Adult Care Facility Mental Health Evaluation

Directions

In accordance with 18 NYCRR § 487.4(i), § 488.4(e)(3), and § 490.4(f), each mental health evaluation shall be a written and signed report, from a psychiatrist or other physician, physician assistant, psychologist, nurse practitioner, registered nurse, or social worker, licensed or certified and acting within their scope of practice, who has experience in the assessment and treatment of mental illness. This form must be completed prior to admission for any proposed adult care facility resident who has met established criteria (e.g., a positive pre-screen) for a mental health evaluation, or for whom the medical evaluation or resident interview suggests a psychiatric disability; for annual evaluations thereafter; and for any change in condition of a resident that would warrant such evaluation. No section of this document may be omitted or crossed out. Additional supporting documentation may be attached to this form on the professional's letterhead to clarify answers.

I. IDENTIFYING DATA

Individual's Name (Print): _____ Date of Birth (mm/dd/yyyy): _____

Current Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

II. SERIOUS MENTAL ILLNESS

A person with serious mental illness (SMI) means an individual who meets criteria established by the Commissioner of Mental Health, which shall be persons: (1) who have a diagnosis of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders (excluding neurocognitive, substance use, and neurodevelopmental disorders); and (2) whose severity and duration of mental illness results in substantial functional disability. See guidance from the New York State Office of Mental Health (OMH) available at: https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html.

A. Diagnosis of Mental Illness

1. Based upon your examination and/or review of available records, conducted within the scope of your professional practice, does this person have a diagnosis or diagnoses of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders? ☐ Yes ☐ No
2. If you answered "Yes" to Question A.1. above, list the diagnosis or diagnoses, indicate which data source(s) you used, and identify the records you reviewed:

List of Diagnosis or Diagnoses:

Indicate which data source(s) you used:

☐ a. Your examination ☐ b. A review of records ☐ c. Both your examination and a review of records

Identify the records reviewed if you checked box 2b. or 2c. above:

B. Substantial Functional Disability

1. During the five years preceding the date of this report, did the individual receive BOTH:
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and
- One or more services from a provider licensed by Office of Mental Health under Article 31 of the Mental Hygiene Law (excluding services that only include an intake visit)

☐ Yes ☐ No ☐ Unknown

2. During the five years preceding the date of this report, did the individual receive any of the following? Any high-intensity Office of Mental Health ambulatory service: Health Home Plus, Home and Community Based (HCBS) Core Services, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Prepaid Mental Health Plan (PMHP), or Partial Hospitalization.

☐ Yes ☐ No ☐ Unknown

3. During the five years preceding the date of this report, did the individual have EITHER of the following?
- One or more psychiatric hospitalizations for three or more days; or
- Three or more psychiatric hospitalizations.

☐ Yes ☐ No ☐ Unknown

4. At any point during the five years preceding the date of this report, was the individual hospitalized in an Office of Mental Health Psychiatric Center?

☐ Yes ☐ No ☐ Unknown

5. At any point during the five years preceding this report, was the individual a resident in Office of Mental Health-funded housing for persons with mental illness?

☐ Yes ☐ No ☐ Unknown

6. Does the individual have a current or expired Assisted Outpatient Treatment (AOT) order?

☐ Yes ☐ No ☐ Unknown

7. Does the individual have any history of mental health treatment in a county or state correctional facility, or mental health treatment in an Office of Mental Health forensic hospital, including individuals under the custody of the Office of Mental Health Commissioner (330.20 status)?

☐ Yes ☐ No ☐ Unknown

III. CURRENT PSYCHIATRIC STATUS AND SUBSTANCE USE DISORDER TREATMENT

Is the individual currently hospitalized? ☐ Yes ☐ No

If yes, please provide the following:

Name of facility: _____

Admission Date (mm/dd/yyyy): _____

Reason for Admission: _____

Clinical Course: _____

Describe any functional impairment _____

If no, name of facility and date of last in-patient psychiatric hospitalization (If applicable):

Name of facility: _____

Date of last in-patient psychiatric hospitalization (mm/dd/yyyy): _____

List primary psychiatric diagnosis first followed by remaining disorders in order of focus, attention, and treatment:

Primary Diagnosis: _____

Other Diagnosis:

Include onset of illness, in-patient and outpatient treatment, history of suicidal/homicidal behavior or ideation, violence, criminal activity, and substance use:

IV. MENTAL STATUS EXAM

Describe the individual in terms of the following characteristics:

Appearance: _____

Orientation: _____

Speech: _____

Affect: _____

Memory: _____

Intelligence: _____

Cognition: _____

Perception: _____

Suicidal/Homicidal (Ideation & Potential): _____

Judgment: _____

Insight: _____

Impulse Control: _____

V. SUMMARY OF CURRENT MEDICATION REGIMEN AND ADHERENCE

A. Describe current treatment plan and medication, including the individual's current adherence to medication, based on records reviewed:

B. Describe the frequency of treatment sessions such as therapy or counseling:

VI. TYPE OF EVALUATION AND DETERMINATION

Based upon your evaluation and your review of the Office of Mental Health guidance found at https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html, indicate your determination below. Residents identified as meeting the criteria for serious mental illness must be counted within an Adult Care Facility's Serious Mental Illness census.

A. For preadmission evaluations, choose one of the following:

- ☐ The individual does not meet the criteria for serious mental illness and admission discussion may continue.
- ☐ The individual meets the criteria for serious mental illness and admission requirements per Title 18 NYCRR Subchapter D - Adult-Care Facilities apply.

B. For annual and resident change in condition evaluations, choose one of the following:

- ☐ The individual does not meet the criteria for serious mental illness.
- ☐ The individual meets the criteria for serious mental illness.
- ☐ The individual's mental health needs cannot be appropriately met in an adult care facility at this time due to the following:

VII. ATTESTATION BY PRACTITIONER

I, the undersigned, attest to the fact that I have conducted a face-to-face examination of the above-mentioned individual on _____ (enter date of face-to-face examination) and that such face-to-face examination, if conducted for an annual evaluation or due to a change in condition, was conducted no more than 30 days prior to the date of this report, which is set forth below. I further attest that the contents of this report are true and accurate to the best of my knowledge.

Practitioner's Name (printed): _____

Practitioner's Signature: _____

Title: _____ NYS License #: _____

Employer: _____

Employment Address: _____

Telephone Number: _____ Email Address: _____

Date of Report (mm/dd/yyyy): _____

VIII. ATTESTATION BY ADULT CARE FACILITY

This section must be signed by the Adult Care Facility operator, approved administrator, or case manager. Residents identified as meeting the criteria for serious mental illness must be counted within an Adult Care Facility's Serious Mental Illness census.

I, the undersigned, attest that I have reviewed the information in Sections I through VII completed by the practitioner whose signature appears in Section VII above. If conducted for the purpose of a preadmission evaluation, I attest that the date of the face-to-face examination conducted by the practitioner whose signature appears in Section VII above occurred no more than 30 days prior to the resident's admission, which occurred on _____ (enter date on which resident was admitted).

If the examination was conducted for the purpose of a preadmission evaluation, I attest to my understanding that the practitioner has determined that (check one as applicable):

☐ The individual is a person with serious mental illness because the practitioner determined that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

☐ The individual is not a person with serious mental illness because the practitioner did not determine that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

Name (printed): _____ Signature: _____

Title: _____

Adult Care Facility: _____

Telephone Number: _____ Email Address: _____

Date Signed: _____ (mm/dd/yyyy)