MEMORANDUM OF UNDERSTANDING BETWEEN THE NEW YORK CITY DEPARTMENT OF HOMELESS SERVICES AND THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

THIS MEMORANDUM OF UNDERSTANDING ("MOU" or "Agreement"), effective as of July 5, 2018 ("Effective Date"), between the New York City Department of Social Services / Department of Homeless Services ("DHS"), with offices at 33 Beaver Street, New York, NY 10004, and New York City Department of Health and Mental Hygiene ("DOHMH"), with offices at 42-09 28th Street, Queens, NY 11101 (collectively referred to as "the Parties").

WITNESSETH:

WHEREAS, pursuant to §551 and §556 of the New York City Charter, DOHMH is the local social service district that performs all functions and operations performed by the City that relate to the health of the people of the City; and

WHEREAS, as part of its operations, DOHMH manages the Single Point of Access ("SPOA") Program, which connects mentally ill New Yorkers to mental health services; and

WHEREAS, pursuant to §612 of the New York City Charter, DHS is the local social service district that is responsible for administering housing support and ancillary services for eligible homeless individuals, including homeless individuals with mental illness; and

WHEREAS, in a joint effort to link mentally ill DHS clients to DOHMH mental health care services, DHS wishes to share client information with DOHMH to facilitate client participation in the SPOA Program; and

WHEREAS, the Parties wish to enter into an agreement to set forth the conditions under which DHS will share client information with DOHMH for the purposes set forth herein;

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1. TERM

This term of this Agreement shall be from the Effective Date until either party elects to terminate the Agreement as provided for herein.

ARTICLE 2. SCOPE

A. GENERAL

The purpose of this Agreement is to set forth a framework by which DHS staff and/or contracted shelter staff ("DHS Staff") will electronically submit SPOA applications to DOHMH on behalf of DHS clients with mental health issues as demonstrated by a documented history of severe

mental illness and/or by presenting with behaviors that warrant additional psychiatric supports or mental health services.

B. DHS OBLIGATIONS

1. DHS staff shall submit the SPOA application on behalf of individuals entering and residing in DHS shelters who present mental health issues. The data elements collected about DHS clients that may be shared are limited to the information required to complete the SPOA application as detailed in the attached Exhibit A for hard copy submissions, or as detailed in the attached Exhibit B, for submissions through DOHMH's secure, online SPOA application system. Exhibit B is hereby included for reference, and shall not be used in lieu of Exhibit A when submitting hard copy SPOA applications via encrypted email.

2. DHS staff will submit SPOA applications by utilizing DOHMH's secure, online application or by encrypted email to SPOA@Health.NYC.Gov on an ongoing basis, as necessitated by DHS client need. DHS staff will answer follow-up questions from DOHMH as necessary to facilitate DOHMH's processing of DHS client SPOA applications.

3. DHS staff may submit the SPOA application without client consent on the legal bases detailed in Article 3.

C. DOHMH OBLIGATIONS

DOHMH shall:

1. Receive and process SPOA applications for purposes of assessing eligibility and making referrals for mental health services.

2. Provide feedback to DHS staff on submitted SPOA applications where necessary in order to facilitate care coordination pursuant to Article 41 of the New York Mental Hygiene Law. Such feedback shall be limited to the minimum amount of information necessary.

ARTICLE 3. LEGAL BASIS FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

A. Confidential information relating to DHS clients may be disclosed to another agency without consent of the individual when the public welfare official providing such information is assured that the confidential character of the information will be maintained, the information will be used for the purpose for which it is made available, and such purpose is reasonably related to the purposes of the public welfare program and the function of the inquiring agency, and the information will not be used for commercial or political purposes. Since DHS clients are Public Assistance recipients, disclosure of the information should be limited to purposes directly connected with the administration

of public assistance. Such purposes include establishing eligibility and providing services for applicants and recipients. 45 C.F.R. §205.50(a)(1)(i)(A); N.Y. Soc.Serv. Law §§ 136; and 18 N.Y.C.R.R. §357.2(a), § 357.3(a).

The confidential character of the information will be maintained in accordance with the guidelines established in Article 4, below. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA") and the Office of National Drug Control Policy 20-30% of those experiencing chronic homelessness are also facing a serious mental illness. To assist homeless clients transition into stable and permanent housing, DHS must also address barriers to such housing, such as severe mental illness. This overlaps with the goals of DOHMH to protect and promote the health of New Yorkers. DOHMH will receive demographic information for purposes of providing mental health care outreach, which is a service to Public Assistance recipients. Finally, this information will only be used to connect DHS clients with additional public assistance available through DOHMH, and will not be used for commercial or political purposes.

B. Pursuant to New York State Public Officer's Law §96-a, governmental agencies may disclose client-provided Social Security Numbers absent individual consent to other governmental entities for administrative purposes. The disclosure of client SSNs between DHS and DOHMH is necessary to maintain comprehensive demographics for each client. The purpose of the disclosure satisfies the exception that permits the disclosure of the SSNs for administrative purposes absent individual consent.

ARTICLE 4. CONFIDENTIALITY

A. All information obtained, learned, developed or filed by either Party in connection with this Agreement, including data contained in official DHS files or records, shall be held confidential by the Parties pursuant but not limited to the provisions of the Social Services Law of the State of New York, the New York Mental Hygiene Law, and any applicable regulations promulgated thereunder and shall not be disclosed by either Party to any person, organization, agency or other entity except as authorized or required by law. All of the reports, information or data, furnished to or prepared, assembled or used by either Party under this Agreement are to be held confidential, and the Parties agree that the same shall not be made available to any individual or organization without the prior approval of the non-disclosing Party.

B. DOHMH shall not use the data obtained under this Agreement for any purpose other than those listed in Article 2 of this Agreement.

C. The Parties agree to use and ensure the use of appropriate safeguards to prevent misuse or unauthorized disclosure of any confidential information and to implement administrative, physical, and technical safeguards that reasonably and appropriately protect and secure the confidentiality, integrity, and availability of any electronic or hard copy of individually identifiable information that is created, received, maintained, or transmitted pursuant to this Agreement.

D. The provisions of this Section shall remain in full force and effect following termination of this Agreement.

ARTICLE 5. EFFECT OF UNAUTHORIZED DISCLOSURE

A. The parties agree to report any unauthorized use or disclosure of confidential or protected data, not provided for by this Agreement of which it becomes aware. The parties further agree to immediately report any data security incident of which it becomes aware, including a breach of unsecured protected data.

i. In the event of any unauthorized disclosure data, the party responsible for unauthorized disclosure of data (Responsible Party) shall immediately commence an investigation to determine the scope of the disclosure and immediately inform the other party (Affected Party) in writing following discovery of such incident, but no later than 30 calendar days after discovery. The Responsible Party is responsible for providing a written incident report, within forty-eight (48) hours after the incident is discovered, that details the circumstances surrounding the unauthorized disclosure and the names of the individuals involved, if known. A breach is considered discovered on the first day on which the Responsible Party, its contractors, subcontractors or any agent thereof, knows or should have known of such breach. The HRA Privacy Officer and/or the General Counsel should be immediately notified of any unauthorized disclosure of any HRA client identifiable information.

ii. HRA's Privacy Officer will determine if a data breach has occurred after reviewing the outcome of the investigation. In the event of a data breach, the Responsible Party is required to notify the affected individuals within a reasonable amount of time, but no later than sixty (60) calendar days after the discovery of the breach or earlier if so required by law, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Notification shall be in a form and format prescribed by Affected Party and shall meet the requirements of applicable local, state and federal law. The Responsible Party shall be responsible for all costs associated with providing notification to all affected individuals when notification is required by law.

B. The Responsible Party recognizes that irreparable harm may result to Affected Party, and to the business of the City, in the event of any breach by the Responsible Party of any of the covenants and assurances contained in this Agreement. In the event of a breach of any of the covenants and assurances contained herein, the Affected Party shall restrain the Responsible Party, its contractors, subcontractors or agents thereof, from any continued violation, including but not limited to termination of access to any identifiable client data.

C. A breach of this Article shall constitute a material breach of this Agreement for which the Affected Party may terminate this Agreement as indicated herein. If for any reason term of this Agreement is violated, all Affected Party data shall be either destroyed or returned, unless otherwise authorized by the Affected Party.

ARTICLE 6. TERMINATION

Each party shall have the right to terminate this Agreement, in whole or in part, upon thirty (30) days prior written notice to the other Party, or immediately for cause upon written notice to the other Party.

ARTICLE 7. MODIFICATION

This Agreement may be modified upon mutual agreement between the parties set forth in writing and signed on behalf of each of the Parties. It may not be modified orally.

ARTICLE 8. NOTICES

All notices and requests hereunder by either party shall be in writing or by telephone and directed to the address of the parties as follows:

DHS Contact:

Attn: Jason Hansman
NYC Department of Homeless Services
33 Beaver Street
New York, NY 10004

DOHMH Contact:

Attn: Mary McGovern
NYC Department of Health and Mental Hygiene
42-09 28th Street
Queens, NY 11101

ARTICLE 9. ENTIRE AGREEMENT

This Agreement contains all the terms and conditions agreed upon by the parties hereto, and no other agreement, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto, or to vary any of the terms contained herein.

[SIGNATURE PAGE FOLLOWS]

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IN WITNESS WHEREOF, the parties have duly executed this Agreement on the date last below written.

THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES/
DEPARTMENT OF HOMELES SERVICES

By: _____

_____
Vincent Pullo

_____
ACCO

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

By: _____

Gary Belkin
_____
[Print Name]

_____
[Print Title]

ROCHELLE CAITS
Notary Public, State of New York
No. 01CA4745131
Qualified in Queens County
Commission Expires Jan 31, 2022

STATE OF NEW YORK)
:ss
COUNTY OF NEW YORK)

On this 5th day of July 2016 before me personally came Vincent Pullo, to me known and known to me to be NCCO of the **HUMAN RESOURCES ADMINISTRATION/DEPARTMENT OF SOCIAL SERVICES of the CITY OF NEW YORK**, the person described in and who executed the foregoing instrument, and she/he acknowledged to me that she/he executed the same for the purpose therein mentioned.

Sharon James Leonce
NOTARY PUBLIC

SHARON JAMES-LEONCE
Commissioner of Deeds
City of New York No. 2-13026
Certificate Filed in New York County
Commission Expires May 01, 2020

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ACKNOWLEDGEMENTS:

STATE OF NEW YORK)

COUNTY OF NEW YORK)

On this 18th day of June 201 8, before me personally came (In error)
Gary Belkin, to me known and known to me to be
_____ of the DEPARTMENT OF SOCIAL SERVICES/ DEPARTMENT OF SOCIAL SERVICES of the CITY OF NEW YORK, the person described in and who is duly authorized to execute the foregoing instrument on behalf of the Commissioner, and he acknowledged to me that he executed the same for the purpose therein mentioned.

_____
NOTARY PUBLIC

STATE OF)

COUNTY OF)

On this 18th day of June 201 8, before me personally came
Gary Belkin to me known and known to me to be the
Commissioner of _____ of THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, the person described in and who is duly authorized to execute the foregoing instrument, and acknowledged to me that she/he executed the same for the purposes therein mentioned.

ROCHELLE CAITS
Notary Public, State of New York
No. 01CA4745131
Qualified in Queens County
Commission Expires Jan 31, 2022

_____
NOTARY PUBLIC

Rochelle Caits
June 18, 2018

EXHIBIT A

NYS OMH Single Point of Access (SPOA)
Care Coordination /ACT/FACT 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/FACT Assistance Call 347-396-7258

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

FROM:
Referring Agency/Program: _____

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

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): O Non-Medicaid Care Coordination O ACT O FACT

O 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/FACT 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

NYC Health

New York State OMH Office of Mental Health

SPOA CARE COORDINATION /ASSERTIVE COMMUNITY TREATMENT (ACT) FORENSIC ACT (FACT) 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) or Forensic Assertive Community Treatment (FACT) 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 or FACT services, DOHMH will then need to share information with the assigned Care Coordination or ACT or FACT 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) or Forensic Assertive Community Treatment (FACT). 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 or FACT agency that will be assigned to provide you with services.

You are also being asked to consent to have the assigned Care Coordination, ACT or FACT 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, Assertive Community Treatment (ACT) or Forensic 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, ACT or FACT 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 DOHMH to use and disclose my Confidential Information to the Assigned Care Coordination/ACT/FACT 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, ACT or FACT 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.

NYC Health

New York State 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.

_____ _____

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 I, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

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

Adult Care Coordination ACT and FACT 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),
Most Recent Comprehensive Psychosocial Summary
Most Recent Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner, within the last 30 days if referral is from an inpatient setting
Authorization for Re-release of URF application to assigned Care Coordination, FACT 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 Health Home Care Coordination (Medicaid)
- O Assertive Community Treatment (ACT)
- O Forensic Assertive Community Treatment (FACT)

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):_____
Select Agency:
Health Home Assignment: _____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	_____

Applicant's Last Name:_____

6. English Proficiency: ○ 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

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

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)

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: ○ 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)

Applicant's Last Name:_____

- 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

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

Applicant's Last Name:_____

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:

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

- o 1) Applicant is not Under Criminal Justice Supervision
- o 2) CPL 330.20 order of condition and order of release
- o 3) In NYS Dept. of Correctional Services (State Prison)
- o 4) On Bail, Released on own recognizance (ROR), Conditional Discharge, or other alternative to incarceration
- o 5) Under Probation Supervision (PO/Contact)_____
- o 6) Under Parole Supervision (PO/Contact)_____
- o 7) Under arrest in jail, lockup or court detention
- o 8) Released from jail or prison within the last 30 days
- o 9) Unknown
- o 10) Other (specify): _____

Applicant's Last Name:_____

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	☐ 9. Emergency mental health (non-residential)
☐ 2. State psychiatric center inpatient unit	☐ 10. Prison, jail, or other court mental health service
☐ 3. General hospital unit or certified psychiatric hospital	☐ 11. Local MH Practitioner
☐ 4. Mental health housing & housing support	☐ 12. Assisted Outpatient Treatment (AOT)
☐ 5. MH outpatient clinic, PROS, IPRT	☐ 13. Self help / Peer support services
☐ 6. Alcohol/Drug abuse inpatient treatment (e.g. clubhouse, vocational services)	☐ 14. Community Support Program non-residential mental health program
☐ 7. Alcohol/Drug abuse outpatient treatment	☐ 15. Unknown
☐ 8. ACT, Care Coordination or other case management Name of Program: _____	☐ 16. Other (specify) _____

Applicant's Last Name:_____

2. Psychiatric Services utilization including current hospitalization if applicable. (Indicate the number of utilizations for each. Include "0" if none. "UK" if unknown.)

Psychiatric Hospitalization In 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. 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** = Previously 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?:							
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/FACT

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. To justify FACT assignment, applicant must have had criminal justice involvement within the past 12 months and the referral source must describe how the applicant's criminal justice involvement is related to his/her serious mental illness and non-adherence to medication and treatment.

5. Medication compliance/non-compliance and consequences:

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

7. 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.

EXHIBIT B

02 - Universal Referral Form

Expand Details

Client Information

Level of Service

ACT - For individuals with Serious Mental Illness (SMI) (excluding Dementia, Traumatic Brain Injury (TBI), and Persons with Developmental Disabilities (DD)) that seriously impairs their functioning in the community and with a documented history of lack of engagement traditional outpatient services. Priority is given to people with schizophrenia, other psychotic disorders, bipolar disorder, and/or major or chronic depression. Priority is given to individuals with continuous high service needs that are not being met in more traditional settings. Individuals with primary diagnosis of personality disorders or substance use are not appropriate for ACT.

FACT For individuals with Serious Mental Illness (SMI) (excluding Dementia, Traumatic Brain Injury (TBI), and Persons with Developmental Disabilities (DD)) that seriously impairs their functioning in the community and with a documented history of lack of engagement traditional outpatient services. Priority is given to people with schizophrenia, other psychotic disorders, bipolar disorder, and/or major or chronic depression. Priority is given to individuals with continuous high service needs that are not being met in more traditional settings. Presence of current or recent criminal justice involvement within in the last 12 months, including parole, probation, multiple arrests and/or incarceration. Criminal justice involvement is related to the presence of serious mental illness (SMI) or episodes of non-compliance with treatment

IMT - Intensive Mobile Treatment (IMT) teams offer flexible treatment and support services for individuals who have had recent and frequent contact with the behavioral health, criminal justice, and homeless systems. The individual does not need to meet the criteria for Severe Mental Illness (SMI) and Dementia, TBI and DD are NOT Automatic exclusions. The programs mobility and flexibility, and its focus on cross systems coordination and patient engagement aim to provide a unique service that can best meet the needs of individuals with lack of engagement in traditional outpatient services. IMT teams stay connected to individuals regardless of their location in shelter, on the street, in housing, hospital or jail.

Care coordination - For people with Serious Mental Illness (SMI) (excluding Dementia, Traumatic Brain Injury (TBI), and Persons with Developmental Disabilities (DD)) who are ineligible for Medicaid who have not successfully engaged in community based services.

* Level of Service Requested
- ○ Assertive Community Treatment (ACT)
- ○ Forensic Assertive Community Treatment (FACT)
- ○ Intensive Mobile Treatment (IMT)
- ○ Non-Medicaid Care Coordination
- ○ Health Home Care Coordination
- ○ Level of Service Change Request

Managed Care Organization (MCO)

* Does the client have care coordination? ○ Yes ○ No ○ N/A

Demographics

* First Name: Test
* Last Name: Client SPOA
AKA Name:
* Date of Birth: 04/02/1961
SSN:
* Gender: Male
Phone Number:
Email:

* Highest Education Level on Enrollment
- ○ No formal education or kindergarten only
- ○ Grammar school (Grades 1 to 5)
- ○ Junior high school (Grades 6 to 8)
- ○ Some high school (Grades 9 to 11)
- ○ GED or TASC
- ○ High school diploma
- ○ Business, vocational, or technical training
- ○ Some college but no degree
- ○ Associate's degree
- ○ Bachelor's degree
- ○ Graduate degree
- ○ Unknown
- ○ Other

* Marital Status
- ○ Single, never married
- ○ Currently married
- ○ Cohabitating with significant other/domestic partner
- ○ Widowed
- ○ Separated
- ○ Pending divorce
- ○ Divorced
- ○ Unknown
- ○ Other

* Race/Ethnicity (select all that apply)
- ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
- ☐ White ☐ Other ☐ Unknown

* Hispanic/Non-Hispanic ○ Hispanic ○ Not Hispanic ○ Unknown

* Medicaid ID ○ Known ○ Unknown ○ Non-Medicaid

Medicaid ID:

Additional Contacts for Client

Secondary Contact:
Relationship to person:
Phone Number:
Email:
Tertiary Contact:
Relationship to person:

Phone Number

Email

Language

* Primary Language

* English Proficiency

AOT

* AOT status

AOT Borough

Other info

* Known past history of AOT

Criminal Justice

* Criminal Justice Involvement

- ☐ No past history of criminal justice involvement
- ☐ Current probation
- ☐ Currently on parole
- ☐ Current detention - jail
- ☐ Current detention - prison
- ☐ Currently involved in a Diversion Program
- ☐ Pending matter in Criminal Court
- ☐ Pending matter in Family Court
- ☐ Past adult criminal conviction(s)
- ☐ Criminal Justice Involvement within past 12 months
- ☐ Past juvenile delinquent finding(s)
- ☐ Past probation
- ☐ Past parole
- ☐ Past county jail
- ☐ Criminal Justice Involvement more than 12 months
- ☐ Current Order of Protection
- ☐ Other
- ☐ Unknown

NYSID # (if known)

Has person been arrested in the last 12 months?

Specific charge (if known)

Client Information Notes

Employment and Benefits

* Current employment status

- ○ Paid competitive full-time (35+ hrs/week)
- ○ Paid competitive part-time
- ○ Temporary, seasonal, or per diem
- ○ Internship or volunteer
- ○ Transitional employment
- ○ None
- ○ Unknown
- ○ Other

* Current Income Sources

- ☐ Earned income (i.e. employment income)
- ☐ Unemployment Insurance
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Income (SSDI)
- ☐ VA Benefits
- ☐ Private disability insurance
- ☐ Workers Compensation
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Retirement Income from Social Security
- ☐ Pension or retirement income from a former job
- ☐ Child support
- ☐ Alimony and other spousal support
- ☐ Trust
- ☐ Unknown
- ☐ None of the above
- ☐ Other source

Housing

* Current living situation

Has the individual resided in more than one borough within the last 3 months?

Where did person live prior to current housing situation?

* Last Known Location

Street Address

Street 2

Borough

Diagnosis and Treatment

Mental Health Diagnosis

DSM 4/5 Diagnosis

Physical Health Diagnosis

Physical Health Diagnosis

- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Metabolic Syndrome
- ☐ Coronary heart disease
- ☐ Diabetes
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Obesity
- ☐ Liver Disease/Cirrhosis
- ☐ None of the above
- ☐ Unknown
- ☐ Other

Medication Adherence/Treatment

Applicant adherence to medication regimen

- ○ Takes medication as prescribed
- ○ Takes medication as prescribed most of the time
- ○ Sometimes takes medication as prescribed
- ○ Rarely takes medications as prescribed
- ○ Never takes medication as prescribed
- ○ Refuses medication
- ○ Medication not prescribed
- ○ Unknown
- ○ Other

* Is client currently connected to treatment (i.e. going to mental health clinic, seeing a psychiatrist, has a clinic assigned, etc.)?

Co-Occurring Disabilities

Does the applicant have a co-occurring disability?

- ☐ None
- ☐ Cognitive disorder
- ☐ Mental retardation/Developmental disorder
- ☐ Blindness
- ☐ Impaired ability to walk
- ☐ Wheelchair required
- ☐ Hearing impairment
- ☐ Speech impairment
- ☐ Visual impairment
- ☐ Deaf
- ☐ Bedridden
- ☐ Amputee
- ☐ Incontinence
- ☐ Other

Does the applicant have a medical condition that requires special services (i.e. special medical equipment, medical supplies, etc.)?

Utilizations

Psychiatric Hospitalizations

* Has applicant had any psychiatric hospitalizations in the last 5 years?

Emergency Room

* Has applicant had any ER visits for psychiatric conditions in the last 5 years?

Mobile Crisis

* Has applicant had any mobile crisis visits in the last 5 years?

Mental Health Programs

* Has applicant attended any mental health programs (i.e. mental health clinics, ACT, Care Coordination, PROS, OPD, etc.) in the last 5 years?

Substance Use Programs

* Has applicant attended any substance use programs (i.e. substance use treatment program and/or day treatment) in the last 5 years?

Arrests

* Has applicant had any arrests in the last 5 years?

Incarcerations

* Any incarcerations in the last 5 years?

Risk and Substance Use

Risk Assessment

* Please identify which risk behaviors the applicant has engaged in:

- ☐ None
- ☐ Unknown
- ☐ Expressed suicide threat
- ☐ Attempted suicide
- ☐ Physically harmed self
- ☐ Taken property w/o permission
- ☐ Damaged or destroyed property
- ☐ Homelessness
- ☐ Created a public disturbance
- ☐ Verbally assaulted another person
- ☐ Threatened assault or physical violence
- ☐ Been suspected of sexual abuse of a child/adult
- ☐ Physically abused and/or assaulted a child/adult
- ☐ Engaged in arson
- ☐ Was a victim of physical or sexual abuse
- ☐ Wanders or runs away
- ☐ Transient/moves frequently
- ☐ High recidivism of incarceration
- ☐ No engagement after multiple referrals
- ☐ Attempted or committed homicide
- ☐ Other

Please explain any of the above selected:

Substance Use

* Reported Substance Use

Tobacco Use

* Has the applicant used tobacco within the past 6 months?

- ○ No, quit within the last 6 months
- ○ No, quit more than 6 months ago
- ○ No, never
- ○ Unknown
- ○ Yes

Justification

* Provide a brief statement regarding applicant's current functioning level (including mental status, relationship with family, community supports, health, etc.) and justification for level of service requested

Notes

Notes

Requested Documents

The following documents are requested with the application. Please check the documents that you are attaching (on the next page):

- ☐ Consent and Release Forms

- ☐ Psychosocial Evaluation
- ☐ Psychiatric Evaluation
- ☐ Managed Care Level of Care Determination
- ☐ HIV Consent (Required if HIV-related data is disclosed)

Please upload the most recent version of supporting documents via the "Attached Documents" tab on the following page.

URF Status

The status of this form from the DOHMH SPOA team will be shown here. When the status changes, an email will be sent to the address provided under the previous Referral Information form.

URF Status Determination

* Indicates required field

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