

**NYS Office of Addiction Services and Supports  
CLIENT ADMISSION REPORT INSTRUCTIONS (PAS-44N)  
FOR ADMISSIONS DATED 12/1/2018 AND BEYOND**

*These instructions are for the purpose of completing the PAS-44N form only.  
They do not supersede or replace existing regulations.*

**PROVIDER NUMBER**

Enter the five-digit provider number assigned by OASAS that identifies the treatment service provider.

**PROGRAM NUMBER**

Enter the five-digit number assigned by OASAS which identifies the program the client is being admitted to.

**CLIENT ID INFORMATION**

**CLIENT ID**

The client identification number selected by the program may contain a maximum of 10 alpha-numeric digits. The number may be entered using any of the available 10 spaces. Do not use the client's social security number as the Client ID number.

**For all clients prescribed methadone, the identification number assigned by the NYS Central Registry must be used.** All clients who are prescribed methadone and are new admissions or readmissions will be randomly assigned an ID number.

Note: Client ID Numbers are not used for data analysis by OASAS and are for provider use only.

**SPECIAL PROJECT**

The Special Project field is not required. This Special Project designation is assigned to programs by OASAS. Do not use this unless you have been assigned a Special Project designation. If the program has been approved for a special project code and this admission meets the qualifying criteria for that project code, use the dropdown list to select the appropriate code.

**SEX (at birth)**

Enter gender, Male, Female, or X, as documented on birth certificate. If the client is transgender, gender non-conforming or non-binary, use the gender that was recorded at time of birth.

**BIRTH DATE**

Enter two digits each for the month and day and four digits for the year of birth (e.g., March 8, 1998 would be 03/08/1998).

**LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER**

Enter the last four digits of the **client's** Social Security number (SSN), as assigned by the Social Security Administration. If the client does not have an SSN, enter 0000. If another person is providing insurance coverage, be sure to use the client's SSN, not the SSN of the insured. Please be sure that the numbers are entered in the correct order. **These numbers are critical to OASAS' ability to track clients as they move through the treatment system.**

**FIRST TWO LETTERS OF LAST NAME AT BIRTH**

Enter the first two letters of the client's last name at **birth** (Smith = SM, O'Brien = OB). For clients who have changed their last name, use their BIRTH name (e.g., Maiden Name).

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**FIRST TWO LETTERS OF LAST NAME CURRENT**

Enter the first two letters of the client's current last name (Smith = SM, O'Brien = OB). Having both the first two letters of the client's last name at birth and the first two letters of the client's current last name (if different) will increase OASAS' ability to correctly track the client as the client moves through the treatment system.

**ADMISSION DATE**

For **ambulatory (Part 822) programs**, the Admission Date is the date of the first treatment or clinical service following the decision to admit the client. This may be the first counseling session, a medical visit or a visit to collect information for the comprehensive evaluation. It **is not** the day the admission decision is made unless the client receives a treatment service on the same day that the admission decision is made. For example, if a program completes an assessment on March 1, makes the decision to admit the client in a case conference on March 3 and the client shows up for their first group counseling session on March 6, the admission date is March 6. An admission date of March 6, 2017, would be entered as 03/06/2017. For purposes of reporting, a client may not be admitted more than once in a calendar day.

For **residential/inpatient programs**, the Admission Date is the date of the first overnight stay (i.e., the date that the client first sleeps in a program bed) following at least a preliminary determination that the individual appears to need residential/inpatient substance use disorder services. In most cases, the determination is made that the individual is appropriate for this level of care prior to an overnight stay. In some cases, this decision is made on the same day of the overnight stay.

Example 1: An individual arrives at an inpatient program for a scheduled interview on March 1 and a level of care determination is completed on that date. The intake counselor meets with the admission team on March 4<sup>th</sup> to make a recommendation. The team agrees to admit the individual who is contacted and told to come the next day to be admitted. The individual arrives on March 5, receives orientation and is assigned to a bed. The program enters March 5 as the Admission Date on the PAS-44N.

Example 2: An individual arrives at a residential program late in the day of March 1. A staff member interviews the individual and determines that the individual appears appropriate for admission. The staff member completes a level of care determination and the individual is confirmed to be appropriate for admission. The client has dinner and is assigned to a bed. The program enters March 1 as the Admission Date on the PAS-44N.

**PART 820 PROGRAMS ONLY**

**Element of Care**

Select the element of care the client is being admitted into.

- Stabilization**
- Rehabilitation**
- Reintegration**

If **Stabilization** or **Rehabilitation** is chosen, then **Reintegration Setting** will not be used. If **Reintegration** is chosen, then a **Reintegration Setting** is required.

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**REINTEGRATION SETTING**

If element of care selected is **Reintegration**, then enter one of the following reintegration settings.

**Congregate**  
**Scatter-Site**

**LOCADTR INFORMATION**

\*Please note that the Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient LOCADTR Assessment (TRS-62) applies to LOCADTR data entry. CDS data entry is still required even if a client declines to sign the above identified form.

Both **Assessment ID** and **Created Date** are optional items and can be entered at the program's discretion.

**ASSESSMENT ID**

The Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0 Assessment ID will be generated at the administration of LOCADTR 3.0 to substantiate the clinical rationale for admission. The most recent Assessment ID should be documented. It can be found on the Assessment Dashboard page of LOCADTR 3.0 and is the first column next to client name. The assessment ID will appear on the assessment table located on the LOCADTR dashboard only for the clinician who completed the assessment. If a person uses the "Other Clinicians' option to retrieve this information, the CSV file will need to be downloaded to get the Assessment ID number. The use of LOCADTR 3.0 Protocol has been mandated for all OASAS certified substance use disorder treatment providers to be utilized to determine the most appropriate level of care for a client and therefore it must be utilized for all admissions, transfers, transitions, and discharges. Further information on LOCADTR 3.0 can be found here- [LOCADTR 3.0](#).

**CREATED DATE**

The Created Date is the date the LOCADTR 3.0 assessment which supports this admission was created. Enter two digits for the month, two digits for the day, and four digits for the year.

**TRS-61 IDENTIFYING INFORMATION (ID)**

**AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH INFORMATION**

The data items that are addressed by this authorization of disclosure were added to the data collected by OASAS to assist OASAS in implementing the Medicaid Redesign initiative and to comply with mandatory federal reporting requirements. Clients should be offered the opportunity to sign the *Authorization for Release of Behavioral Health Information Form (TRS-61)* at the time of admission or, if admitted prior to October 1, 2014, at the completion of the Treatment Update. The client should be aware that signing or refusing to sign the consent form does not impact admission disposition. A client can sign the consent form at any time during their treatment episode with the knowledge that it allows consent of the data for the entire treatment episode, from admission through discharge and is valid for three years following the last date of service. Clients have the right to revoke this consent at any time. OASAS will not re-disclose any information. Please see the document titled *Guidance for Using the Authorization for Release of Behavioral Health Information (TRS-61)* for further information. ***If a client refuses to sign the TRS-61, the program is STILL required to report all other***

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***data items in the Client Admission Report. The only exception to this is HIV status which should be reported as “Unknown”.***

**ID CONSENT DATE**

This is the date that the client signed the *Authorization for Release of Behavioral Health Information Form (TRS-61)*. Enter two digits for the month, two digits for the day, and four digits for the year. The date may be prior to the date of admission. The date of signature cannot be a future date. If the client signs and dates the TRS-61, the following data items may be entered: Last Name (Birth), Last Name (Current), First Name, and Medicaid Client ID. If a date has been entered in the ID Consent Date field, then, at a minimum, the client’s Last Name at Birth and Current Last Name are required.

**ID CONSENT REVOKE DATE**

This date is not required but if entered, it must be ON or AFTER the ID Consent Date. Enter two digits for the month, two digits for the day, and four digits for the year.

**LAST NAME (BIRTH NAME)**

Enter the letters of client’s full last name as recorded at birth. This item is required if a date has been entered in ID Consent Date.

**LAST NAME (CURRENT NAME)**

Enter the letters of client’s current full last name. This item is required if a date has been entered in ID Consent Date.

**FIRST NAME**

Enter the letters of the client’s full first name.

**MEDICAID CLIENT ID**

Enter the client’s full Medicaid Client ID if applicable. This is usually two letters followed by five numeric digits and ending with one letter.

**SOCIAL SECURITY NUMBER**

Enter the client’s full nine-digit Social Security number. The full Social Security number should only be entered if, in addition to signing and dating the TRS-61, the client also initialed the section allowing disclosure of Social Security number to OASAS.

**NUMBER OF ASSESSMENT VISITS OR DAYS**

Enter the actual number of visits or days spent conducting an assessment prior to treatment.

An **assessment visit**, for a Part 822 treatment program, is a visit to the program with the purpose of determining need for services and the visit occurs prior to, or on the same day as, (1) an admission for treatment services, (2) referral to another provider for substance use disorder treatment, or (3) another disposition or termination of the assessment process.

An **assessment day**, for an inpatient/residential program, is any day, or part of a day, spent by an individual as an inpatient or resident being assessed to determine the need for inpatient or residential treatment, prior to receiving treatment services.

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*If no assessment visits or assessment days were provided, enter "0."*

**SIGNIFICANT OTHER**

Enter one of the following:

**Yes** The client will be admitted as a Significant Other; not for treatment of their own alcohol or substance misuse problems.

**No** The client will be admitted for treatment of their own alcohol or substance misuse problems, not as a Significant Other.

*"Significant Other" means an individual who is related to, a close friend of, associated with, or directly affected by, an individual misusing substances. Substance use disorder treatment should include services to the significant others of those who are misusing substances, in recognition that addiction has a significant negative impact on such individuals. Significant Others may be admitted to the treatment program, regardless of whether the individual misusing substances is in treatment, or the Significant Other may be treated as part of a family. **If a person is experiencing problems with alcohol or other substances requiring treatment, they should not be admitted as a Significant Other.***

**By regulation, substance use disorder outpatient clinics (Part 822) are permitted to admit Significant Others for treatment services.**

**DEMOGRAPHICS**

**SEXUAL ORIENTATION**

Sexual orientation refers to a person's attraction to another person romantically, emotionally, and sexually. Common sexual orientations include straight (heterosexual), gay, lesbian, and pansexual.

**Bisexual** A person romantically, emotionally, and sexually attracted to more than one gender.

**Lesbian or Gay** A person romantically, emotionally, and sexually attracted to another person of the same gender.

**Pansexual** A person romantically, emotionally, and sexually attracted to another person of any gender.

**Straight** A person romantically, emotionally, and sexually attracted to another person of the opposite gender.

**I use a different term** Select this option when the client uses a different term than those identified above.

**Questioning/Unsure** Select this option if the client is unsure or undecided.

**Prefer not to answer** Select this option if the client does not want to answer this question.

**GENDER IDENTITY**

Gender identity refers to a person's concept of self as male, female, a blend of both, or neither. A person's gender identity can be the same or different from the gender associated with a person's assigned sex at birth. A person's gender identity may be consistent for their whole life or may change over time.

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**Intersex** A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit typical definitions of male or female.

**Man** A male human being, including a person who lives and identifies as a man.

**Non-Binary** A person that does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside of these categories. Non-binary may also encompass identities such as genderqueer or gender-fluid.

**Two-Spirit** A unique alternative gender status, this term describes a person's sexual, gender and/or spiritual identity that identifies as male, female, neither or both.

**Woman** A female human being, including a person who lives and identifies as a woman.

**I use a different term**

**Questioning/Unsure** Select this option if the client is unsure or undecided.

**Prefer not to answer** Select this option if the client does not want to answer this question.

### **TRANSGENDER**

Transgender is an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.

**Yes** A person who identifies as transgender.

**No** A person does not identify as transgender.

**Questioning/Unsure** Select this option if the client is unsure or undecided.

**Didn't Answer** Select this option if the client does not want to answer this question.

### **RACE**

Based on client self-identification and/or staff observation, enter the appropriate race. If the client is multiracial, enter the race with which the client most identifies.

**Alaska Native** A person having origins in any of the Native people of Alaska.

**Asian**

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)

**Black or African American** A person having origins in any of the black racial groups of Africa.

**Hawaiian or Other Pacific Islander**

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**Middle Eastern or North African** A person having origins in any of the original peoples of the Middle East or North Africa.

**Native American, Indigenous or American Indian** A person having origins in any of the original peoples of North, Central and/or South America and who maintains cultural identification through tribal affiliation or community attachment.

**White** A person having origins in any of the original peoples of Europe.

**Some other race, ethnicity, origin**

A category for use when the client's race is not classified above, where the client does not identify with any one particular racial group, or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.

### **ASIAN ORIGIN**

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A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)

Indicate the most appropriate origin.

**Asian Indian (East Indian)**

**Bangladeshi**

**Burmese**

**Cambodian**

**Chinese**

**Filipino**

**Hmong**

**Indonesian**

**Japanese**

**Korean**

**Laotian**

**Malaysian**

**Nepalese**

**Pakistani**

**Sri Lankan**

**Taiwanese**

**Thai**

**Tibetan**

**Vietnamese**

**Asian, Not Specified**

**Not of Asian Origin**

**HISPANIC ORIGIN**

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Indicate the most appropriate origin.

**Central American**

**Colombian**

**Cuban**

**Dominican**

**Ecuadorian**

**Guatemalan**

**Honduran**

**Mexican**

**Peruvian**

**Puerto Rican**

**Salvadorian**

**South American**

**Hispanic/Latino/a/x, Not Specified**

**Not of Hispanic Origin**

**PACIFIC ISLANDER ORIGIN**

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A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Island.

Indicate the most appropriate origin.

**Fijian  
Guamanian  
Hawaiian  
Samoan  
Tongan  
Pacific Islander, Not Specified  
Not of Pacific Islander Origin**

**PRIMARY LANGUAGE**

Enter the primary language of the client with which the client prefers to communicate. The following list is not all inclusive. If the client prefers a specific language not listed, check "Other."

<b>Arabic</b>	<b>Japanese</b>
<b>Bengali</b>	<b>Korean</b>
<b>Chinese</b>	<b>Polish</b>
<b>English</b>	<b>Portuguese</b>
<b>French</b>	<b>Russian</b>
<b>Greek</b>	<b>Spanish</b>
<b>Haitian Creole</b>	<b>Yiddish</b>
<b>Hindi</b>	<b>Sign Language</b>
<b>Italian</b>	<b>Other</b>

**VETERAN STATUS**

Enter **Yes** or **No**.

A veteran is any person who has served on active duty in the armed forces of the United States, including the Coast Guard. Not counted as veterans are those whose only service was in the Reserves, National Guard or Merchant Marines and were never activated. For purposes of reporting, "veteran" does not in any way reflect the type of military discharge received.

**U.S. MILITARY STATUS**

Enter the status that most accurately reflects the client's current military participation. **If the client has no current military status, skip this item.**

**Active Duty**

A person who is currently in active status in any of the U.S. Military's armed forces and is not a member of the Reserves or National Guard.

**Reserves/National Guard**

A person who is a member of any of the U.S. Military's Reserve or National Guard forces and who is not currently in active status.

**Both Active Duty and Reserves/National Guard**

A person who is a member of any of the U.S. Military's Reserves or National Guard and is currently on active duty.

**ZIP CODE OF RESIDENCE**



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Enter the five-digit zip code for the client's county of residence. If the client is homeless/unstably housed and does not live in a shelter, use the program's zip code. If the client is homeless/unstably housed and lives in a shelter, use the shelter's zip code. **For Canada use 88888.** If the client is not homeless/unstably housed and coming to your program directly from an inpatient or residential facility (substance use disorder or otherwise), enter the zip code of the client's residence prior to the first inpatient or residential admission in the sequence (i.e., where the client lived in the community prior to entering treatment).

**COUNTY OF RESIDENCE**

From the drop down list, click on the NY county code or the values for any of the listed border states. If the zip code for Canada was entered (88888), click on "**Canada.**" If the client's zip code is outside of these geographic areas, the user should click on "**Other**" from the drop down list. If the client is not homeless/unstably housed and coming to your program directly from an inpatient or residential facility (substance use disorder or otherwise), enter the county of the client's residence prior to the first inpatient or residential admission in the sequence (i.e., where the client lived in the community prior to entering treatment). County of residence must match the zip code entered or an error message will be displayed. Do not enter the incorrect county. If necessary, first correct the zip code.

<b>Connecticut</b>	<b>CT</b>
<b>New Jersey</b>	<b>NJ</b>
<b>Pennsylvania</b>	<b>PA</b>
<b>Massachusetts</b>	<b>MA</b>
<b>Vermont</b>	<b>VT</b>
<b>Other</b>	<b>OTHER</b>
<b>Canada</b>	<b>CANADA</b>

**TYPE OF RESIDENCE**

Enter the category that best describes the client's type of residence at the time of admission. When a client is admitted directly from a substance use disorder or other inpatient or residential facility, report the type of residence immediately prior to the first episode of treatment in the sequence (i.e., where the client lived in the community prior to entering treatment).

**Private Residence**

**Homeless/Unstably Housed, Shelter** Includes a person or family who is undomiciled, has no fixed address, lacks a regular nighttime residence, and is residing in some type of temporary accommodation (e.g., hotel, shelter, residential program for the victims of domestic violence).

**Homeless/Unstably Housed, No Shelter** a person or family who is undomiciled, has no fixed address, lacks a regular nighttime residence, and circulates among acquaintances or is residing in a place not designed or originally used as a regular sleeping accommodation for human beings.

**Single Resident Occupancy** Hotel, rooming house, adult home, or residence for adults.

**Residential Services for SUD\*/Congregate** A community living experience in one location with onsite staff available seven days a week, twenty-four hours a day, such as a community residence or Part 820 residential program.

**Residential Services for SUD/Scatter-Site** A community living experience where housing is provided at various locations where staff provide, at a minimum, case management and supervision through weekly in-house visits. Examples include

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supportive living or Part 820 residential programs with a reintegration setting of scatter-site.

**MH/DD Community Residence** Mental Health/Developmental Disabilities Community Residence

**Other Group Residential Setting** Other Group Residential may include group homes, supervised apartments, college housing or military barracks.

**County Operated or Other Local Jail**

**DOCCS Operated Prison** NYS Department of Corrections and Community Supervision Operated Prison

**Institution, Other** (e.g., hospital, etc.)

**Other**

*\*SUD=Substance use disorder*

### **LIVING ARRANGEMENTS**

Enter the client's living arrangements at the time of admission. If the client is not homeless/unstably housed and coming to your program directly from an inpatient or residential facility (substance use disorder or otherwise), enter the client's living arrangements prior to the first inpatient or residential admission in the sequence (i.e., where the client lived in the community prior to entering treatment). If the client was in jail or prison and is being admitted directly into inpatient or residential treatment, select "living with non-related person."

**Living Alone**

**Living with Non-Related Persons**

**Living with Spouse/Relatives**

### **PRINCIPAL REFERRAL SOURCE**

Indicate the agency, individual, or legal entity that referred the client. If the client can be included under more than one, choose the category that represents the agency, individual or legal situation most responsible for the client seeking treatment in this program. If the client is currently involved with the criminal legal system and initially indicates "Self-Referral," probe to determine if the referral source may be more appropriately categorized using one of the criminal legal system options.

#### *Criminal Legal System Involvement*

**District Attorney** A direct referral from a District Attorney.

**Drug Court** A direct referral from a court (in the vast majority of cases, a drug court).

**Probation** A direct referral from a county Probation Department.

**Parole General** A direct referral from the New York State Department of Corrections and Community Supervision and the client is not being resentenced.

**Parole Release Resentence** A direct referral from the New York State Department of Corrections and Community Supervision for a drug offender who was resentenced and released.

**Impaired Driver Referral** A direct referral from the Department of Motor Vehicles' Impaired Driver Program (IDP), or a referral resulting from a specific Driving While Intoxicated (DWI) or Driving While Ability Impaired (DWAI) law enforcement incident (which could involve alcohol and/or drugs). All DWI/DWAI referrals belong in this category regardless of related criminal legal system status.

**Police** A direct referral from a municipal, town, county, or state police agency, including the sheriff's department. However, this does not include referrals from jails, which are

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normally operated by a sheriff, which should be reported using “City/County Jail.” In all cases this will be before, or in lieu of, adjudication.

**Family Court** Family Court has jurisdiction over all juvenile cases (under the age of 16), except for juvenile offenders. It also has jurisdiction over neglect and some domestic violence cases.

**Other Court** This includes town and village, district, New York City criminal and federal courts. *It does not include referrals from a drug court or drug treatment court.* Referrals, in this category, will come directly from the court in lieu of sentencing to a jail or prison.

**Alternatives to Incarceration** A referral made by a criminal legal system entity (e.g., federal probation), as an alternative to incarceration (e.g., local court, non-drug court, a federal court). *This does not include DWI or DWAI cases which should be reported in “Impaired Driver Referral.”*

**City/County Jail** This would include referrals for detainees and sentenced offenders that are referred by local jail personnel (including personnel working in the jail for other agencies) for treatment provided in the community or jail itself. This does not include the NYS Department of Corrections and Community Supervision (DOCCS).

**NYS Department of Corrections and Community Supervision** This category is for use only for those offenders that are under the jurisdiction of the State prison system (DOCCS), either within the prison or who are receiving treatment off-site, as part of a work release program. *It does not include offenders who are under community supervision/parole.*

**Office of Children and Family Services (OCFS)** This category includes all direct referrals of a youth from an OCFS facility or office.

Self, Family, Other

**Self-Referral**

**Family, Friends, Other Individuals**

**Self-Help Group**

**HOPEline**

Substance Use Disorder Treatment (SUD)

**SUD Program in New York State** Excludes VA SUD programs located in New York State.

**SUD Program Out of State** Excludes VA SUD programs located outside of New York State.

**SUD VA Program** Includes VA SUD programs regardless of location.

**SUD Private Practitioner**

Prevention/Intervention Services

**School-Based Prevention Program**

**Community-Based Prevention Program**

**Employee Assistance Program**

**Other Prevention/Intervention Program**

Health Care Services

**Developmental Disabilities Program**

**Mental Health Provider**

**Managed Care Provider**

**Health Care Provider**

**AIDS Related Services**

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**Primary Care Health Professional** Examples include Physician, Nurse Practitioner, Physician's Assistant

**Comprehensive Psychiatric Emergency Program (CPEP)**

**Hospital Emergency Department**

**TBI Waiver** The New York State Department of Health (DOH) Traumatic Brain Injury (TBI) waiver program provides services to persons with a TBI. The purpose of the program is to help persons with a TBI live in the community setting of their choice. Medicaid funds the program. For more information on TBI Waivers, visit <https://www.health.ny.gov/publications/1111.pdf>.

Employer/Educational/Special Services

**Employer/Union (Non-EAP)**

**School (Other than Prevention Program)**

**Special Services (e.g., Shelters)**

Social Services

**Local Social Services – Child Protective Services/CWA (Child Welfare Agency)**

**Local Social Services – Income Maintenance**

**Local Social Services Treatment Mandate/Public Assistance** The referral was made by a local social services district, or an authorized agent acting on its behalf, following an assessment by an OASAS credentialed individual who has determined that the individual's alcohol/substance misuse precludes participation in work at the time of referral and is mandated to treatment as a condition for continued receipt of Public Assistance.

**Local Social Services Treatment Mandate/Medicaid Only** The referral was made by a local social services district, or an authorized agent acting on its behalf, following an assessment by an OASAS credentialed individual who has determined that the individual's alcohol/substance misuse precludes participation in work at the time of referral and is mandated to treatment as a condition for continued receipt of Medicaid.

**Other Social Services Provider**

Recovery Support Services (For a definition of these services and other information, please refer to the following link: [Regional Services](#))

**Recovery Community and Outreach Center**

**Youth Clubhouse**

**Peer Advocate**

**Open Access Center**

**Family Support Navigator**

**Regional Addiction Resource Center**

\*\*\*\*

**Other** Select this code if the source of referral cannot reasonably be reflected by any of the codes above.

### **HIGHEST GRADE COMPLETED**

Enter the client's highest grade **completed at the time of admission**. If the client is in a special education class, select the grade that most accurately reflects the client's level of performance.

**No Education**

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**01 to Grade 11**– Enter grade completed

**High School Diploma**

**General Equivalency Diploma (GED)**

**Vocational Certificate w/o Diploma/GED** A Vocational Certificate is any certificate received as a result of vocational training or special skill trade.

**Vocational Certificate w/Diploma/GED**

**Some College - No Degree**

**Associate Degree**

**Bachelor's Degree**

**Graduate Degree**

**INDIVIDUAL (INDIVIDUALIZED) EDUCATION PLAN (IEP)**

Indicate **Yes** or **No**. Select **Unknown** if this information is not known.

Note: An IEP is offered for a variety of disabilities not just Intellectual/Developmental Disabilities. Someone could have been diagnosed on an IEP as having an emotional disability which is the term the Education Department uses for young people. An updated DSM 5 diagnosis of a psychiatric disorder may be made when the individual becomes an adult. Other disabilities severe enough to warrant an IEP include hearing loss, spinal cord injuries, cerebral palsy, muscular dystrophy, traumatic brain injury, visual impairments and severe burns. This status will follow them for life and will allow access to the state vocation rehabilitation system, such as ACCESS VR (formerly VESID) as an adult and may even support evidence or need for Social Security benefits.

**EMPLOYMENT STATUS**

Indicate the client's employment status at time of admission. If a client may be counted in more than one category, choose the status which most appropriately indicates their employment status, except for individuals attending primary or secondary school. See examples below. **A client working off-the-books or in a volunteer position is not considered employed.**

**Employed Full-Time – 35+ Hrs per Week** Use this status for active military personnel.

**Employed Part-Time – <35 Hrs per Week**

**Employed in Sheltered Workshop**

**Unemployed, In Treatment** The reason that the client is unemployed is that immediately prior to this admission, the client was in an inpatient or residential treatment program.

**Unemployed, Looking for Work** This status should only be used if the client has *actively* sought employment within the last 30 days.

**Unemployed, Not Looking for Work** Programs may use this status for clients who are working off-the-books or in a volunteer position.

**Not in Labor Force – Child Care issues**

**Not in Labor Force – Disabled** The client has been assessed and identified as disabled and is not required to work pending the results of an application for SSI benefits for public assistance purposes.

**Not in Labor Force – In Training** To be used when a client is unemployed but taking part in a formal training program such as a program via ACCES-VR, Department of Labor, BOCES, etc. This includes if a client has a scheduled appointment to engage in a program at one of the above-mentioned training programs.

**Not in Labor Force – Inmate** Can be used if the client is in a jail-based or prison-based program.

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**Not in Labor Force – Retired**

**Not in Labor Force – Student** Use this status if the client is engaged in school, including postsecondary education or GED studies, and is not employed or if the client is employed, but engaged in primary or secondary education (K-12).

**Not in Labor Force – Other**

**Social Services Work Experience Program (WEP)** A specific set of work/work related tasks to which a public assistance recipient is assigned for a specific number of hours per week by a local Social Services District as a condition for receipt of a public assistance grant and/or related benefit.

**Social Services Determined, Not Employed/Able to Work** The client is seeking or is on Public Assistance and has been assessed by treatment program staff or an OASAS credentialed individual acting on behalf of a local Social Services District as able to engage in work, but is not employed.

**Social Services Determined, Unable to Work, Mandated Treatment** The client has been assessed by an OASAS credentialed individual acting on behalf of a local Social Services District as unable to work and is in treatment as a condition for receiving public assistance.

**PRIMARY SOURCE OF INCOME AT ADMISSION**

Enter the category which corresponds to the primary or major source of income for the client, either currently or in the 30 day period prior to admission. If the client's Employment Status is "Unemployed" or "Not in Labor Force," the primary source of income cannot be "Wages/Salary."

**None**

**Wages/Salary** This category should be used only if it relates to the client's wages/salary. Wages/Salary of the client's spouse/family should be indicated by Family and/or Spouse Contribution.

**Alimony/Child Support**

**Department of Veterans Affairs**

**Family and/or Spouse Contribution**

**SSI/SSDI or SSA**

**Safety Net Assistance**

**Temporary Assistance for Needy Families** TANF provides cash assistance to eligible needy families that include a minor child living with a parent (including families where both parents are in the household), or a caretaker relative.

**Other**

**FAMILY HISTORY**

**MARITAL STATUS**

Enter the current marital status of the client. A person whose only marriage was annulled should be classified as Never Married. A status of Separated includes legal separation as well as informal separations.

**Married**

**Never Married**

**Living as Married**

**Separated**

**Divorced**

**Widowed**

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**CHILD OF SOMEONE WHO MISUSES ALCOHOL/OTHER SUBSTANCES**

Enter the category that best describes the status of the client. For this question, “misuse” should be defined as meeting the criteria for a clinical diagnosis of a substance use disorder.

**No**

**Both** Child of Someone Who Misuses Both Alcohol and Other Substances

**Child of Someone Who Misuses Alcohol**

**Child of Someone Who Misuses Other Substances**

**NUMBER OF CHILDREN**

Enter one digit (0-9) \* to indicate the total number of children (under the age of 19) that the client is legally responsible for, including biological children, stepchildren, adopted children, and foster children.

**NUMBER OF CHILDREN LIVING WITH CLIENT**

Enter one digit (0-9) \* to indicate the total number of children that the client is legally responsible for that are living with the client, including biological children, stepchildren, adopted children and foster children.

**NUMBER OF CHILDREN LIVING IN FOSTER CARE**

Enter one digit (0-9) \* to indicate the total number of biological and adopted children that the client has in foster care.

**\*Use nine (9) if the total number of children exceeds 9.** Although this may result in inaccurate information for a few clients, not having a two-digit field will prevent the vast majority of data entry errors for this item.

**CASE WITH CHILD PROTECTIVE SERVICES**

Enter **Yes** or **No** whether client has an ACTIVE case with Child Protective Services (CPS). An active CPS case means that the local Department of Social Services, Child Protective Service Division, or in the case of New York City, the NYC Administration for Children's Services, has an open case for one or more of the children associated with this particular parent whether or not the child(ren) has been removed from the household.

**CRIMINAL LEGAL SYSTEM INVOLVEMENT**

**CRIMINAL LEGAL SYSTEM INVOLVEMENT STATUS**

Please select the option or options that reflect the client’s criminal legal system status at the time of admission (check all that apply).

**None**

**Probation** The client is under the supervision of any Department of Probation. This must be checked if the program has selected Probation as the Principal Referral Source.

**Parole** The client is under the supervision of the New York State Department of Corrections and Community Supervision. This must be checked if the program has selected any of the Parole categories as the Principal Referral Source.

**Work Release** The client is currently in the custody of the New York State Department of Corrections and Community Supervision or a local jail and is participating in a work

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release program.

**In Prison/Jail** The client is currently in the custody the New York State Department of Corrections and Community Supervision or a local jail (and **is not** participating in a work release program.)

**In OCFS Facility** The client is currently in the custody of the New York State Office of Children and Family Services.

**Charges Pending** The client has criminal charges pending, but has been released into the community awaiting disposition.

**Any Treatment or Specialty Court** The client is participating in Drug Court or other Specialty Court programs. This must be checked if the program has selected Drug Court as the Principal Referral Source.

**Other (e.g., District Attorney)** This must be checked if the program has selected District Attorney as the Principal Referral Source.

**CRIMINAL ARRESTS/INCARCERATION**

**IS THIS ADMISSION THE RESULT OF AN ALTERNATIVE TO INCARCERATION?**

Indicate whether the client's admission is the result of their participation in one of the various alternatives to incarceration programs. Check "Yes" for all clients referred from District Attorneys, Drug Courts, and Probation. For all clients referred from Parole General, or Parole Release Resentence, select "No".

**NO. OF CRIMINAL ARRESTS IN PRIOR 30 DAYS**

Enter the number of criminal arrests in the prior 30 days. An arrest should be counted if the client was legally processed and detained.

**NO. OF CRIMINAL ARRESTS IN PRIOR 6 MONTHS**

Enter the number of criminal arrests in the six months prior to admission. An arrest should be counted if the client was legally processed and detained. Any arrest that the client had in the last 30 days will also be counted here since the last 30 days is part of the last six months.

**NO. OF DAYS INCARCERATED IN PRIOR 6 MONTHS**

Enter the number of whole or partial days that the client was remanded (incarcerated) to jail or prison in the six months prior to admission.

**PRIMARY ICD-10 DIAGNOSIS CODE**

Enter one of the following primary diagnosis codes, based on ICD-10, for the substance that is primarily responsible for the client's substance use disorder treatment. Enter up to 3 additional characters to specify clinical detail (optional). Skip this section if client is being admitted as a significant other.

- F10 Alcohol related disorders
- F11 Opioid related disorders
- F12 Cannabis related disorders
- F13 Sedative, hypnotic, or anxiolytic related disorders
- F14 Cocaine related disorders
- F15 Other stimulant related disorders
- F16 Hallucinogen related disorders
- F18 Inhalant related disorders



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F19 Other psychoactive substance related disorders

**PROBLEM SUBSTANCES**

At least one, and up to three substances may be identified (primary, secondary, and tertiary). The order should be determined by clinical judgment, history and frequency of use, client's perception, medical issues, and problem areas of client functioning with the substance primarily responsible for the client's admission listed first.

**TYPE**

**None** Only Significant Others may report none for a primary substance at admission.

**Alcohol**

**Cocaine**

**Crack** This is the street name for a more purified form of cocaine that is smoked.

**Marijuana/Hashish** This includes THC and any other cannabis sativa preparations.

**Synthetic Cannabinoids** (e.g., K2/Spice)

**Heroin**

**Buprenorphine**

**Non-Rx Methadone** Methadone obtained and used without a legal prescription.

**OxyContin**

**Other Opiate/Synthetic** This includes Codeine, Dilaudid, Morphine, Demerol, Opium, and any other drug with morphine-like effects.

**Alprazolam (Xanax)**

**Barbiturate** This includes Phenobarbital, Seconal, Nembutal, etc.

**Benzodiazepine** This includes Diazepam, Flurazepam, Chlordiazepoxide, Clorazepate, Lorazepam, Oxazepam, Prazepam, Triazolam, Clonazepam, Klonopin, and Halazepam.

**Catapres** Clonidine

**Other Sedative/Hypnotic** This includes Methaqualone, Chloral Hydrate, Placidyl, Doriden, etc.

**Elavil**

**GHB**

**Khat**

**Other Tranquilizer**

**Methamphetamine** (e.g., Ice)

**Other Amphetamine** This includes Benzedrine, Dexedrine, Preludin, Ritalin, and any other amines and related drugs.

**Synthetic Stimulant** (e.g., Bath Salts)

**Other Stimulant**

**PCP** (Phencyclidine)

**Ecstasy**

**Other Hallucinogen** This includes LSD, DMT, STP, Mescaline, Psilocybin, Peyote, etc.

**Ephedrine**

**Inhalant** This includes Ether, Glue, Chloroform, Nitrous Oxide, Gasoline, Paint Thinner, etc.

**Ketamine**

**Rohypnol**

**Over-the-Counter** This includes Aspirin, Cough Syrup, Sominex, and any other legally obtained, non-prescription medicine.

**Other**

*For admission to a federally approved Opioid Treatment Program also referred to as an*

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*opioid full agonist treatment program, the primary substance must be Heroin, Buprenorphine, OxyContin, Non-Prescription Methadone, or Other Opiate/Synthetic.*

**ROUTE OF ADMINISTRATION**

Enter the usual route of administration for each substance reported.

**Inhalation**  
**Injection**  
**Oral**  
**Smoking**  
**Vaping**  
**Other**

**FREQUENCY OF USE**

Enter the frequency of the client's use of the problem substance during the last 30 days for each substance reported.

**No use in last 30 days**  
**1-3 times in last 30 days**  
**1-2 times per week**  
**3-6 times per week**  
**Daily**

**AGE OF FIRST USE**

Enter the age at which each problem substance was first used (use two digits for ages 00-98). For drugs other than alcohol, enter the age of first use. **For alcohol, enter the age of first intoxication.** If unknown, please estimate the probable age of first use. **Do not enter 99.**

**Medication for Addiction Treatment (MAT)**

For all MAT questions documented in this CDS transaction, MAT refers to the use of a medication that is FDA approved for treating a substance use disorder, in conjunction with psychosocial therapies and supports as needed, to provide appropriate treatment for a substance use disorder and support the client in achieving and maintaining clinical gains in their recovery process. **Medications, such as Narcan/Naloxone or medications for Nicotine use, are not considered MAT for the purposes of responses to these questions.**

Additional information on MAT and approved medications can be found [here](#).

OASAS is collecting this information regarding MAT as part of an individual's treatment to better understand the impact of MAT use on progress in treatment as individuals move through the OASAS system over time.

This specific question will also allow OASAS to identify individuals that are engaging in treatment services without the use of MAT, treatment services that include MAT for alcohol use disorder (AUD) and/or medication for Opioid use disorder (MOUD) for the treatment episode, and whether that MAT is prescribed, administered, or dispensed by this program.

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**Select the medication included in client's treatment (select all that apply):**

**Methadone Dispensed at the Window** Select this option if the client is receiving their methadone at the window. This includes take home dosage or medication dispensed at a mobile medication unit or OTP additional location, as well as at additional locations identified on the OASAS certification document. This option should also be selected if an individual is residing in a long-term care facility (nursing home), residential treatment program, carceral setting or similar settings and receiving medication through delivery or 3<sup>rd</sup> party pickup.

**Buprenorphine Dispensed at the Window** Select this option if the client is receiving buprenorphine at the program. If client is being given a prescription to fill elsewhere, select the 'Buprenorphine Prescribed by Program Practitioner' option even if the client returns to ingest this medication at the program site.

**Naltrexone for MOUD Administered at Program Site** Select this option if the client is receiving Naltrexone in any form for **MOUD** at the program. If client is being given a prescription to fill elsewhere, select the 'No MOUD or AUD Medication within Program' option for this question.

If client is receiving naltrexone for anything other than for opioid and/or alcohol use disorder(s), select 'No MOUD or AUD Medication within Program.'

If client is being given a prescription to fill elsewhere, select the 'Other AUD Prescribed by Program Practitioner' option for this question.

**Naltrexone for AUD Administered at Program Site** Select this option if the client is receiving Naltrexone in any form for **AUD** at the program. If client is receiving naltrexone for opioid use disorder, select the 'Naltrexone for MOUD Administered at Program Site option.' If client is receiving naltrexone for anything other than for opioid and/or alcohol use disorder(s), select 'No MOUD or AUD Medication within Program.' If client is being given a naltrexone prescription to fill elsewhere, select the 'Other AUD Prescribed by Program Practitioner' option for this question.

**Buprenorphine Prescribed by Program Practitioner** Select this option if the program is providing a prescription to be filled by the client at a pharmacy as part of treatment for opioid use disorder.

**Other AUD Prescribed by Program Practitioner** Select this option if the client is being prescribed any other medication for the treatment of alcohol use disorder.

If Naltrexone is prescribed for AUD or MOUD, select 'Other AUD Prescribed by Program Practitioner.'

**No MOUD or AUD Medication within Program** Select this option if no medication is prescribed, dispensed or administered by the program for the treatment of alcohol and/or opioid use disorder, or if the medication prescribed by this program is not include in the above options.

**SELF-HELP (Mutual Assistance)**

**IS THE CLIENT CURRENTLY ATTENDING SUBSTANCE USE SELF-HELP GROUP MEETINGS (LAST 30 DAYS)?**

Indicate whether the client has reported attendance at least one substance use self-help or mutual assistance meeting during the 30 days prior to admission.

**NICOTINE**

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**HAS THE CLIENT EVER USED NICOTINE?**

Indicate whether the client has ever smoked or chewed tobacco or vaped nicotine. If the response to this question is **No**, the remaining questions in this Nicotine section can be blank.

**Enter Yes or No**

**AGE OF FIRST USE**

Enter the age at which the client reports first using nicotine.

**FREQUENCY OF USE (LAST 30 DAYS)**

Enter the frequency of the client's use of nicotine during the last 30 days.

**No use in last 30 days**

**1-3 times in last 30 days**

**1-2 times per week**

**3-6 times per week**

**Daily**

**DATE LAST USED: MONTH, YEAR**

Enter the date (month and year) that the client last used a nicotine product. This information is **not** required if the client has been in treatment for less than 30 days.

**PRIMARY ROUTE OF ADMINISTRATION**

Indicate whether the client usually smokes or chews tobacco or vapes nicotine. If the client reports using multiple routes equally, select *Smoking* if the client reports smoking as one of the routes. If smoking is not one of the identified routes, select *Vaping*.

*If the client reports using a nicotine-free e-cigarette or other nicotine-free vaping device, do not report vaping in this section.*

**PRIOR TREATMENT EPISODES**

Enter the number of prior substance use disorder treatment episodes in the client's lifetime. If the number of prior treatment episodes is greater than 5, enter 5. Although this may result in inaccurate information for a few clients, limiting the highest number to 5 will prevent most data entry errors for this item.

**PHYSICAL HEALTH-RELATED CONDITIONS**

Enter **Yes** or **No** for the physical health related conditions listed below.

*Impairment (Hearing, Mobility, Speech, Sight) refers to any condition which renders that body system diminished or less than fully functional. It is understood that many persons cope successfully with physical impairment. **However, if the impairment does or has the potential to interfere with successful treatment within the system, it should be recorded as "Yes."***

*Other **Major Physical Health Conditions** may include any condition not already noted, that requires regular health care, which may be a complicating factor in successful treatment of the client.*

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**Pregnant  
Hearing Impairment  
Mobility Impairment  
Sight Impairment  
Speech Impairment  
Acquired or Traumatic Brain Injury  
Other Major Physical Health Condition**

Enter **Yes**, **No**, or **Unknown** for the following health related conditions.

**Asthma  
Hypertension  
Diabetes**

**HIV Status**

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.

Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.

Select **Unknown** if the client has NOT authorized consent to release this information by initialing the “HIV-AIDS Related” section of the *Authorization for Release of Behavioral Health Information TRS-61* or if the client has not reported an HIV status and HIV status has not been indicated in history/client record.

**Hepatitis B Status**

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.

Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.

Select **Unknown** if the client has not reported a status and status has not been indicated in history.

**Hepatitis C Status**

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.

Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.

Select **Unknown** if the client has not reported a status and status has not been indicated in history.

**Result of TB (Tuberculosis) Test**

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.

Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.

Select **Unknown** if the client has not reported a status and status has not been indicated in history.

**MENTAL HEALTH-RELATED CONDITIONS**

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Enter **Yes** or **No** to each of the following:

**Intellectual Disability/Developmental Disability** Describes a group of disorders, acquired before the age of 22, the predominant feature of which is a disturbance in the acquisition of cognitive, language, motor or social skills. If available, the IQ is less than 70.

**Co-existing Psychiatric Disorder** Refers either to a diagnosis of mental illness which is available to the clinician at the time of admission by mental health screen, client report, significant other report, records, or by presenting symptoms which the clinician recognizes as possibly being symptomatic of mental illness. The recognition of symptoms does not constitute a diagnosis on the part of the clinician, but may indicate symptoms which need to be addressed in the treatment plan.

**HISTORY OF MENTAL HEALTH TREATMENT**

Enter **Yes** or **No** to each of the following:

**Ever Treated for Mental Illness** Involves the planned intervention designed to relieve the distress and/or disability associated with mental illness.

**Ever Hospitalized for Mental Illness** Means the admission to some type of hospital or inpatient facility for the treatment of the distress and/or disability associated with mental illness. **If “Yes,” Ever Treated for Mental Illness must be “Yes.”**

**Ever Hospitalized 30 or More Days for Mental Illness** Means the admission to some type of hospital or inpatient facility for the treatment of the distress and/or disability associated with mental illness for 30 or more consecutive days. **If “Yes” is entered, the previous two items must be “Yes.”**

***THE FOLLOWING ITEMS RELATE TO THE SIX-MONTH PERIOD PRIOR TO THIS ADMISSION***

**NUMBER OF DAYS IN INPATIENT DETOX**

Enter the number of days that the client spent in inpatient detoxification during the last six months.

**NUMBER OF EMERGENCY ROOM EPISODES FOR WHICH THE CLIENT RECEIVED TREATMENT**

Enter the number of separate incidences in which the client used emergency room services during the last six months.

**NUMBER OF DAYS THE CLIENT WAS HOSPITALIZED FOR NON-DETOX SERVICES**

Enter the number of days that the client spent in a hospital for other than detoxification services during the last six months.

**IF HOSPITALIZED, PLEASE SPECIFY REASON: MEDICAL, PSYCHIATRIC, OR BOTH**

**GAMBLING**

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**DID THE CLIENT SCREEN POSITIVE FOR A GAMBLING PROBLEM?**

Using a formal gambling screening instrument, client report, significant other report, or clinical records, indicate whether the client appears to have a gambling problem.

**TRAUMA**

Trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and/or mental, physical, social, emotional, or spiritual well-being.

Select **Yes, No, Unknown, or Refused to Answer** to the following questions based on client report, case records, or other reliable sources of information. If there is no information available, to complete the item, select **Unknown**. If the client refused to respond to inquiries on the topic, select **Refused to Answer**.

**Client ever experience/witness trauma that impacts current life experience?**

**Client ever a victim of Domestic Violence/Intimate Partner Violence?**

**Client ever a perpetrator of Domestic Violence/Intimate Partner Violence?**

**ORIENTATION TO CHANGE – For use only by Residential Rehabilitation for Youth Programs or Other Program Types Participating in Special Projects with OASAS. If your program is participating in a Special Project with OASAS be sure to check with your OASAS Project Manager to verify if this item applies to your special project code.**

Indicate the stage that best reflects the client's stage of change at the time of admission:

**Ambivalent**

The client does not verbalize responsibility for any problems or harm the client has caused to self, others or property that resulted from their substance use or related behavior.

**Change Oriented**

The client actively verbalizes one or more problems or harmful consequences to self, others or property that result from their substance use or related behavior. The client has verbalized no plan, nor taken any action, to address these.

**Planning Change**

The client has formulated and verbalizes at least one strategy to reduce or discontinue alcohol/drug use, resolve related issues, or support a drug/alcohol free lifestyle. The client is presently taking no observable action to carry out this strategy.

**Active Early Recovery**

In accordance with their own planned strategies, the client is engaged in *one or more observable action steps* designed to reduce or discontinue alcohol/drug misuse, resolve related issues, or support a drug/alcohol free lifestyle. Thus far, *no more than one* action step has resulted *in at least partial* measurable goal achievement.

**Ongoing Recovery and Recurrence Prevention**

In accordance with their own planned strategies, the client is engaged in *two or more observable action steps* designed to discontinue alcohol/drug misuse, resolve related issues, or support a drug/alcohol free lifestyle. Thus far, *at least two* action steps have

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resulted in *at least partial* measurable goal achievement.

***For Provider Use (Optional) Box***

***Some providers may elect to keep OASAS PAS reports signed by the clinician in the client's file. This box may be used for that purpose and is not required by OASAS.***