

**CORRECTIONAL FACILITY  
RE-ENTRY**

**INITIAL ASSESSMENT**

**A. Personal Data**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ NYSID# \_\_\_\_\_  
Release Date: \_\_\_\_\_

Currently housed: Bayview Correctional facility \_\_\_\_\_ County Jail \_\_\_\_\_

Proposed Address:

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Telephone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_ Seq/Gp#: \_\_\_\_\_

Medicaid Card

DSS/Insurance Caseworker: \_\_\_\_\_ Phone #: \_\_\_\_\_

**B. Parole**

P.O. Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Special Conditions: \_\_\_\_\_

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**C. Identification**

What type of I.D. do you have? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Social Security Card          | <input type="checkbox"/> Drivers License                |
| <input type="checkbox"/> Birth Certificate             | <input type="checkbox"/> Non-driver Identification Card |
| <input type="checkbox"/> Picture I.D. (can be expired) | <input type="checkbox"/> PA Card                        |
| <input type="checkbox"/> Other                         | <input type="checkbox"/> Medicaid Card                  |

**D. Education/Employment/Military**

Education:

Highest Grade Completed \_\_\_\_\_  GED  Associate Degree  Bachelor Degree  
 Masters Degree  Other

Additional Education or Training: \_\_\_\_\_

Describe any Learning Disabilities or Limitations: \_\_\_\_\_

\_\_\_\_\_

Describe your grades:  Below Average  Average  Above Average

Did you have any disciplinary actions in school?  Yes  No

If yes, explain: \_\_\_\_\_

What was the impact of alcohol/drug use on education (note any performance issues):

\_\_\_\_\_

\_\_\_\_\_

Do you have any future educational plans?  Yes  No

If yes, explain: \_\_\_\_\_

Employment History:

Last Employer: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Longest period of employment? \_\_\_\_\_

Occupation/Job Skills: \_\_\_\_\_

\_\_\_\_\_

Military:

Have you ever served in the military?  Yes  No

Branch: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_ Discharge Type \_\_\_\_\_

Describe alcohol and drug use while in the military: \_\_\_\_\_



**G. Living Arrangement**

- Own household
- Another relative's household
- Homeless, no permanent residence
- Parent's household
- Shares household
- other \_\_\_\_\_

List persons living in the household: \_\_\_\_\_

List sober support system: \_\_\_\_\_

**H. Physical Health**

Date of last TB test: \_\_\_\_\_ Results:  Positive  Negative

Did you have a chest X-ray?  Yes  No  
 If yes, date: \_\_\_\_\_ Results:  Positive  Negative

Date of last physical exam: \_\_\_\_\_

List hospitalizations: \_\_\_\_\_  
 \_\_\_\_\_

List medical conditions and treatment/medications: \_\_\_\_\_  
 \_\_\_\_\_

**I. Mental Health**

<b>Mood Disorders</b>	<b>Yes</b>	<b>No</b>
1. <i>Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?</i>		
2. <i>In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?</i>		
3. <i>Have you felt sad, low or depressed most of the time for the last two years?</i>		
4. <i>In the past month, did you think that you would be better off dead or wish you were dead? <b>“Yes” response to Question #4: REFER for MH Assessment</b></i>		
5. <i>Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol)</i>		
6. <i>Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?</i>		

<b>Anxiety Disorders</b>		
<p>7. <i>Note this question has two parts</i></p> <p>a. <i>Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? <b>Yes or No</b></i></p> <p>b. <i>If Yes, did these intense feelings get to be their worst within 10 minutes? <b>Yes or No</b></i>  <i>If the answer to both a and b is Yes, answer the question Yes</i>  <i>If the answer to either or both a and b is No, answer the question No</i></p>		
<p>8. <i>Do you feel anxious or uneasy in places or situations where you might have the panic like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? (examples include: being in a crowd, standing in a line, crossing a bridge, etc)</i></p>		
<p>9. <i>Have you worried excessively or been anxious about several things over the past 6 months?</i>  <i>If No, answer no to Question 10 and proceed to Question 11</i></p>		
<p>10. <i>Are these worries present most days?</i></p>		
<p>11. <i>In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? (Examples include: speaking in public, eating in public, being in social situations, etc)</i></p>		
<p>12. <i>In the past month, have you been bothered by thoughts, impulses or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? (examples include: worrying a lot about being dirty, hoard or collect things, religious obsessions, etc)</i></p>		
<p>13. <i>In the past month, did you do something repeatedly without being able to resist doing it? (examples include washing or cleaning excessively, counting or checking, etc)</i></p>		
<p>14. <i>Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? <b>“Yes” responses to Questions #14 and #15:REFER for MH Assessment</b></i></p>		
<p>15. <i>Have you re-experienced the awful event in a distressing way in the past month? (examples include dreams, recollections, flashbacks, etc) <b>“Yes” responses to Questions #14 and #15:REFER for MH Assessment</b></i></p>		

<b>Anxiety Disorders</b>		
16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?		
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could read someone's mind or hear what another person was thinking?		
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own or made you act in a way that was not your usual self? Or have you ever felt that you were possessed?		
19. Have you ever believed that you were being sent special messages through the t.v., radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?		
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?		
21. Have you ever heard things other people couldn't hear, such as voices?		
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?		

**Scoring the Screen:**

**Number of "Yes" responses:**

**If 6 or higher, refer for MH Assessment**

Psychiatric Treatment: (List names of Inpatient, Outpatient, Physician, Diagnosis medication, etc)

None

**Adult Risk Status Evaluation**

Baseline Risk Factor Summary

(Check all that apply and provide details in Clinical Formulation)

**Client's History**

Suicide Attempts: None 1 2 3+

Violence: None 1 2 3+

Lethality Method: Low Mod High

Recent Hospitalization

Abuse by others: Childhood Adult

Self Abuse: Current Past

Drug/Alcohol Problems: Current Past Substance(s) Used:

**Ideation History**

Suicide: Occasional Persistent When?

Violence: Occasional Persistent When?

**High Risk Diagnosis:**

Major Depression (most common dx for suicide) BiPolar Disorder (highest risk dx)

Schizophrenia w/command hallucinations Eating Disorder

Personality Disorder (esp. borderline, narcissistic, anti social)



## J. Chemical Use

### DEPENDENCY REVIEW

	Alcohol	Drugs
Have you increased the use of the substance to obtain the desired effect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the high decreased when you use the same amount of the substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced withdrawal symptoms when you don't use the substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken other substances to help you through withdrawal from the first substance? If Yes, what substance? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used the substance in larger amounts or over longer periods of time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a desire to cut down or control your use of the substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you spend a great deal of time getting, using or recovering from your substance use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your substance use caused loss or separation from jobs, family, friends or hobbies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you increase time spent with substance using friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you continued to use the substance even after it had caused you physical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Symptoms the client has experienced: (Check all that apply)

- |                                    |  |                                    |  |
|------------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Sleeping Disturbances   | <input type="checkbox"/> Shakes    | <input type="checkbox"/> Morning Nausea        |
| <input type="checkbox"/> Sweats    | <input type="checkbox"/> Auditory Hallucinations | <input type="checkbox"/> DT's      | <input type="checkbox"/> Visual Hallucinations |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Tactile Hallucinations  | <input type="checkbox"/> Hangovers |  |

#### CAGE

**C** - Have you ever felt you should **cut down** on your drinking? \_\_\_Yes \_\_\_No

**A** - Have people **annoyed** you by criticizing your drinking? \_\_\_Yes \_\_\_No

**G** - Have you ever felt bad or **guilty** about your drinking? \_\_\_Yes \_\_\_No

**E** - Eye opener: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? \_\_\_Yes \_\_\_No

- Two "yes" answers to the CAGE test indicates problems with alcohol.

**K. CHEMICAL USE**

	Age Started	Amount	Frequency	Duration	How Used
Alcohol					
Heroin					
Marijuana					
Cocaine					
Amphetamines					
Barbiturates					
Hallucinogens					
Methadone					
Valium					
Inhalants					
Other					

Drug use while incarcerated:  Yes  No

**L. Treatment History**

Alcohol and Drug Treatment: (include Detox, Inpatient, Outpatient, AA & NA)

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Legal History:

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**M. Diagnostic Criteria for Abuse in Remission Due to Incarceration:**

- At least 1 of the following in a 12-month period prior to incarceration:
  - A. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
  - B. Recurrent substance use in situations in which it is physically hazardous.
  - C. Recurrent substance-related legal problems.
  - D. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- 2. The symptoms have never met the criteria for substance dependence for this class of substance.

**N. Diagnostic Criteria for Dependence in Remission Due To Incarceration:**

At least 3 of the following in a 12 month period prior to incarceration:

- 1. Tolerance, as defined by either of the following:
  - A. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
  - B. Markedly diminished effect with continued use of the same amount of the substance.
- 2. Withdrawal, as manifested by either of the following:
  - A. The characteristic withdrawal syndrome for the substance.
  - B. The same or closely related substance is taken to relieve or avoid withdrawal symptoms.
- 3. The substance is often taken in larger amounts or over a longer period than was intended.
- 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
- 7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

## DEPENDENCE/ABUSE CONTINUUM

1.  ***Established opiate dependence condition.*** The individual is:
  - a.  age 21 or older and has had a physiological opiate dependence condition for one year based on DSM IV criteria; or
  - b.  age 18-20 and has had a physiological opiate dependence condition for two years based on DSM IV criteria
  - c.  pregnant meets (a) or (b) above except current physiological dependence not demonstrated.
  - d.  recently incarcerated/institutionalized, meets (a) or (b) except current physiological dependence not demonstrated.
2.  ***Moderate to severe dependence condition.*** The individual
  - a.  meets 4 or more of the DSM IV criteria for dependence
  - b.  is dependent on more than one substance
  - c.  experiences withdrawal symptoms
  - d.  other:
3.  ***Dependence condition.*** The individual meets the DSM-IV-TR criteria for dependence.
4.  ***Abuse condition.*** The individual meets the DSM-IV-TR criteria for abuse.
5.  ***Significant other.*** See definition.

## OTHER PLACEMENT FACTORS (mark all that apply)

1.  ***Unable to participate in or comply with treatment outside 24-hour structured treatment setting based on:***
  - a.  history of dependence
  - b.  unsuccessful attempts at abstinence/maintenance
  - c.  current intoxication
  - d.  failure to complete ambulatory treatment
  - e.  prior treatment episodes
  - f.  likelihood of rapid relapse upon release from controlled setting
  - g.  history of escaping or absconding from controlled setting
  - h.  history of non-compliance with mandated sanctions
  - i.  history of resistance to treatment
  - j.  other:
2.  ***Imminent health risk from continued AOD use due to***
  - a.  Pregnancy
  - b.  Other biomedical condition: \_\_\_\_\_

3.  **Complications or comorbidities requiring medical management/monitoring daily including:**
  - a.  Mental illness
  - b.  Developmental disabilities
  - c.  Pregnancy
  - d.  Moderate to severe organ damage
  - e.  Public health-related (HIV, TB, hepatitis STDs)
  - f.  Other health conditions: \_\_\_\_\_
  
4.  **Substantial deficits in functional skills.** A need for extensive rehabilitation or habilitation is indicated by problems with
  - a.  **activities of daily living:**  hygiene;  diet;  keeping appointments;  managing medications;  finances;  caring for child;  accessing services;  transportation
  - b.  **interpersonal skills:**  asking for help/responding to others;  locus of control;  avoiding relationships/drift;  sober friends/recreation;  handling conflicts;  family responsibilities;  use of anger to manipulate others;
  - c.  **vocational/educational skills:**  literacy;  goals/expectations;  job seeking skills;  attendance/punctuality;  identification as “worker”;  understanding job role/norms of work environment;  hustling/illegal activity
  - d.  **maladaptive social behavior:**  respecting property;  threatening/abusing others;  child neglect/abuse;  reckless behavior;  lying/conning;  violating court orders;  lack of remorse/guilt;  accepting authority/rules
  - e.  **other:** \_\_\_\_\_
  
5.  **Inadequate social support system.** The emotional and social support necessary for recovery is not available:
  - a.  family and friends (if any) are unable to provide support needed;
  - b.  family and friends are likely to subvert the treatment process.
  
6.  **Physical health care needs.** Physical health care needs require attention or monitoring by program health care staff.
  - a.  infectious diseases specify:
  - b.  chronic health conditions specify:
  - c.  other, specify:
  
7.  **Substantial risk of relapse.** The individual will very likely continue or relapse to drinking or other drug use without close outpatient monitoring and structured therapeutic services, as indicated by:
  - a.  lack of awareness of relapse triggers.
  - b.  difficulty postponing immediate gratification.
  - c.  ambivalence/resistance to treatment.
  - d.  other:
  
8.  **Inadequate living environment.** Unable to maintain recovery without structured, supportive living environment because:
  - a.  inadequate support for recovery from household members (if any) and community resources, or
  - b.  the individual is homeless.

Initial Determination/ Level of Care		
Client Name:		Date:
Step 1: A. The individual appears to be in need of chemical dependency services. <input type="checkbox"/> Yes <input type="checkbox"/> No B. The individual does not appear to be in need of acute hospital care, acute psychiatric care, or other intensive services which could not be provided with outpatient care or would prevent him/her from participating in chemical dependency treatment. <input type="checkbox"/> Yes <input type="checkbox"/> No C. The individual appears to be free of serious communicable diseases that can be transmitted through ordinary contact. <input type="checkbox"/> Yes <input type="checkbox"/> No D. Does the individual meet initial determination? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, stop do not complete Level of Care Determination Proceed to Step 3		
Step 2 Non Crisis Level of Care Determination		
LOCADTR CRITERIA	INDICATED LEVEL OF CARE	
1. Dependence or abuse condition	<input type="checkbox"/> Yes Go to #2	<input type="checkbox"/> No Go to #14
2. Unable to participate or comply with treatment outside 24 hour structured treatment setting	<input type="checkbox"/> Yes Go to #4	<input type="checkbox"/> No Go to #3
3. Imminent health risk from continued alcohol or drug use	<input type="checkbox"/> Yes Go to #4	<input type="checkbox"/> No Go to #6
4. Substantial deficits in functional skills	<input type="checkbox"/> Yes Go to #5	<input type="checkbox"/> No Refer to Inpatient Rehab
5. Complications or co morbidities requiring medical management/monitoring	<input type="checkbox"/> Yes Refer to Inpatient Rehab	<input type="checkbox"/> No Refer to Intensive Residential Rehab
6. Established opiate dependence condition	<input type="checkbox"/> Yes Offer referral Methadone tx & consult with supervisor to determine appropriateness for referral to Detox, Go to #7	<input type="checkbox"/> No Go to #8
7. Chooses to participate in Methadone Treatment	<input type="checkbox"/> Yes Refer to Methadone tx Go to #8	<input type="checkbox"/> No Go to #8
8. Substantial deficits in functional skills	<input type="checkbox"/> Yes Go to #10	<input type="checkbox"/> No Go to #9
9. Physical health care needs	<input type="checkbox"/> Yes Go to #10	<input type="checkbox"/> No Go to #11
10. Inadequate social support system	<input type="checkbox"/> Yes Admit to outpatient rehab go to #13	<input type="checkbox"/> No Go to #11
11. Moderate to severe dependence condition	<input type="checkbox"/> Yes Admit to Intensive outpatient go to #13	<input type="checkbox"/> No Go to #12
12. Substantial risk of relapse	<input type="checkbox"/> Yes Admit to Intensive outpatient go to #13	<input type="checkbox"/> No Admit to outpatient non intensive go to #13
13. Inadequate living environment	<input type="checkbox"/> Yes Refer to Community residence/supportive living	<input type="checkbox"/> No End
14. Significant Other	<input type="checkbox"/> Yes Admit to non intensive outpatient	<input type="checkbox"/> No End
Appropriate for: <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Intensive Residential <input type="checkbox"/> Non Intensive Outpatient <input type="checkbox"/> Community Residence/Supportive Living		
Step 3: <input type="checkbox"/> Yes approved for referral to <input type="checkbox"/> No, if disapproved, rationale and recommendations		

Diagnostic Impressions:

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Assets: \_\_\_\_\_

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Needs: \_\_\_\_\_

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Recommendations: \_\_\_\_\_

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**Completed by:**

Care Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_