



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 /x408 Fax: (212) 253-8679	Program Director: Kearyann Austin, LMHC
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Potential Guest: _____

Date of Birth: _____

Referral Source: _____

Potential Guest Contact # _____

Date of Referral: _____

Medicaid # _____

Social Security # _____

These questions are for the potential guest:

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)?
6. Do you have a health home care coordinator?

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 PPS partner? If yes, which one(s): _____

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. Currently receives Health Home Care Coordination? If yes, name of agency: _____

Yes No

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

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

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

16. Outpatient Appointments over the next 30 days:

Date	Time	Provider	Provider Type	Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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, 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.*****