GUIDELINES FOR COMPLETING THE 2005 PATIENT CHARACTERISTICS SURVEY

(OMH form number 296.1)

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A. DEFINITIONS

Facility: a "mental health facility" is an organization, or company that provides mental health services under the same administrative management. It is the largest organizational division identified during the Patient Characteristics Survey and each facility is distinguished by a unique four-digit numeric code. There are 27 state-operated facilities (e.g., Manhattan Psychiatric Center, Mid-Hudson Psychiatric Center, Hutchings Psychiatric Center) and more than 700 locally-operated facilities (e.g., Tompkins County Mental Health Association, Elmhurst Hospital, Black Veterans for Social Justice, Rehabilitation Support Services.) A facility typically has sub-divisions called "units" that provide a specific program or service (see next definition.)

Unit: a "mental health unit" is a subdivision of a facility that provides a specific program of service. For example, NYC-based Graham Windham Services has 3 units: 1 for the subdivision that provides "clinic services", 1 for the subdivision that provides "advocacy services", and 1 for the subdivision that provides "school-based MH services". Each unit is distinguished by a three-digit numeric code. On average, each facility has approximately 7 units.

Site: a "mental health site" is the further breakdown of a "unit" when the unit has multiple locations of operation. Each site is distinguished by a two-digit alphabetic code. For instance, Schenectady-based Ellis Hospital has 2 locations for its clinic services: a main site notated by the code "AX" and a satellite site notated "BX".

FUS: a FUS (pronounced "FOOSE") is the combination of Facility, Unit and Site codes. The FUS code uniquely identifies each provider/program/location of mental health service. These are the smallest mental health service entities identified by the OMH.

The "Facility Survey": the "Facility Survey", also known as "OMH form 296.0", is a questionnaire which solicits information about the provider of MH services in the state of New York. This survey is conducted every other year during the spring.

The "Patient Characteristics Survey": the "Patient Characteristics Survey", also known as "OMH form 296.1", is a survey soliciting information about the consumer of MH services in the state of New York. It, too, is conducted biennially, but in the autumn following the Facility Survey.

Survey Coordinator: One person at each facility has been designated "survey coordinator". This person will be the liaison between the OMH and the facility. The coordinator's role is detailed below in section D, bullet 6.

State Survey Director: The State Survey Director is Ms. Jeraldine Braff.

B. INTRODUCTION

The Patient Characteristics Survey (PCS) is a one-week survey of all persons served by the mental health system in New York State. It is conducted every two years, and it collects demographic, clinical and service information about approximately 170,000 persons served in over 5000 programs. Survey information is used for planning and program evaluation by the NYS Office of Mental Health ("OMH") and local governmental units. It is also used to describe the mental health system of New York State to state and federal funding agencies and legislative bodies. Tables summarizing the survey data at the facility-level are mailed to each respective facility, while tables summarizing data at state-, region- and county-levels can be found on the OMH website:
www.omh.state.ny.us/omhweb/pcs/pcsmain.htm

Similar to the previous PCS, the new PCS requires each FUS to complete a survey form for each client that receives services during the survey week. If a client receives services from more than one FUS during the survey week, each FUS will fill out a form for that client.

C. REVISIONS SINCE THE 2003 SURVEY

1. The old item which was "Current Educational Enrollment" has been removed
2. The old item which was "Prior Mental Health Services" has been removed

3. The old item which was “Diagnosis System” has been removed
4. The old item which was “Inpatient Legal Status” has been removed
5. The old item which was “Disposition” has been removed

6. A new item “10d. Household Composition” has been added
7. A new item “10e. Minor Children” has been added
8. A new item “15. Does client receive special education services” has been added
9. A new item “20c. Is client enrolled in an HMO or managed care” has been added

10. Old items for “Current Benefits” and “Source of Payment” have been modified into 2 new items: “20a. Cash Assistance Benefits” and “20b. Health Insurance Coverage”.

11. Item 10a, Residence Type, has a new selection of outcomes. Also new this year, we ask for **PRIOR** Residence Type for those who are either:
    - an inpatient, or
    - in a Residential Treatment Facility (“RTF”), or
    - incarcerated.

    In the previous PCS, those in an RTF were not asked to provide the “prior” residence type.

12. For clarity, item 12 has been reworded from “Is client a veteran?” to “Does client have prior active US military service?@ though we wish to target the same population.

13. Item 13, “Employment Status”, has a new selection of outcomes.

14. Item 14, “Education”, solicits:
    - client’s current grade level, **if client is currently enrolled in school**, or
    - client’s highest level of education completed, **otherwise**.

15. For item 18, GAF score, we ask that “unknown GAF score” be indicated by “00” (two zeroes).

16. Item 22, “Source of Referral,” has a new selection of outcomes.

17. Item 23, “Criminal Justice or Juvenile Justice Status,” has a new selection of outcomes.

D. GENERAL INFORMATION

1. **DATE OF SURVEY:** All programs shall report data on clients served during the one-week period of **October 31** through **November 06, 2005**, inclusive.

2. **WHO MUST REPORT:** All state-operated and locally-operated FUS’s in New York State must report with the following exceptions:

    a) State-operated family care programs, state-operated PMHP programs, state-operated inpatient programs and state-operated certified outpatient programs are **not** required to report

    b) Locally-operated transportation programs and locally-operated Single Point of Access (SPOA) programs are **not** required to report

3. **WHO SHOULD BE REPORTED**

    a) Residential-type FUS's should include all persons in residence during the survey week.

    b) Nonresidential FUS's should include persons receiving client or collateral services during the survey week. Where collateral services are involved, information reported should pertain to the client not the collateral.

    c) Forms shall **not** be completed for those clients who were screened during the survey week but not subsequently admitted to a program.

d) Transportation services shall **not** be reported.

e) FUS's with no clients during the survey week should return one survey form with the notation **" NO CLIENTS DURING THE SURVEY WEEK"** written conspicuously across it. Either use a survey form with a pre-printed header or complete data items 1a-4b (Facility Code and Name; Unit Code and Name; Site Code; and Program Code and Name) on a blank survey form to identify the FUS.

f) FUS's that do not keep records on individual clients (e.g. telephone hotlines) should return one survey form with the notation **"DO NOT KEEP RECORDS ON CLIENTS"** written conspicuously across it. Either use a survey form with a pre-printed header or complete data items 1a-4b (Facility Code and Name; Unit Code and Name; Site Code; and Program Code and Name) on a blank survey form to identify the FUS.
NOTE: There are very few FUS's that fall into this latter category. Before submitting forms with this notation, your facility's survey coordinator should contact the State Survey Director to confirm this status. Failure to submit properly completed survey forms will delay processing of your facility's data.

4. **REPORTING METHODS**

a) **Electronic Medium**. An **entire facility** may elect to submit the survey data as an ASCII file on computer disk or CD-ROM (the individual FUS should not elect to do so). A facility wishing to report using electronic medium must contact the State Survey Director (see section "E" below) for approval and instructions, since the readability of these files requires precise columnar formatting. Facilities which maintain electronic client data bases are encouraged to use electronic reporting.

b) **Paper Medium**. Survey forms will be completed as described later in this document.

c) **Web-Based**. State Psychiatric Centers and a few locally-operated facilities will submit data using a web-based application.

5. **PROCEDURE FOR REPORTING ON SURVEY FORMS**

a) Print entries legibly with a No. 2, black pencil. **Please do not use ink**, which creates problems during OMH's editing process.

b) Use these Guidelines when completing the survey to ensure accuracy of reporting. Doing so will avoid returning incomplete or inaccurate survey forms.

c) A separate form must be completed for each separate admission to the same FUS during the survey week (e.g. client terminated and readmitted to the same FUS during the survey week). In all other cases, the FUS should complete only one survey form for each client served.

d) When all forms for a FUS are complete, each form must be numbered sequentially **within the FUS** (e.g., 1 of 3, 2 of 3, 3 of 3). Enter the sheet numbers in the spaces provided in the upper right corner of each form (item 26), and the bottom right corner of each form. Sheet numbers should be used only one time within a given FUS. Once numbered, the FUS should make and retain a photocopy of each form submitted. Forward the **original** completed form(s) to your facility's survey coordinator.

6. **SURVEY COORDINATOR=S RESPONSIBILITIES**

One person at each facility has been designated "survey coordinator". These coordinators will receive a packet of survey material for each FUS in his/her facility. Each packet will contain forms with FUS names and codes printed at the top of each form. The coordinator should:

a) Verify that a packet of survey forms is included for each FUS on the listing of FUS=s within the facility.

b) Distribute packets to each FUS. If additional forms are required, copies can be made by using the form with the correct FUS as the master. Additionally, two blank forms per facility are included with this mailing (i.e., forms with items 1a through 4b left blank on the form). They should be used to report clients for any open FUS which inadvertently did not receive pre-printed forms, including clients in any open FUS that was not previously reported to OMH on the "Facility Survey, Form 296.0". Copies of blank forms should be made at the facility as necessary.

c) Collect each FUS's completed forms and assure proper numbering in survey item 26.

d) Assure that each FUS has completed at least one form (see #3 under "D. GENERAL INFORMATION" above).

e) Review each form and assure that all items have been completed and that entries are legible.

f) Assure that the information provided is consistent with this set of Guidelines.

g) Assure that either they or the FUS makes copies of each form before the client name section is removed. However, **only original survey forms should be forwarded to the State Survey Director after the client name section is removed.**

h) Assure that the FUS retains the client name cutoff section of each form in case verification of client information is required

i) Forward the entire survey to the State Survey Director **(address listed on page 7)** when survey forms have been collected from all of the facility's FUS's. Please affix a **Facility ID Label** to the outside of the package. The Facility ID Labels contain your facility code and facility name, and were included with the survey mailing.

Questions about the survey should be directed to your facility's survey coordinator. Subsequently, these facility survey coordinators should contact the State Survey Director at (800) 430-3586 if there are questions they cannot answer.

E. SAFEGUARDS FOR CONFIDENTIALITY

1. Information collected on the survey forms will be treated in accordance with confidentiality provisions of Mental Hygiene Law ' 33.13 and federal HIPAA regulations.

2. Completed survey forms are stored in locking file cabinets in OMH's Data Management Unit.

3. Only persons employed by OMH, either as regular employees or under contract for purposes of survey editing or data entry, will have access to the survey forms. Persons who are not regular employees of OMH will be required to sign a Confidentiality Oath which requires that they not divulge any information contained on the forms.

4. It will not be possible to use the survey information to identify a particular person once the information is entered into an electronic database. Each client's initials and birth date will be removed from the electronic database after calculating client age and appending an unidentifiable client counter.

5. The survey forms will be shredded prior to being discarded.

F. DEADLINES

Survey data reported either through electronic media or paper forms must be received by the State Survey Director by **November 28, 2005.** NOTE: Any FUS that did not complete a "2005 Facility Survey" (form 296.0) is required to do so, and is also required to report on the "2005 Patient Characteristics Survey" (form 296.1). The "2005 Facility Survey" forms can be obtained from your facility's survey coordinator or the State Survey Director. Only one "Facility Survey" is required for each FUS. If a "Facility Survey" form was completed any time between July 2005 and the present date, do **not** complete another one. Check with your facility's survey coordinator or the State Survey Director before completing a "2005 Facility Survey" if you are uncertain whether one has been filed.

For **additional copies of this manual** or **additional blank survey forms,** contact the State Survey Director at:

Jeraldine L. Braff
NYS Office of Mental Health
Bureau of Data Management, Analysis and Reporting
44 Holland Avenue
Albany, New York 12229

phone (800) 430-3586

G. COMPLETING FORM 296.1

Each program is required to complete items 1-26 of the survey form. It is worth noting that blank responses are only permissible in items 19a and 19b.

FORM HEADER. Items 1a - 4b constitute the header of the PCS form. Each FUS should receive survey forms with items 1a-4b ("the header") already printed. Verify that the printed information is accurate and that it corresponds to your FUS. Any information that is not correct must be corrected, but not before it is verified with your facility's survey coordinator. If your FUS did not receive forms with pre-printed headers, you must contact the State Survey Director who will furnish the appropriate header codes**.**

FORM BODY. Items 5a-26 constitute the body of the Patient Characteristics Survey form.

ITEM 5a. **INITIAL, FIRST NAME.** Print the initial letter of the client=s first name, in uppercase.

ITEM 5b. **INITIAL, LAST NAME.** Print the initial letter of the client=s last name, in uppercase.
Special Note: if <u>either</u> initial is unknown, then use the combination "QQ" for <u>both</u> initials.

ITEM 6. **DATE OF BIRTH.** Enter the client's month, day and year of birth, in that order. Use two digits for month (e.g., January ="01"), two digits for the day, and four digits for year.
If the exact date of birth is unknown, <u>estimate the year of birth</u> based on the client's approximate age, and enter "99" in the month and day boxes. <u>A year of birth may not be entered as "unknown"</u>.

ITEM 7. **GENDER.** Choose one response only.
1. Male
2. Female
9. Unknown

ITEM 8. **HISPANIC ETHNICITY.** Choose one response only.
0. No, client is <u>not</u> Hispanic/Latino
1. Yes, client is Hispanic/Latino
9. Unknown

ITEM 9. **RACE.** Circle all that apply.
1. White
2. Black/African American
3. Asian
4. Amer. Indian/Alaska Native
5. Native Hawaiian/Other Pacific Islander
6. Other
9. Unknown

NOTE: For the next five items pertaining to the client's residence (items 10a-e) please:
• choose responses according to the client's **PRIOR** living situation if client is currently:
(**a) a psychiatric inpatient, or**
(b) in a Residential Treatment Facility, or
(c) incarcerated

OR…

• choose responses according to the client's **CURRENT** living situation for **all other clients** (including those in other residential-type FUS's).

ITEM 10a. **RESIDENCE TYPE.** Choose one response only.
01. Private Residence (Home/Apartment), Rooming House, Hotel, SRO
02. Licensed MH Housing (e.g., community resid, crisis resid, FBT, family care)
03. Adult Home (DOH licensed residential program for adults)
04. NYS Office of Children & Family Services (OCFS) Foster Care
05. Institutional setting for youth (e.g., OCFS, DSS, or Juvenile Justice Facility)
06. Youth community-based residence (e.g., OCFS, DSS, NYS Education Dept.)
07. Nursing or Health-Related Facility (e.g., nursing home, skilled nursing facility)
08. Homeless (e.g., shelter, street, Transitional Living Center)
09. Other
99. Unknown

ITEM 10b. **ZIP CODE OF CLIENT'S RESIDENCE.** Enter the 5 digit zip code for the client's residence. Enter: '88888' if the client is homeless, or '99999' if zip code cannot be determined.

ITEM 10c. **COUNTY OF RESIDENCE.** Enter the 2 digit county code for the client's residence type coded above.

COUNTY CODES:

01 Albany	18 Fulton	35 Ontario	52 Suffolk
02 Allegany	19 Genesee	36 Orange	53 Sullivan
03 Bronx	20 Greene	37 Orleans	54 Tioga
04 Broome	21 Hamilton	38 Oswego	55 Tompkins
05 Cattaraugus	22 Herkimer	39 Otsego	56 Ulster
06 Cayuga	23 Jefferson	40 Putnam	57 Warren
07 Chautauqua	24 Kings (Brooklyn)	41 Queens	58 Washington
08 Chemung	25 Lewis	42 Rensselaer	59 Wayne
09 Chenango	26 Livingston	43 Richmond(Staten Is)	60 Westchester
10 Clinton	27 Madison	44 Rockland	61 Wyoming
11 Columbia	28 Monroe	45 St. Lawrence	62 Yates
12 Cortland	29 Montgomery	46 Saratoga	
13 Delaware	30 Nassau	47 Schenectady	**Miscellaneous**
14 Dutchess	31 New York (Manhat.)	48 Schoharie	70 NYS, County Unkn.
15 Erie	32 Niagara	49 Schuyler	80 Other State
16 Essex	33 Oneida	50 Seneca	90 Other Country
17 Franklin	34 Onondaga	51 Steuben	99 Unascertained

ITEM 10d. **HOUSEHOLD COMPOSITION** select all that apply"

0. Not applicable, client is NOT in a private residence (i.e., client has NOT chosen outcome #1 for Residence Type question)
1. Client lives alone
2. Client's child, stepchild, foster child or grandchild
3. Client's parent
4. Client's spouse or domestic partner
5. Other relatives of client not specified above
6. Other people unrelated to client
9. Unknown

ITEM 10e. **DOES CLIENT HAVE MINOR CHILDREN?** Answer yes if client has any children under the age of 18.

0. No
1. Yes
9. Unknown

ITEM 11. **PRIMARY LANGUAGE.** Enter the language most frequently spoken by the client.

01. English	07. Italian	13. Yiddish
02. Spanish	08. Japanese	14. German
03. Chinese	09. Russian	15. Polish
04. Creole	10. Vietnamese	16. Sign Language
05. French	11. Korean	17. Other
06. Greek	12. Indic (e.g., Hindi, Urdu, Sindi)	99. Unknown

ITEM 12. **DOES CLIENT HAVE PRIOR ACTIVE U.S. MILITARY SERVICE?.** Answer "yes" if client has served or currently is serving on <u>active duty</u> in the Armed Forces of the United States, including the Coast Guard. <u>Do not</u> count those whose only service was in the Reserves, National Guard, or Merchant Marines UNLESS those units were activated.

0. No
1. Yes
9. Unknown

ITEM 13. **CURRENT EMPLOYMENT STATUS.** Choose one response only.

01. Competitive employment (employer-paid position) with no formal supports
02. Competitive employment (employer-paid position) with ongoing supports
03. Community-integrated employment run by a state or local agency (agency-funded positions only)
04. Non-integrated employment run by state or local agency (sheltered workshop, affirmative businesses, enclaves, mobile work crews)
05. Sporadic or casual employment for pay (includes odd jobs)
06. Non-paid work experience (volunteer)
07. Unemployed but looking for work
08. Not in labor force: retired, homemaker, student, incarcerated
09. Not in labor force: disabled, psychiatric inpatient
99. Unknown

ITEM 14. **EDUCATION.** If client is currently enrolled in an academic program then enter the client's current grade level, otherwise enter the highest level of education completed.

00. No formal education
01. first grade
02. second grade
03. third grade
04. fourth grade
05. fifth grade
06. sixth grade (grammar sch. graduate)
07. seventh grade
08. eighth grade
09. ninth grade
10. tenth grade
11. eleventh grade
12. twelfth grade, no diploma
13. high school diploma or GED
14. Business, technical training
15. Some college, no degree
16. Associate's degree
17. Bachelor's degree
18. Graduate degree
19. Other
99. Unknown

ITEM 15. **DOES CLIENT RECEIVE SPECIAL EDUCATION SERVICES?** Circle one response.

0. Not applicable. Client is not enrolled in elementary or secondary education, or client is 22 years of age or older
1. Yes
2. No
9. Unknown

ITEM 16. **CURRENT DISABILITIES/DISORDERS.** Identify any significant disabilities the client has that are diagnosable and cause functional impairment. Circle all that apply.

0. None
1. Mental Illness
2. Mental Retardation
3. Developmental Disability
4. Alcohol Related Disorder
5. Drug/Substance Related Disorder
6. Physical Disability
9. Unknown

ITEM 17. **SEVERE AND PERSISTENT MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCE.** Circle one response only.

0. No
1. Yes, Client has a Severe and Persistent Mental Illness (if age 18 or older) **OR** Severe Emotional Disturbance (if under age 18)
9. Unknown

For clients aged 18 and over, answer 'yes' to this question if the client meets the SPMI criteria listed in Appendix A.

For clients under age 18, answer 'yes' to this question if the client meets the SED criteria listed in Appendix B.

If you have previously determined SPMI and SED status for your clients, it will not be necessary to reassess them with the criteria for the purpose of this survey. Rather, report the client's status from the previous assessment. Use the criteria in the appendices only for those clients for whom SPMI/SED status has not been previously determined.

ITEM 18. **GLOBAL ASSESSMENT OF FUNCTIONING (GAF).** Report the GAF that appears in the clinical record. It will not be necessary to conduct a new assessment for the purpose of this survey. Enter '00' if the GAF is unknown.

ITEM 19a. **PRINCIPAL PSYCHIATRIC DIAGNOSIS.** Enter the code for the principal psychiatric diagnosis. If the diagnosis has less than 5 digits, begin the entry in the left-hand column and leave the right-hand column(s) blank. If there is no diagnosis available, leave blank.

ITEM 19b. **ADDITIONAL DIAGNOSIS.** Enter the 5 digit code for the diagnosis that is second most important to the focus of treatment. If there is no additional diagnosis, leave blank.

ITEM 20a. **CASH ASSISTANCE BENEFITS.** Circle all that apply.

0. No Cash Assistance
1. Supplemental Security Income (SSI)
2. Social Security Disability Insurance (SSDI)
3. Public assistance cash program (e.g., TANF, Safety Net)
4. Veterans' Cash Assistance
5. Other
9. Unknown

ITEM 20b. **HEALTH INSURANCE COVERAGE.** Circle all that apply.

0. No insurance coverage
1. Medicaid
2. Medicare
3. Private Insurance
4. Child Health Plus
5. Family Health Plus
6. Other
9. Unknown

ITEM 20c. **IS CLIENT ENROLLED IN AN HMO OR MANAGED CARE?** Circle one response only.

0. No
1. Yes
9. Unknown

ITEM 21. **ADMISSION DATE, CURRENT EPISODE.** Many mental health programs formally admit clients to their programs and discharge them when services are no longer being provided. These include all of the residential programs and licensed outpatient programs. Other programs like clubs, and drop-in centers may not formally record the start or end of a person=s participation.

• **If your program does formal admission paperwork,** enter the date of the client's current admission to the reporting FUS (do not consider admissions to other FUS=s.) Be sure that the admission date neither precedes date of birth nor follows the first date of service during the survey week. Use 4 digits for year and 2 digits each for month and day, adding a leading zero if month or day is less then 10. **If date of admission cannot be ascertained enter "99999999"**

• **If your program does not do formal admission paperwork, enter "77777777"**.

If the client was screened but not admitted to the program during the survey week, do not complete a form for that person.

ITEM 22. **SOURCE OF REFERRAL.** Enter the code for the type of individual, facility or agency which referred the client. If there is more than one referral source, enter the code for the one most directly related to treatment. Choose one response only.

01. Self, family or friend
02. State psychiatric center inpatient unit
03. General or certified hospital psychiatric inpatient
04. Residential treatment facility for children and youth

05. Local Assisted Outpatient Treatment (AOT) coordinator
06. Single Point of Access (SPOA)
07. Mental health noninpatient residential program
08. Mental health outpatient program
09. Emergency program or general hospital emergency room
10. CSP nonresidential program
11. Local mental health practitioner
12. Other medical care provider
13. Facility for the mentally retarded/developmentally disabled
14. Alcohol or substance abuse program
15. School /educational system
16. Juvenile justice system
17. Adult criminal justice system
18. Family court
19. Shelter for homeless
20. Other non-mental health community service provider
21. Other
99. Unknown

ITEM 23. **CRIMINAL JUSTICE OR JUVENILE JUSTICE STATUS.** Every effort should be made to locate criminal or juvenile justice status in the clinical record. If source of referral (item 22) was a criminal or juvenile justice agency then it is likely that the client has a criminal or juvenile justice status. Clients referred for OMH Family Court evaluations are not criminal justice clients. Note that other types of evaluations may be requested by the courts that also do not involve criminal statutes (e.g. custody or treatment issues unrelated to criminal proceedings). Choose one response only.

00. Not a criminal justice nor juvenile justice client
01. Police Lockup Prisoner
02. County/City Jail or Court Detention Prisoner
03. NYS Dept. of Correctional Services Prisoner
04. Adjudicated Juvenile Delinquent or Juvenile Offender in juvenile justice facility
05. Adjudicated PINS (Person in Need of Supervision) or Juvenile Delinquent in youth residential facility other than juvenile justice facility
06. Adjudicated Juvenile Delinquents or PINS on OCFS Aftercare
07. Probationer (adults, Juvenile Delinquents and PINS on probation)
08. Parolee **(**adults and Juvenile Offenders on parole**)**
09. Criminal Procedure Law (CPL) 330.20 Order of Conditions & Order of Release
10. On bail, released on own recognizance (ROR), conditional discharge
11. Alternative to incarceration (ATI) status, Mental Health Court, PINS Diversion
12. Under arrest
99. Unknown whether or not client has a criminal justice or juvenile justice status

ITEM 24. **DATE LAST SERVED BEFORE 10/31/05 BY THIS PROGRAM.** Enter the date when the client was last seen in this FUS, prior to the survey week. Enter **00000000** if the client has never been served before in this program. Enter **99999999** if you do not know when this client was last served by this program. Use MMDDYYYY format with 2-digit month, 2-digit day, and 4-digit year.

Helpful Hint: If a residential or inpatient program is the reporting FUS and the date of admission was before the first day of the survey, the date the client was last seen in that FUS before 10/31/2005 would be 10/30/2005.

ITEM 25. **DATE(S) OF CLIENT SERVICE.** Circle the date(s) that this client received direct services (client individual, group, or collateral services) during the survey week from this FUS. All clients will have at least one service date circled.

Helpful Hint: An inpatient FUS should circle every day during the survey week the client was on inpatient status. A housing FUS should circle every day during the survey week the client was on the housing roster (not only those days they received a case management or other clinical or support service).

ITEM 26. SHEET NUMBER. See explanation below under “cutoff section”.

CONTACT NAME AND PHONE NUMBER (INCLUDING AREA CODE). Print the name and telephone number of the person responsible for completing or assembling the form(s) and to whom questions should be directed.

“CUTOFF SECTION”:

CLIENT NAME. Write in the client=s full name. This will enable you to locate the proper records if we call you to verify survey information.

FACILITY/UNIT/SITE (FUS) CODE. For most forms, the FUS will be pre-printed. If not, write in the facility, unit, and site codes from items 1a, 2a, and 2b.

SHEET NUMBER. Each form must be numbered sequentially within a FUS. Sheet numbers should be assigned **only after all survey forms for a FUS have been completed and collected.** In the boxes, enter the sequential sheet number for the FUS followed by the total number of sheets submitted for the FUS (e.g., 1 of 25, 2 of 25, 3 of 25). Sheet numbers should be used only one time within a given FUS. When you have recorded the sheet numbers in the cutoff section, write the same numbers into item 26 at the upper right corner of the form. Sheet numbers in the cutoff section must be the same as those used in item 26.

When completed, make and retain a copy of each form. Then cut the bottom section off of the original forms and send the originals to your facility’s survey coordinator. Inquiries will be made by sheet number, so keep the copies and the cutoff sections in case they are needed at a later date.

Appendix A: CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness **A must be met. In addition, 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 or ICD-9-CM diagnosis* other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominant psychiatric features, or social conditions (V-Codes). DSM-IV categories and codes that do not have an equivalent in ICD-9-CM are not included as designated mental illness diagnoses.

B. **SSI or SSDI Enrollment due to Mental Illness**. The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*.

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 adhering to 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.

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.

Appendix B: CRITERIA FOR SERIOUS EMOTIONAL DISTURBANCE AMONG CHILDREN AND ADOLESCENTS

To be considered a child or adolescent with serious emotional disturbance **A must be met. In addition, B or C must be met:**

A. **Designated Emotional Disturbance Diagnosis**. The youngster is younger than 18 years of age and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders, delirium, dementia, and amnestic and other cognitive disorders; developmental disabilities; or other conditions that may be a focus of clinical attention. DSM-IV categories and codes that do not have an equivalent in ICD-9-CM are also not included as designated mental illness diagnoses.

B. **Extended Impairment in Functioning due to Emotional Disturbance**. The youngster must meet 1 *and* 2 below:

1. The youngster has experienced functional limitations *due to emotional disturbance over the past 12 months* on a continuous or intermittent basis. *The functional problems must be at least moderate in at least two of the following areas or severe in at least one of the following areas.*[1]

    a. **Self-care** (personal hygiene; obtaining and eating food; dressing; avoiding injuries).
    b. **Family life** (capacity to live in a family or family-like environment; relationships with parents or substitute parents, siblings, and other relatives; behavior in family setting).
    c. **Social relationships** (establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time).
    d. **Self-direction/self-control** (ability to sustain focused attention for long enough periods of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability).
    e. **Learning ability** (school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

2. The youngster has met criteria for ratings of *50 or less* on the Children's Global Assessment Scale (CGAS) *due to emotional disturbance for the past twelve months* on a continuous or intermittent basis.[2]

C. **Current Impairment in Functioning with Severe Symptoms**. The youngster must meet 1 *and* 2 below:

1. The youngster *currently* meets criteria for a rating of 50 or less on the Children's Global Assessment Scale (CGAS) *due to emotional disturbance*.[2]

2. The youngster must have experienced at least one of the following within the past 30 days:

    a. Serious suicidal symptoms or other life-threatening, self-destructive behaviors.
    b. Significant psychotic symptoms (hallucinations, delusions, bizarre behavior).
    c. Behavior caused by emotional disturbances that placed the youngster at risk of causing personal injuries or significant property damage.

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[1] It is intended that the clinician assess the youngster's functioning in at least these five domains in consideration of assigning a single numerical rating on the CGAS.

[2] While the CGAS is recommended, ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-V) may be substituted. The CGAS is described in Shaffer, D. et al. (1983) "A children's global assessment scale (CGAS)." Archives of General Psychiatry 40:1228-1231.