. Blended Case Management
○ 8. other mental health program	○ 20. Supportive Case Management
○ 9. physician	○ 21. Intensive Case Management
○ 10. emergency room (psychiatric & general hospital)	○ 22. OMRDD
○ 11. hospital medical unit	○ 23. shelter
○ 12. outpatient mental health service	○ 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 ACT/Case Management

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, Community Day Treatment, Partial Hospitalization Program, Assertive Community Treatment, Case Management, etc.) *and outcome,* i.e. rarely attended, never attended, refused services.

_____

_____

_____

3. What community based supports and interventions/strategies (e.g. ICM, 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:

_____

_____

_____

Worker: _____ _____

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

Title: _____ **Phone #:** _____

Applicant's Last Name:_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV (Human Immunodeficiency Virus) related is any information indicating that a person had an HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release by calling the HIV Confidentiality Law Hotline at (800) 962-5065.

If you sign this form, HIV related information can be given to the people or organizations listed on the form. You do not have to sign the form, and you can change your mind at any time. If you experience discrimination because of release of HIV related information, you can contact the New York State Division of Human Rights at (212)961-8624 or the New York City Commission of Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:	**Reason for release of HIV related information:** To provide appropriate medical, case management and/or ACT services
Name and address of facility/provider obtaining release:	**Extent or nature of information to be released:** Universal Referral Form, Psychosocial Summary, Medical and Psychiatric Reports, Treatment Plans, Progress Notes and other related information as required.
Name and address of person signing this form (if other than the person whose HIV related info will be released): **Relationship to person whose HIV info will be released:**	
Time during which release is authorized: **From:** **To:**	

I authorize the provider/facility listed above to release HIV related information to the people/agencies listed below. I also authorize the agencies listed below to release such records back to the named provider and to share necessary HIV related information among and between themselves for the purpose of providing assistance in receiving needed services. I understand that these records, including the HIV related information, cannot be shared with persons or organizations not named or identified on this release form.

Note: Unused boxes **MUST** be crossed out prior to authorizing signature.

Agency Name:	Agency Name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

Agency Name:	Agency Name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

My questions about this form have been answered. I know that I do not have to allow release of HIV related information and that I can change my mind at any time. I have received a copy of this release.

Signature: _____ **Date:** ____/____/____

Signature of parent or guardian if required: _____ **Date:** ____/____/____

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.