ACMH Inc.
Care Management & Housing

Short-Term Crisis Respite & Transitional Step-Down Housing Enrollment Form

(Completed by Potential Guest and Referring Worker)

ACMH Short-Term Crisis Respite and Transitional Step-Down Housing offers a temporary stay in a home-like environment. Short-Term Crisis Respite provides 24/7 support by staff with lived experience. Crisis Respite prevents hospitalizations and emergency room visits. Guests may stay the same day, if a room is available, up to 7 days. During their stay at Crisis Respite, guests are encouraged and helped to continue with their usual routines, including meeting with their treatment providers. Collaboration between Respite staff and treatment providers is encouraged, with guest's consent.

Contact information for ACMH Short-Term Crisis Respite is below.

Phone: (212)253-6377 x406 **Fax**: (212) 253-8679	**Program Director:** Kearyann Austin, LMHC

Potential Guest: _____ **Date of Birth**: _____

Referral Source: _____

Potential Guest Contact # _____ **Date of Referral:** _____

Medicaid #_____ **Social Security #**_____

<u>These questions are for the potential guest:</u>

1. Why do you want to stay at ACMH Short-Term Crisis Respite?

2. What do you hope to get from your stay?

3. What will help you manage your emotional crisis?

4. Would you like reminders to take medications daily?

5. What is your daily routine (i.e. work, school, volunteer, day program, exercise)?

_____ _____

Signature of Potential Guest **Date**

The questions below are for the referring provider:

Eligibility Criteria for Enrollment:

1. The person being referred is experiencing emotional/mental distress or crisis
   ☐Yes ☐No Explain: _____
_____
_____
_____

2. Is a resident of New York City
   ☐Yes ☐No

3. Is 18 years or older
   ☐Yes ☐No

4a. Has stable permanent housing to return to

   ☐Yes ☐No Address: _____

b. What type of housing (check one) ☐ own residence ☐ living with family ☐ supportive housing ☐ shelter

5. Are you a Mount Sinai PPS partner?

   ☐Yes ☐No

6. Is in stable physical health and can manage personal care

   ☐Yes ☐No

7. Manages medication independently, if he/she chooses to take medications (medications are not dispensed at Respite)
   ☐Yes ☐No ☐N/A

8. Voluntarily wants Respite services
   ☐Yes ☐No

9. Receives AOT services?

   ☐Yes ☐No

10. Receives ACT services?

   ☐Yes ☐No

11. Uses Assisted Living Devices?
   ☐ Walker ☐ Cane ☐ Wheelchair ☐ Homecare Bed ☐ Other_____ ☐N/A

12. Currently receiving home care? ☐Yes ☐No

   If Yes, Name of Agency: _____

   Phone: _____ How Often? _____

13. Date potential guest last used Respite services of any agency: _____

14. Current Medications: (Additional document may be attached).

Medication Name	Strength/Unit	Dosage/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACMH Short-Term Crisis Respite & Transitional Step-Down Housing is not able to serve individuals with the situations below. Please indicate if the person is:

- at imminent risk to themselves or others
  ☐Yes ☐No
- diagnosed with dementia, organic brain disorder or traumatic brain injury (TBI)

  ☐Yes ☐No
- has intellectual impairments
  ☐Yes ☐No If yes, Explain: _____
- a registered sex offender
  ☐Yes ☐No
- in need of inpatient detoxification services
  ☐Yes ☐No
- currently in another Respite

  ☐Yes ☐No

Brief Psychosocial History

Current DSM-5/ICD-10 Diagnoses and Codes

DSM 5 Diagnosis: _____ ICD-10 Code: _____

DSM 5 Diagnosis: _____ ICD-10 Code: _____

DSM 5 Diagnosis: _____ ICD-10 Code: _____

DSM 5 Diagnosis: _____ ICD-10 Code: _____

Current Medical Diagnosis/es

Diagnosis: _____ Diagnosis: _____

Diagnosis: _____ Diagnosis: _____

Suicidal History: _____

_____

_____

Homicidal History: _____

_____

_____

Current Substance Use: _____

_____

Current Tobacco User: _____

Forensic History: _____

With my signature below, I attest that the individual being referred meets the indicated enrollment criteria, and would benefit from a stay at ACMH Short-Term Crisis Respite & Transitional Step-Down Housing.

Provider Organization & Provider Name: _____

Signature: _____ Telephone: _____

License Number: _____ (Circle One: MD, PhD, NP, RN, LMSW, LCSW, LMHC, LMFT, LCAT)

Email: _____ Fax: _____

Date: _____

*****While not required for enrollment, any additional documents (such as most recent psychosocial or psychiatric evaluation), may be sent with this enrollment form and are appreciated. Thank you for your referral. *****