New York State Department of Health
Adult Care Facility Mental Health Evaluation

Directions

In accordance with 18 NYCRR § 487.4(i) and § 488.4(e)(3), each mental health evaluation shall be a written and signed report from a psychiatrist or other licensed physician, a nurse practitioner or other registered nurse, a certified psychologist, or a certified social worker 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 a known history of chronic mental disability or for whom the medical evaluation or resident interview suggests such disability; for annual evaluations thereafter; and for any change in condition of a resident that would warrant such evaluation.

I. Identifying Data

Individual's Name (Print Name) _____ Date of Birth _____

Current Address _____ Phone Number _____

II. Type/Date of Evaluation (check one):

- ☐ An initial evaluation conducted prior to a prospective resident's admission
- ☐ An annual evaluation conducted each year following a resident's admission
- ☐ An evaluation following a resident's change in condition

III. Serious Mental Illness

A person with serious mental illness 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 18 NYCRR § 487.2(c).

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 your answer to Question #1 above is "Yes," list the diagnosis or diagnoses:

_____

_____

_____

_____

3. If your answer to Question # 1 above is "Yes," explain whether this conclusion is based on:

- ☐ Yes ☐ No Your examination
- ☐ Yes ☐ No A review of records
- ☐ Yes ☐ No Both your examination and a review of records

4. If your answer to Question # 3(b) or (c) is yes, identify the records reviewed:

_____

_____

_____

_____

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B. Substantial Functional Disability

1. Does the individual meet ALL THREE of the following?

☐ Yes ☐ No ☐ Unknown • The individual is less than 65 years old; and

☐ Yes ☐ No ☐ Unknown • The individual is a recipient of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

***If yes, is the SSI or SSDI due to mental illness (excluding neurocognitive, substance use, and neurodevelopmental disorders);* and

☐ Yes ☐ No ☐ Unknown

☐ Yes ☐ No ☐ Unknown • During the year preceding the date of this report, the individual received one or more services from a provider licensed by the New York State Office of Mental Health (OMH) under Article 31 of the Mental Hygiene Law.

2. Does the individual meet BOTH of the following?

☐ Yes ☐ No ☐ Unknown • The individual is NOT a recipient of SSI; and

• During the year preceding the date of this report, the individual received three or more months of Health Home services, Assertive Community Treatment (ACT) services, or Personalized Recovery Oriented Services (PROS) services.

3. Does the individual meet EITHER of the following?

☐ Yes ☐ No ☐ Unknown • During the three years preceding the date of this report, the individual had three or more psychiatric inpatient admissions; or

• During the three years preceding the date of this report, the individual had more than 30 days of psychiatric inpatient services (regardless of number of hospitalizations).

4. During the year preceding the date of this report, was the individual discharged from an OMH Psychiatric Center after an inpatient stay that lasted 60 days or more?

☐ Yes ☐ No ☐ Unknown

5. At any point during the five years preceding the date of this report, did the individual have a current or expired Assisted Outpatient Treatment (AOT) order?

☐ Yes ☐ No ☐ Unknown

6. During the five years preceding the date of this report, was the individual discharged from a correctional facility with a history of inpatient or outpatient behavioral health treatment?

☐ Yes ☐ No ☐ Unknown

7. At any point during the three years preceding this report, was the individual a resident in OMH-funded housing for persons with mental illness?

☐ Yes ☐ No ☐ Unknown

8. a. If you checked "Yes" to Question # 1, 2, 3, 4, 5, 6 or 7, then the individual should be considered to have a substantial functional disability as a result of mental illness (check "Yes" below), unless there is some information obtained from your face-to-face examination or your review of records that indicates the individual currently does not have a substantial functional disability (check "No" below).

☐ Yes ☐ No

If you have checked no, explain the basis of your finding.

_____

_____

_____

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b. If you checked "No" for all seven questions (Question # 1, 2, 3, 4, 5, 6 and 7), state whether the individual has a substantial functional disability as a result of mental illness and explain the basis for this conclusion.

☐ Yes ☐ No

Explain your finding:

_____

_____

_____

IV. Current Psychiatric Status and Substance Use Disorder Treatment

Is the individual currently hospitalized? ☐ Yes ☐ No

If yes, name of facility _____ Admission Date _____/_____/_____

Reason for Admission _____

Clinical Course _____

Describe any functional impairment _____

V. Psychiatric, Substance Abuse and Treatment History

Psychiatric Diagnosis: List primary diagnosis first followed by remaining disorders in order of focus and attention and treatment.

Primary Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Other 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:

_____

_____

_____

Date and location of last in-patient psychiatric hospitalization (if applicable): _____/ _____ / _____

VI. Mental Status Exam

Describe the individual in terms of the following characteristics:

Appearance _____

Orientation _____

Speech _____

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VI. Mental Status Exam (continued)

Affect _____

Memory _____

Intelligence _____

Cognition _____

Perception _____

Suicidal/Homicidal (Ideation & Potential) _____

Judgment _____

Insight _____

Impulse Control _____

VII. Summary of Current Medication Regimen and Adherence

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

_____

_____

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

_____

_____

VIII. Determination (check one):

☐ The individual's mental health needs can be adequately met in an Adult Care Facility and the individual does not evidence need for placement in a residential treatment facility licensed or operated pursuant to Article 19, 23, 29, or 31 of the Mental Hygiene Law.

☐ The individual is mentally unsuited for an adult care facility due to the following:

_____

_____

_____

IX. 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:

_____

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IX. Attestation by Practitioner (continued)

Title: _____ NYS License #: _____

Employer: _____

Employment Address: _____

Telephone Number: _____

Email Address: _____

Date of Report: _____/_____/_____

X. Attestation by Adult Care Facility for Initial Evaluations

Directions: This section must be signed by the Adult Care Facility operator, approved administrator, or case manager.

I, the undersigned, attest that I have reviewed the information in Sections I through IX completed by the practitioner whose signature appears in Section IX above. If conducted for the purpose of an initial evaluation, I attest that the date of the face-to-face examination conducted by the practitioner whose signature appears in Section IX 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 an initial 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: _____/_____/_____