

**UNIFIED SERVICES TRANSACTION
CLIENT REGISTRY**

>ACCEPTANCE<

INSTRUCTIONS: PLEASE TYPE ENTRIES 1. THROUGH 5.

1. PROJECT NAME: _____

2. PROJECT CODE

3. CLIENT/PATIENT NO.

4. DATE OF BIRTH

MONTH DAY YEAR

5. UNIQUE CLIENT ID

INSTRUCTIONS: HANDPRINT CLEARLY IN BOXES AND CIRCLE LETTERS FOR MULTI-RESPONSE QUESTIONS 6. THROUGH 51. SEE CODES ON REVERSE.

6. ZIP CODE

7. CO-MUN CODE OF RESIDENCE

8. SERVICE AREA OF RESIDENCE

9. PROGRAM ELEMENT

10. APPLICATION DATE / CONTACT ON BEHALF OF CLIENT

 MO DA YR

11. DATE OF FIRST FACE-TO-FACE CONTACT

 MO DA YR

12. REFERRAL SOURCE

13. SEX
 M - Male
 F - Female

14. RACE/ ETHNICITY

15. ENGLISH SPEAKING

16. MARITAL STATUS

17. LIVING CIRCUMSTANCE

18. RESIDENTIAL ARRANGEMENT

19. VETERAN

Y - Yes
 N - No

20. EMPLOYMENT STATUS

21. EDUCATION (Highest grade level)

22. CURRENT TYPE OF EDUCATION

23. SOURCE OF REIMBURSEMENT (Circle up to 4)

A B C D E
 F G H

24. INCOME SOURCE (Circle up to 8)

A B C D E
 F G H J

25. GROSS ANNUAL FAMILY INCOME

26. TOTAL PERSONS DEPENDENT ON INCOME

27. S.S. ELIGIBILITY

28. PAST SERVICE HISTORY (Circle up to 12)

A B C D E
 F G H J K
 L M N O P
 R S T V W
 X 1 2 3 4
 5 6

29. CURRENT SERVICE INVOLVEMENT (Circle up to 12)

A B C D E
 F G H J K
 L M N O P
 R S T V W
 X 1 2 3 4
 5 6

30. HOSPITAL DISCHARGED FROM IN LAST 30 DAYS

31. NON MENTAL HEALTH NEEDS (Circle up to 5)

A B C D E
 F G H J K
 L M N P

32. PROGRAM / SERVICE NEEDS (Circle up to 10)

A B C D E
 F G H J K
 L M N O P
 R S T V W
 X 1 2

33. LEVEL OF FUNCTIONING

34. PRIMARY THERAPIST/ CASE MANAGER

35. PRESENTING PROBLEMS (Circle up to 17)

A B C D E
 F G H J K
 L M N O P
 R S T V W
 X 1 2 3 4
 5 6 7 8 9

36. PRIMARY PRESENTING PROBLEM

ADMITTING DIAGNOSIS

37. PRINCIPAL DIAGNOSIS

38. SECONDARY DIAGNOSIS

39. PHYSICAL DIAGNOSIS

40. HANDICAPPING CONDITIONS (Circle up to 7)

A B C D E
 F G H J K

ITEMS 41. TO 49. FOR INPATIENT SERVICES ONLY

41. COUNTY OF COMMITMENT

42. PERSON ADMITTED ON DETAINER?

Y - Yes
 N - No

43. TRANSFER FROM OTHER INPATIENT

44. FIRST ADMISSION TO THIS INPATIENT FACILITY?

Y - Yes
 N - No

45. COMMITMENT TYPE

46. ARRIVAL TIME

47. TRANSPORTING AGENT

48. SCREENING TYPE

49. ADMISSION REASON

50. OPTIONAL / SPECIAL USE

51. FUTURE USE

52. TRANSACTION TYPE **1**

SIGNATURE OF PERSON COMPLETING FORM

DATE

9. PROGRAM ELEMENT

- A. Clinical Case Management
- B. Youth Case Management
- C. Designated Screening
- D. Emergency
- E. Children's Mobile Outreach/Treatment Team
- F. Inpatient
- G. Liaison Services
- H. Outpatient
- J. Partial Care
- K. Residential Treatment
- L. System Advocacy
- M. Other

12. REFERRAL SOURCE**EMERGENCY / SCREENING / INPATIENT**

- A. Designated Screening Center
- B. Emergency
- C. CCIS Inpatient
- D. County Psychiatric Hospital
- E. State Psychiatric Hospital
- F. Other Psychiatric Inpatient
- G. General Hospital

COMMUNITY PROGRAMS/**RESIDENTIAL SOURCES**

- H. Community M. H. Agency
- J. Alcohol Treatment Program
- K. Drug Treatment Program
- L. School System
- M. Other Social Service Agency
- N. Nursing Home
- O. Boarding Home
- P. Homeless Shelter
- R. Other Residential Program

LEGAL /JUSTICE SYSTEM

- S. Police / Court / Jail
- T. State Correctional Program
- V. Community Correctional Program
- W. Family Crisis Intervention Unit

INDIVIDUALS

- X. Self
- 1. Family or Friend
- 2. Private M. H. Practitioner
- 3. Private Psychiatrist
- 4. Medical Doctor
- 5. Clergy

DEPT. OF HUMAN SERVICES

- 6. DYFS
- 7. DDD
- 8. Other

14. RACE / ETHNICITY

- A. American Indian/Alaskan Native
- B. Asian / Pacific Islander
- C. Black, Not of Hispanic Origin
- D. Hispanic
- E. White, Not of Hispanic Origin
- F. Other

15. ENGLISH SPEAKING

- A. Yes
- B. No. Spanish Speaking
- C. No. Other Foreign Language
- D. No. American Sign Language

16. MARITAL STATUS

- A. Married/Living as Married
- B. Widowed
- C. Divorced
- D. Separated
- E. Never Married
- F. Unknown

17. LIVING CURCUMSTANCES

- A. Alone/Independent
- B. With Relatives/Family
- C. Other

18. RESIDENTIAL ARRANGEMENT

- A. Private Residence
- B. Cooperative Living Situation (No MH Svcs)
- C. Foster Family Care
- D. Homeless/On Street
- E. Community Residential Program (With MH Svcs)
- F. Boarding Home/RHCF
- G. Nursing Home/SNF/ICF
- H. Residential Substance Abuse Program
- J. DDD/MR Residence
- K. DYFS Residential Treatment Center
- L. Children's Group Home Teaching Family Program
- M. Homeless Shelter
- N. Other Residential Program
- O. State Psychiatric Hospital
- P. County Psychiatric Hospital
- R. CCIS Inpatient
- S. Other Psychiatric Inpatient
- T. State Correctional Facility
- V. Detention Center
- W. Other Institutional Setting
- X. Unknown

20. EMPLOYMENT STATUS

- A. Employed – Full – Time
- B. Employed – Part – Time
- C. Armed Services
- D. Sheltered Employment
- E. Unemployed
- F. Not in Labor Force
- G. Unknown

22. CURRENT TYPE OF EDUCATION

- A. Regular /Vocational Education
- B. Special Education
- C. Post High School Education
- D. Not in School

23. SOURCE OF REIMBURSEMENT

- A. None – Organization to absorb total cost
- B. Self/Legally Responsible Relative
- C. Medicaid
- D. Medicare
- E. Other Public Sources
- F. Service Contract (e.g., HMO)
- G. Other Third Party Insurance
- H. Unknown

24. INCOME SOURCE

- A. Disability Insurance / Workman's Comp.
- B. Family or Relative
- C. Pension
- D. Public Assistance
- E. Social Security
- F. Unemployment Insurance
- G. Wage/Salary Income
- H. Other
- J. Unknown

27. S. S. ELIGIBILITY

- A. Determined Eligible
- B. Potentially Eligible
- C. Probably Not Eligible
- D. Determined to be Ineligible

28. PAST SERVICE HISTORY and**29. CURRENT SERVICE INVOLVEMENT**

- A. Alcohol Treatment Program
- B. Drug Treatment Program
- C. Community Corrections Program
- D. Correctional Facility

28. and 29. (continued)

- E. Detention Center
- F. Probation
- G. DDD
- H. DYFS
- J. Family Crisis Intervention Unit
- K. Child Study Team Evaluation
- L. Group Home With MH Services
- M. Specialized Foster Care
- N. Public Welfare
- O. Other Social Service Agency
- P. State Psychiatric Hospital
- R. County Psychiatric Hospital
- S. CCIS Inpatient
- T. Other Psychiatric Inpatient
- V. Clinical Case Management / Youth Case Management
- W. Outpatient /Counseling
- X. Partial Care
- 1. Residential Care
- 2. Emergency Mobile Outreach / Treatment Team
- 3. Liaison Services
- 4. System Advocacy
- 5. Self Help Services
- 6. None

31. NON-MENTAL HEALTH NEEDS

- A. Alcohol Abuse Services
- B. Correctional
- C. Drug Abuse Services
- D. Education
- E. Employment
- F. Financial
- G. Housing
- H. Legal/Justice
- J. Medical/Health Related
- K. Pastoral
- L. Recreation
- M. Transportation
- N. Other
- P. None

32. PROGRAM / SERVICE NEEDS

- A. Crisis Stabilization/ Emergency Services
- B. CCIS Inpatient
- C. Other Psychiatric Inpatient
- D. Client Advocacy
- E. Dally Living Skills
- F. Medication Monitoring / Education
- G. Partial Care
- H. Psychological / Psychiatric Evaluation Only
- J. Psychotherapy / Counseling
- K. Self-Help Services
- L. Service Coordination / Linkage
- M. Community Residential Program (With MH Svcs)
- N. Crisis Housing
- O. Outreach / In-Home Services
- P. Residential Support Services
- S. Pre-Vocational Services
- T. Transitional/Supported Employment
- V. Child Study Team Evaluation
- W. DDD
- X. DYFS
- 1. Information and Referral
- 2. Other

35. PRESENTING PROBLEMS and**36. PRIMARY PRESENTING PROBLEM**

- A. Alcohol Abuse
- B. Anxiety
- C. Assaultive Behavior/Threat
- D. Bizarre Behavior
- E. Compulsive Gambling
- F. Dally Living Problems
- G. Depression/Mood Disorder
- H. Destructive to Property
- J. Developmental Disability
- K. Drug Abuse
- L. Eating Disorder

35. and 36. (continued)

- M. Economic Stress
- N. Fire Setting/Ideation
- O. Homicidal Behavior/Threat
- P. Legal/Justice Involvement
- R. Marital/Family Problem
- S. Medical/Somatic Complaints
- T. No Social Support Resources
- V. Organic Mental Disorder
- W. Physical Abuse/Assault Victim
- X. Physical Neglect
- 1. Runaway Behavior
- 2. School Problems
- 3. Sexual Abuse/Rape Victim
- 4. Sexual Abuser
- 5. Social/Interpersonal (other than family)
- 6. Suicide Attempt
- 7. Suicide Threat
- 8. Thought Disorder
- 9. Other

40. HANDICAPPING CONDITIONS

- A. Ambulatory/Orthopedic
- B. Auditory
- C. Communication
- D. Developmental Disability/MR
- E. Neurologically Impaired
- F. Medical
- G. Visual
- H. Emotionally Disturbed (Ed. Classification Only)
- J. Perceptually Impaired (Ed. Classification Only)
- K. None

43. TRANSFER FROM OTHER**INPATIENT**

- A. No
- If Yes:
- B. One-Way (State/County Hosp.)
- C. Two-Way (State/County Hosp.)
- D. CCIS
- E. Short Term Care Facility
- F. Other Inpatient Facility

45. COMMITMENT TYPE

- A. Screening Certificate
- B. Clinical Certificate
- C. NGRI
- D. IST
- E. Voluntary Admission

46. ARRIVAL TIME

- A. 8 am – 4 pm
- B. 4 pm – Midnight
- C. Midnight – 8 am

47. TRANSPORTING AGENT

- A. Ambulance
- B. Family/Self
- C. Police/Correction Officer
- D. Social Service Agent
- E. DYFS
- F. Other

48. SCREENING TYPE

- A. By Designated Screener
- B. By CCIS
- C. By Community Agency
- D. Other/None
- E. Unknown

49. ADMISSION REASON

- A. Meets Policy
- B. Mandate by Court
- C. Interstate Compact
- D. Community Inpatient Unavailable
- E. CCIS Inpatient Unavailable
- F. Refused by Community Inpatient
- G. Other

UNIFIED SERVICES TRANSACTION
CLIENT REGISTRY
>TERMINATION<

INSTRUCTIONS: PLEASE TYPE ENTRIES 1. THROUGH 5.

1. PROJECT NAME: _____

2. PROJECT CODE

3. CLIENT/PATIENT NO.

4. DATE OF BIRTH

MONTH DAY YEAR

5. UNIQUE CLIENT ID

INSTRUCTIONS: HANDPRINT CLEARLY IN BOXES AND CIRCLE LETTERS FOR MULTI-RESPONSE QUESTIONS 6. THROUGH 37. SEE CODES ON REVERSE.

6. CO-MUN CODE WHERE CLIENT WILL RESIDE

7. SERVICE AREA WHERE CLIENT WILL RESIDE

8. PROGRAM ELEMENT

9. TERMINATION DATE

MO DA YR

10. LIVING CIRCUMSTANCES AT TERMINATION (Circle one)

- A - Alone / Independent
- B - With Relatives / Family
- C - Other

11. RESIDENTIAL ARRANGEMENT AT TERMINATION

12. EMPLOYMENT STATUS AT TERMINATION (Circle one)

- A - Employed – Full-time
- B - Employed – Part-time
- C - Armed Services
- D - Sheltered Employment
- E - Unemployed
- F - Not in Labor Force
- G - Unknown

13. PRIMARY AGENCY RESPONSIBLE FOR FOLLOW-UP SERVICES

14. M. H. AGENCY / HOSPITAL CODES

A-PRIMARY

B-SECONDARY

15. CIRCUMSTANCE AT TIME OF TERMINATION (Circle one)

A - Termination with Referral

Termination without Referral:

B - No Further Services Needed /Treatment Goal Met

C - Further Services Needed But Not Available

D - Further Services Needed But Rejected By Client

E - Further Services Needed But Rejected By Parent /Guardian

F - Client Lost To Contact, Follow-Up Attempted , No Contact Made

G - Client Lost To Contact, No Follow-Up Attempted

H - Client Moved / Known To Be Unavailable

J - Client Died On Premises

K - Client Died Off Premises

16. NON-MENTAL HEALTH NEEDS AT TIME OF TERMINATION (Circle up to 5)

- A B C D E F G
- H J K L M N P

17. PROGRAM / SERVICE NEEDS AT TIME OF TERMINATION (Circle up to 10)

- A B C D E F G
- H J K L M N O
- P R S T V W X
- 1 2 3

18. FINAL DIAGNOSIS PRINCIPAL

19. FINAL DIAGNOSIS SECONDARY

20. FINAL DIAGNOSIS PHYSICAL

21. LEVEL OF FUNCTIONING

22. DATE OF FIRST FACE-TO-FACE THERAPEUTIC CONTACT

MO DA YR

NUMBER OF PROGRAM CONTACTS

23. INPATIENT DAYS

24. RESIDENTIAL DAYS

25. PARTIAL CARE CONTACTS

26. OUTPATIENT VISITS

27. EMERGENCY CONTACTS FACE-TO-FACE

28. SCREENING CONTACTS

29. CLINICAL CASE MANAGEMENT CONTACTS

30. YOUTH CASE MANAGEMENT CONTACTS

31. TREATMENT TEAM CONTACTS

32. FACE-TO-FACE LIAISON CONTACTS WITH CLIENT

NUMBER OF SYSTEM ADVOCACY CONTACTS

33. FACE-TO-FACE CONTACTS WITH CLIENT

34. CONTACTS ON BEHALF OF CLIENT

35. OPTIONAL/ SPECIAL USE

36. FUTURE USE

SIGNATURE OF PERSON COMPLETING FORM

DATE

37. TRANSACTION TYPE

1

8. PROGRAM ELEMENT

- A. Clinical Case Management
- B. Youth Case Management
- C. Designated Screening
- D. Emergency
- E. Children's Mobile Outreach / Treatment Team
- F. Inpatient
- G. Liaison Services
- H. Outpatient
- J. Partial Care
- K. Residential Treatment
- L. Systems Advocacy
- M. Other

11. RESIDENTIAL ARRANGEMENT

- A. Private Residence
- B. Cooperative Living Situation (No MH Svcs)
- C. Foster Family Care
- D. Homeless / On Street
- E. Community Residential Program (With MH Svcs)
- F. Boarding Home / RHCF
- G. Nursing Home / SNF / ICF
- H. Residential Substance Abuse Program
- J. DDD / MR Residence
- K. DYFS Residential Treatment Center
- L. Children's Group Home / Teaching Family Program
- M. Homeless Shelter
- N. Other Residential program
- O. State Psychiatric Hospital
- P. County Psychiatric Hospital
- R. CCIS Inpatient
- S. Other Psychiatric Inpatient
- T. State Correctional Facility
- V. Detention Center
- W. Other Institutional Setting
- X. Unknown

13. PRIMARY AGENCY RESPONSIBLE FOR FOLLOW-UP

- SCREENING / INPATIENT
- A. Designated Screening Center
 - B. Short Term Care Facility
 - C. CCIS Inpatient
 - D. County Psychiatric Hospital
 - E. State Psychiatric Hospital
 - F. Other Psychiatric Inpatient
 - G. General Hospital

- COMMUNITY PROGRAMS / RESIDENTIAL SOURCES
- H. Community Mental Health Agency
 - J. Alcohol Treatment Program
 - K. Drug Treatment Program
 - L. School System
 - M. Other Social Service Agency
 - N. Nursing Home
 - O. Boarding Home
 - P. Homeless Shelter
 - R. Other Residential Program

- LEGAL / JUSTICE SYSTEM
- S. Police / Court / Jail
 - T. State Correctional Program
 - V. Community Corrections Program
 - W. Family Crisis Intervention Unit

- INDIVIDUALS
- X. Private Mental Health Practitioner
 - 1. Private Psychiatrist
 - 2. Medical Doctor
 - 3. Clergy

- DEPARTMENT OF HUMAN SERVICES
- 4. DYFS
 - 5. DDD
 - 6. Other
 - 7. No Referral

16. NON-MENTAL HEALTH NEEDS AT TIME OF TERMINATION

- A. Alcohol Abuse Services
- B. Correctional
- C. Drug Abuse Services
- D. Education
- E. Employment
- F. Financial
- G. Housing
- H. Legal/Justice
- J. Medical/Health Related
- K. Pastoral
- L. Recreation
- M. Transportation
- N. Other
- P. None

17. PROGRAM / SERVICE NEEDS AT TERMINATION

- A. Crisis Stabilization/Emergency Services
- B. CCIS Inpatient
- C. Other Psychiatric Inpatient
- D. Client Advocacy
- E. Daily Living Skills
- F. Medication Monitoring/Education
- G. Partial Care
- H. Psychological/Psychiatric Evaluation Only
- J. Psychotherapy/Counseling
- K. Self-Help Services
- L. Service Coordination/Linkage
- M. Community Residential Program (with MH Services)
- N. Crisis Housing
- O. Outreach / In-home Services
- P. Residential Support Services
- R. Respite Care
- S. Pre-Vocational Services
- T. Transitional /Supported Employment
- V. Child Study Team Evaluation
- W. DDD
- X. DYFS
- 1. Information And Referral
- 2. Other
- 3. None