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

Complete the Case Management/ACT Application Package Including:

1. The Universal Referral Form (URF). Please answer all questions and write legibly.
2. A Comprehensive Psychosocial Summary completed or updated within the last 90 days.
3. A Comprehensive Psychiatric Evaluation signed by a Psychiatrist and completed within the last 30 days for inpatient referrals and within 90 days for outpatient referrals.
4. A Physical Exam is requested for referrals from out-patient programs and required for referrals from inpatient programs, including PPD results within the last year.
5. Authorization for Release of Confidential HIV-Related Information, if HIV-related information is disclosed.
6. If an application is being made for a transfer to another agency, please complete a new URF Application Package and attach the most recent Baseline and follow-up assessments, the last 4 weeks of progress notes, the most recent treatment plan, the last six completed NYC Acuity Scales (if applicable), and a copy of the complete initial Case Management/ACT Application and Referral packet.

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 212-801-3333.

Services Being Requested: (check all that apply)

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

Section A: Demographics

1. Name:
First: _____ Last: _____

2. DOB: ☐☐/☐☐/☐☐

3. Sex: ○ Male ○ Female

4. Medicaid # (if applicable): ☐☐☐☐☐☐☐☐ Medicaid Sequence #: ☐☐

5. Primary Language:

○ 1. English	○ 4. Spanish	○ 7. Chinese	○ 10. Vietnamese	○ 13. German
○ 2. Greek	○ 5. Italian	○ 8. Japanese	○ 11. French	○ 14. Hindi
○ 3. No language	○ 6. American Sign Language	○ 9. Creole	○ 12. Urdu	○ 15. Other (specify): _____

6. Social Security Number: ☐☐☐-☐☐-☐☐☐☐

If Not Provided, indicate reason: ○ Applicant declines to provide ○ Applicant does not have a SSN

Applicant's Last Name:_____

7. Address: (If applicant is hospitalized, please give address prior to admission.)

_____

_____

Telephone:_____

If applicant is being discharged to a different address, please indicate:

_____

_____

Telephone:_____

8. Is this applicant Spanish/Hispanic/Latino?

○ No ○ Yes **If Yes**, check below:

○ 1. Mexican, Mexican American or Chicano ○ 3. Dominican ○ 5. Unknown

○ 2. Puerto Rican ○ 4. Cuban ○ 6. Other: _____

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

○ 1. White, European American ○ 5. Chinese ○ 9. Native Hawaiian ○ 13. Korean

○ 2. Black, African American ○ 6. Filipino ○ 10. Guamanion/Chamorro ○ 14. Unknown

○ 3. American Indian or Alaskan Native ○ 7. Vietnamese ○ 11. Samoan ○ 15. Other Pacific Islander

○ 8. Other Asian ○ 12. Japanese ○ 16. Other (specify): _____

○ 4. Asian Indian

10. English Proficiency: (Check one)

○ Does not speak English ○ Poor ○ Fair ○ Good ○ Excellent

Section B: Family Contacts

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

_____

_____

_____

Section C: AOT

1. AOT: ○ Yes ○ No ○ Pending **If Yes**, is order ○ Voluntary or ○ Involuntary

Section D: Characteristics

1. Current Living Situation: (Check one)

○ 1. Private residence alone

○ 2. Private residence with spouse or domestic partner

○ 3. Private residence with parent, child, other family

○ 4. MH Supported Housing (Supported Housing or Supported SRO)

○ 5. MH Housing Support Program (Congregate Support or Service Enriched SRO)

○ 6. MH apartment treatment program

○ 7. MH congregate treatment program

○ 8. MH crisis residence

○ 9. Inpatient state psychiatric hospital

○ 10. Private residence with others

○ 11. DOH adult home

○ 12. Drug or alcohol abuse residence or inpatient setting

○ 13. Correctional Facility

○ 14. Homeless, street, parks, drop in center, or undomiciled

○ 15. Unknown

○ 16. Drug or alcohol abuse residence or inpatient setting

○ 17. Shelter or emergency housing

○ 18. Inpatient, general hospital or private psychiatric

○ 19. Other (specify): _____

Applicant's Last Name:_____

2. Has an HRA 2000 housing application been submitted within the last 3 months for this applicant?
   ○ Yes ○ No ○ Not Applicable ○ Unknown
3. Has the applicant ever been homeless? ○ Yes ○ No
4. Does the person have a current NY/NY housing approval? ○ Yes ○ No
5. If you answered "Yes" to Question 3 or 4, 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**

6. 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
○ 7. Adult home/residence
○ 8. Inpatient psychiatric facility
○ 9. Unknown
○ 10. Other (specify) _____

Facility Name: _____

Address: _____

7. Length of occupancy (in months): ☐
8. Reason for leaving: _____
9. 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 of local agency
○ 8. Unknown
○ 9. Other_____

10. 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. Veteran benefits
○ 5. Worker's compensation or disability insurance
○ 6. Hospital-based Medicaid
○ 7. Unemployment or union benefits
○ 8. Soc. sec. retirement, survivor's, dependants (SSA)
○ 9. Medicaid pending
○ 10. Railroad, retirement pension (excluding SSA)
○ 11. Medicare
○ 12. Medicaid
○ 13. Public assistance cash program, TANF, Safety, temporary disability
○ 14. Hospital-based Medicaid
○ 15. Private insurance, employer coverage, no fault or third party insurance
○ 16. None
○ 17. Other: _____

Applicant's Last Name:_____

11. For any current benefits checked in Question 10, indicate the type and amount per month:

Type of benefit	Amount per month	Type of benefit	Amount per month

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

_____

_____

13. 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): _____

14. Marital Status: (Check one)

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

Section E: Clinical

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

Diagnosis	DSM-IVR Code

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

Diagnosis	DSM-IVR Code

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

Diagnosis

_____

_____

_____

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 :_____

6. Current Psychotropic Medications:

Name	Dosage	Schedule

7. Current Medications for Physical Illness:

Name	Dosage	Schedule

8. Applicant Adherence to Medication Regimen: (Check one)
   - ○ 1. Takes medication exactly as prescribed
   - ○ 2. Rarely or never takes medication as prescribed
   - ○ 3. Takes medication as prescribed most of the time
   - ○ 4. Sometimes 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 regime?
   ○ Dispensing ○ None, independent ○ Supervision ○ Not applicable ○ Reminders ○ 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 MD or facility: _____

12. Medical Tests:
    Has applicant been tested for TB in the past 6 months? ○ 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	○	○

Applicant's Last Name:_____

Section F: Utilization

1. Applicant Services within the last 12 months, other than current: (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
- ○ 13. Self help / Peer support services
- ○ 14. Community Support Program non-residential mental health program
- ○ 15. Unknown
- ○ Other (specify) _____

2. Psychiatric Services within the last 12 months, other than current: (Indicate the number of utilizations for each)

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:			

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

Hospital/ER	Admission Date	Discharge Date	Source of Data

4. Indicate any mental health or substance abuse program the applicant attends or, if applicable, was attending prior to hospitalization: (e.g., mental health clinic, substance abuse treatment program, clubhouse, day treatment, vocational services program)

Program Name	Contact Name	Telephone Number

Applicant's Last Name:_____

Section G: Well Being

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

0=never
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.
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

	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. Other co-occurring disabilities, if any: (Check all that apply)

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

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:_____

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 AND PERSISTENT 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.