

Western Connecticut Mental Health Network REQUEST FOR SERVICES

Danbury Area
78 Triangle Street, Bldg. I
Danbury, CT 06810
203-448-3200

Torrington Area
249 Winsted Road
Torrington, CT 06790
860-496-3700

Waterbury Area
95 Thomaston Avenue
Waterbury, CT 06702
203-805-5300

Section I: Applicant Information

Name: _____ Phone #: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Male Female

Do you speak English? Yes No Is an Interpreter needed? Yes No

Primary Language: _____ Other Language(s): _____

Conservator of Person No Yes Name: _____ Phone: _____

Conservator of Estate No Yes Name: _____ Phone: _____

Section II: Income and Insurance Information

Income (amount): SSI _____ SSDI _____ Other(type/amount) _____

Insurance (policy/card number):

Medicaid (T.19, Husky, LIA) _____ Medicare _____ Veteran's Benefits _____

Other Insurance (name & number) _____

Section III: Service Request Information

What type of help/services do you need? _____

Are you in treatment at this time? _____ NO _____ YES (if yes, please list below)

NAME OF PROVIDER	TYPE OF SERVICE

I wish to be considered for services. I understand that the Western Connecticut Mental Health Network (WCMHN) may gather additional information regarding my mental health history. WCMHN may share any information gathered and contained in this request with relevant service provider agencies.

Applicant Signature: _____ Date: _____

Conservator Signature: _____ Date: _____
(if applicable)

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Section VI: Disposition

Need to obtain additional Information (specify): _____

No referral because: _____

Screener Printed Name: _____ **Title:** _____

Signature: _____ **Date:** _____

FINAL DISPOSITION: _____

Approved by:

Printed Name: _____ **Title:** _____

(Clinical Director or Designee)

Signature: _____ **Date:** _____

Modified Mini Screen

Screening Date: _____

Number of days since last use of alcohol and/or other drugs: _____

Section A

- | | |
|--|--------------------|
| 1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? | YES _____ NO _____ |
| 2. 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 | YES _____ NO _____ |
| 3. Have you felt sad, low or depressed most of the time for the last two years? | YES _____ NO _____ |
| 4. In the past month did you think that you would be better off dead or wish you were dead? | YES _____ NO _____ |
| 5. 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). | YES _____ NO _____ |
| 6. 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? | YES _____ NO _____ |

Section B

7. 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? Did these intense feelings get to be their worst within 10 minutes? (If "yes" to both questions, answer "yes", otherwise check "no") YES _____ NO _____
8. Do you feel anxious, frightened, uncomfortable 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, ___being alone away from home or alone at home, ___crossing a bridge, ___traveling in a bus, train or car? YES _____ NO _____
9. Have you worried excessively or been anxious about several things over the past 6 months? (If you answered "no" to this question, please skip to Question 11.) YES _____ NO _____
10. Are these worries present most days? YES _____ NO _____
11. 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 or with others, ___writing while someone watches, ___being in social situations YES _____ NO _____
12. 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: ___Were you afraid that you would act on some impulse that would be really shocking? ___Did you worry a lot about being dirty, contaminated or having germs? ___Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ___Did you have any fears or superstitions that you would be responsible for things going wrong? ___Were you obsessed with sexual thoughts, images or impulses? ___Did you hoard or collect lots of things? ___Did you have religious obsessions? YES _____ NO _____
13. 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 things over and over; ___Repeating, collecting, or arranging things; ___Other superstitious rituals. YES _____ NO _____
14. Have you ever experienced or witnessed or had to deal with an YES _____ NO _____

extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: ___serious accidents; ___sexual or physical assault; ___terrorist attack; ___being held hostage; ___kidnapping; ___fire; ___discovering a body; ___sudden death of someone close to you; ___war; ___natural disaster.

15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ___Dreams; ___Intense recollections; ___Flashbacks; ___Physical reactions.

YES _____ NO _____

Section C

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?

YES _____ NO _____

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?

YES _____ NO _____

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?

YES _____ NO _____

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?

YES _____ NO _____

20. Have your relatives or friends ever considered any of your beliefs strange or unusual?

YES _____ NO _____

21. Have you ever heard things other people couldn't hear, such as voices?

YES _____ NO _____

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?

YES _____ NO _____

Section D¹

23. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES _____ NO _____

SCORING

SCORE: Number of "Yes" Answers _____

- Screened positive = a score of 6 or greater – **OR** –
- Question 4 = yes (suicidality) – **OR** –
- Question 14 AND 15 = yes (trauma)

Modified Mini International Neuropsychiatric Interview

Alexander, M.J., Haugland, G., Lin, S.P., Bertollo, D.N., and McCorry, F.A. Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. *International Journal on the Addictions*, (forthcoming).

Mini International Neuropsychiatric Interview (MINI)

Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59 (suppl. 20), 1998.

¹ This question was added by Connecticut.
9/20/13

**Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
Screening Instrument**

Screening Date: _____

I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. During the **past 6 months...**

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants). YES _____ NO _____
2. Have you felt that you use too much alcohol or other drugs? YES _____ NO _____
3. Have you tried to cut down or quit drinking or using drugs? YES _____ NO _____
4. Have you gone to anyone for help because of your drinking or drug use? YES _____ NO _____
5. Have you had any health problems? For example, have you:
 - _____ had blackouts or other periods of memory loss?
 - _____ injured your head after drinking or using drugs?
 - _____ had convulsions, delirium tremens (DTs)?
 - _____ had hepatitis or other liver problems?
 - _____ felt sick, shaky, or depressed when you stopped?
 - _____ felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
 - _____ been injured after drinking or using?
 - _____ used needles to shoot drugs?

Give a "YES" answer if at least one of the 8 presented items is marked ✓

YES _____ NO _____

6. Has drinking or other drug use caused problems between you and family or friends?	YES _____	NO _____
7. Has your drinking or other drug use caused problems at school or work?	YES _____	NO _____
8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)?	YES _____	NO _____
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	YES _____	NO _____
10. Are you needing to drink or use drugs more and more to get the effect you want?	YES _____	NO _____
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	YES _____	NO _____
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	YES _____	NO _____
13. Do you feel bad or guilty about your drinking or drug use?	YES _____	NO _____
<u>The next questions are about your lifetime experiences.</u>		
14. Have you ever had a drinking or other drug problem?	YES _____	NO _____
15. Have any of your family members ever had a drinking or drug problem?	YES _____	NO _____
16. Do you feel that you have a drinking or drug problem now ?	YES _____	NO _____

SCORING

SCORE: (Questions 1 and 15 are not scored)

Number of "Yes" Answers _____

Screened positive = a score of 4 or greater.

Center for Substance Abuse Treatment. Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994.