<table>
<thead>
<tr>
<th>2. PROJECT CODE</th>
<th>3. CLIENT/PATIENT NO.</th>
<th>4. DATE OF BIRTH</th>
<th>5. UNIQUE CLIENT ID</th>
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</table>

**INSTRUCTIONS:**
- Please type entries 1. through 5.

**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  
8. SERVICE AREA  
9. PROGRAM ELEMENT  
10. APPLICATION DATE / CONTACT ON BEHALF OF CLIENT  
11. DATE OF FIRST FACE-TO-FACE CONTACT  
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)  
- A  
- B  
- C  
- D  
- E  
- F  
- G  
- H  
- J  
- K  
- L  
- M  
- N  
- P  

22. CURRENT TYPE OF EDUCATION  
- A  
- B  
- C  
- D  
- E  
- F  
- G  
- H  
- J  
- K  
- L  
- M  
- N  
- P  
- X  
- 1  
- 2  

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  

25. GROSS ANNUAL FAMILY INCOME  
- 0  
- 0  
- 0  

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  

30. HOSPITAL DISCHARGED FROM IN LAST 30 DAYS  
- A  
- B  
- C  
- D  
- E  
- F  
- G  
- H  
- J  
- K  

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  

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  
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- T  
- V  
- W  
- X  
- 1  
- 2  
- 3  
- 4  
- 5  
- 6  
- 7  
- 8  
- 9  

36. PRIMARY PRESENTING PROBLEM  

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  
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- S  
- T  
- V  
- W  
- X  
- 1  
- 2  
- 3  
- 4  
- 5  
- 6  

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  

**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
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
Q. 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
Y. Family or Friend
Z. Private M. H. Practitioner
AA. Private Psychiatrist
BB. Medical Doctor
CC. Clergy

DEPT. OF HUMAN SERVICES
D. DYFS
E. DDD
F. 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 CIRCUMSTANCES
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
I. DDD/MR Residence
J. DYFS Residential Treatment Center
K. Children’s Group Home Teaching Family Program
L. Homeless Shelter
M. Other Residential Program
N. Other Program
O. State Psychiatric Hospital
P. County Psychiatric Hospital
Q. CCIS Inpatient
R. Other Psychiatric Inpatient
S. State Correctional Facility
T. Detention Center
U. Other Institutional Setting
V. Unknown

19. 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

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

21. CURRENT TYPE OF EDUCATION
A. Regular Vocational Education
B. Special Education
C. Post High School Education
D. Not in School

22. 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

23. 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

24. S. S. ELIGIBILITY
A. Determined Eligible
B. Potentially Eligible
C. Probably Not Eligible
D. Determined to be Ineligible

25. PRESENTING PROBLEMS and
26. PRIMARY PRESENTING PROBLEM
A. Alcohol Abuse
B. Anxiety
C. Assuasive Behavior/Threat
D. Behavior
E. Compulsive Gambling
F. Daily Living Problems
G. Depression/Mood Disorder
H. Destructive to Property
J. Developmental Disability
K. Drug Abuse
L. Eating Disorder
M. Economic Stress
N. Fire Setting/Ideation
O. Homicidal Behavior/Threat
P. Legal/Justice Involvement
Q. Marital/Family Problem
R. Medical/Somatic Complaints
S. No Social Support Resources
T. Organic Mental Disorder
U. Physical Abuse/Assault Victim
V. Physical Neglect
W. Runaway Behavior
X. School Problems
Y. Sexual Abuse/Rape Victim
Z. Sexual Abuser
AA. Social/Interpersonal (other than family)
BB. Suicide Attempt
CC. Suicide Threat
DD. Thought Disorder
EE. Other

40. HANDICAPPPING CONDITIONS
A. Ambulatory/Orthopedic
B. Auditory
C. Communication
D. Developmental Disability/IMR
E. Neurologically Impaired
F. Medical
G. Visual
H. Emotionally Disturbed
I. Physically Handicapped
J. Perception Impaired
K. Other

43. TRANSFER FROM OTHER INPATIENT
A. No
B. If Yes:
C. One-Way (State/County Hosp.)
D. Two-Way (State/County Hosp.)
E. CCIS
F. Short Term Care Facility
G. 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:**

1. PLEASE TYPE ENTRIES 1. THROUGH 5.

<table>
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**INSTRUCTIONS:**

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

<table>
<thead>
<tr>
<th>6. CO-MUN CODE WHERE CLIENT WILL RESIDE</th>
<th>7. SERVICE AREA WHERE CLIENT WILL RESIDE</th>
<th>15. CIRCUMSTANCE AT TIME OF TERMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>(Circle one)</td>
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| A | - Termination with 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 |

<table>
<thead>
<tr>
<th>8. PROGRAM ELEMENT</th>
<th>9. TERMINATION DATE</th>
<th>23. INPATIENT DAYS</th>
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<td>MO DA YR</td>
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<tr>
<th>10. LIVING CIRCUMSTANCES AT TERMINATION (Circle one)</th>
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| A | - Alone / Independent |
| B | - With Relatives / Family |
| C | - Other |

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<tr>
<th>11. RESIDENTIAL ARRANGEMENT AT TERMINATION</th>
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<tr>
<th>12. EMPLOYMENT STATUS AT TERMINATION (Circle one)</th>
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| A | - Employed – Full-time |
| B | - Employed – Part-time |
| C | - Armed Services |
| D | - Sheltered Employment |
| E | - Unemployed |
| F | - Not in Labor Force |
| G | - Unknown |

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<tr>
<th>13. PRIMARY AGENCY RESPONSIBLE FOR FOLLOW-UP SERVICES</th>
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<th>14. M. H. AGENCY / HOSPITAL CODES</th>
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| A | - PRIMARY |
| B | - SECONDARY |

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<tr>
<th>16. NON-MENTAL HEALTH NEEDS AT TIME OF TERMINATION (Circle up to 5)</th>
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<th>17. PROGRAM / SERVICE NEEDS AT TIME OF TERMINATION (Circle up to 10)</th>
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<th>18. FINAL DIAGNOSIS PRINCIPAL</th>
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<th>19. FINAL DIAGNOSIS SECONDARY</th>
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<th>20. FINAL DIAGNOSIS PHYSICAL</th>
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<th>21. LEVEL OF FUNCTIONING</th>
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<th>22. DATE OF FIRST FACE-TO-FACE THERAPEUTIC CONTACT</th>
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<tr>
<th>23. INPATIENT DAYS</th>
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<tr>
<th>24. RESIDENTIAL DAYS</th>
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<tr>
<th>25. PARTIAL CARE CONTACTS</th>
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<th>26. OUTPATIENT VISITS</th>
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<tr>
<th>27. EMERGENCY CONTACTS FACE-TO-FACE</th>
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<tr>
<th>28. SCREENING CONTACTS</th>
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<tr>
<th>29. CLINICAL CASE MANAGEMENT CONTACTS</th>
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<th>30. YOUTH CASE MANAGEMENT CONTACTS</th>
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<th>31. TREATMENT TEAM CONTACTS</th>
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<tr>
<th>32. FACE-TO-FACE LIAISON CONTACTS WITH CLIENT</th>
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<th>33. FACE-TO-FACE CONTACTS WITH CLIENT</th>
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<th>34. CONTACTS ON BEHALF OF CLIENT</th>
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<tr>
<th>35. OPTIONAL/ SPECIAL USE</th>
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<th>36. FUTURE USE</th>
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<tr>
<th>37. TRANSACTION TYPE</th>
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**NEW JERSEY DEPARTMENT OF HUMAN SERVICES – Division of Mental Health Services**

**FORM NO. USTF-2 (07/89)**
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 Svcs)
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