Instructions for Completing the Universal Referral Form for Adult Care Management and Residential Services Adult Single Point of Access (SPOA) Clinton County, NY

When to use this form

If you would like an adult (age 18 and older) to receive the following intensive mental health services in Clinton County, you must complete this form.

- Health Home Care Management
- Residential Services (Community Residence or Apartment Treatment Program)
- Supportive Housing Services

What to do

For Residential services

Please include a recent mental health evaluation along with the application

Send the original completed form to:
Elizabeth Carpenter
Director of Housing
Behavioral Health Services North, Inc.
17A Wells St., Plattsburgh, NY 12901

To expedite the referral, FAX it to: Fax: 518-561-5410
It is also helpful to call the
Residential Director to discuss the referral. Tel. 518-324-4606 – Email: lcarpenter@bhsn.org

For Supportive Housing services

Send the Original completed form to:
Jacinthe Hernandez
Supported Housing Program Coordinator
Behavioral Health Services North, Inc.
17A Wells St., Plattsburgh, NY 12901

To expedite the referral, FAX it to: Fax: 518-561-5410
It is also helpful to call the Coordinator
of Supportive Housing to discuss the referral. Tel. 518-563-0575 – Email: jhernandez@bhsn.org

For Care Management services

Send the original completed form to:
Mary Baker
Director of Case Management and Clinton County AOT Coordinator
Behavioral Health Services North, Inc.
792 State Rt 3 Suite 2, Plattsburgh, NY 12901

To expedite the referral, FAX it to: Fax: 518-324-5640
It is also helpful to call the Director
of Care Coordinator to discuss the referral. Tel. 518-563-8000 – Email: mbaker@bhsn.org

How decisions are made

The decision about what services will be offered is made at a meeting of the Single Point of Access (SPOA) committee. The committee finds it helpful for the person making the referral to appear before the committee to advocate for the client and answer any questions the committee may have about the referral. Please contact the SPOA Coordinator to discuss the referral further and to make arrangements to appear before the SPOA committee.

Questions? Contact

Clinton County SPOA Coordinator
Lori Jamil
Clinton County Mental Health and Addiction Services
Tel. 518-565-4023
130 Arizona Ave, Suite 1500, Plattsburgh, NY 12903

Fax 518-566-0168
Email: Lori.Jamil@clintoncountygov.com

Universal Referral Form for Adult Care Management and Residential Services

(Single Point of Access)
Clinton County, NY

Application for (check one): **__ Care management** **__ Apartment Treatment Program**
__ Community residence program **__ Supported Housing**

Physicians Authorization REQUIRED for Community Residence & Apartment Treatment Program Only

Client Basic Information

Client Name: _____ **Application Date**: _____
Last First MI

Previous names: _____

DOB: _____ Age: _____ Sex: __ Male __ Female SSN: _____

Ethnicity: _____ Primary Language: _____ Marital Status: _____
(Optional) (Optional)
Address: _____ City: _____ State: _____

Phone(s): _____

Financial information / sources of income
__ Monthly Income Amount: _____

__ Employment: Employer Name: _____

__ SSI __SSD __Public Assistance __ VA __ Alimony __ Child support __ Retirement income

__Other income (Describe source and amount) _____

(If applied and not yet receiving a potential source of income, please describe & give date of application)

Existing Rep. Payee? __ No __Yes (Name, address, phone #)

Health Plan
__ Medicaid Number: _____ __ Medicare Number: _____
__ Other plan: _____ Number : _____

Emergency Contact Information
Name: _____ Relationship: _____
Address: _____ Tel. No. _____
City:_____ State: ___

Referral Information

Person making the referral (name & title): _____
Representing which agency / committee: _____
Address: _____
City: _____ State:_____ Zip:_____
Phone: _____ Fax:_____ Email: _____
Relationship to client:_____

APPLICATION MUST BE COMPETED IN ITS ENTIRETY PRIOR TO BEING REVIEWED FOR ELIGIBILITY

Mental Health Information

DSM IV Diagnosis:

Diagnosed by: _____ Date: _____

Axis I:

Axis II:

Axis III(Medical problem):

Axis IV(Stresses):

Axis V: GAF Current _____ GAF Highest level in past year _____

Risk Factors: (Explain below as necessary)	Unknown	Not Present	Mild	Moderate	Severe
Suicidal (ideation, attempts) (explain below)					
Physical harm to others					
Victimization by others					
Destruction of property					
Fire setting					
Sexually abusive / inappropriate to others					
Reckless behavior possibly leading to physical harm to self or others					
Other (explain)					

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Dementia					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depression					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper outbursts					
Hyperactivity					
Attention deficit					
Eating problems (describe)					
Antisocial behavior					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Other (explain)					

Recent deterioration of functioning, if any? (describe):

Historical Factors	Unknown	No	Yes
Emotionally / verbally abused			
Physically abused			
Sexually abused			
Psychological or social neglect			
Other			

Drug / alcohol use / abuse (Describe substances used and frequency; include date of last use & any substance abuse treatment received)

Other disabilities or medical problems (describe below)	Unknown	Not Present	Mild	Moderate	Severe
Mental retardation					
Other developmental disability / delay					
Learning disabilities not accounted for by developmental delays					
Brain damage due to traumatic brain injury					
Physical handicap					
Severe or disabling medical conditions					
Other (describe)					

Current mental health treatment? (Where, with whom?) (Medications?) (Compliance?)

If the client has a history of *poor compliance* with mental health services, please describe here.

Mental Health treatment history

Inpatient hospitalizations (Where? Dates? For how long? Why?)

Psychiatric ER visits (Where? Dates? Why?)

Outpatient treatment (Where?, Dates? For what? For how long? Therapist? Compliance? Frequency of crisis calls? Effectiveness of treatment?)

Assisted Outpatient Treatment (AOT) Services (Dates? For how long? Compliance?)

Intensive / supportive case management (Where? Dates? For how long? Case manager? Effectiveness?)

Community residence / supportive / supported housing (Where? Dates? For how long? Success?)

Other (E.g. Self help groups, psychosocial club, crisis center calls. Describe in detail, give dates)

Other Information

CURRENT LIVING SITUATION*: ***For Supported Housing Applications only**

Do you wish to stay at your current location? Yes No

Do you have a lease with your landlord for your current location? Yes No

- If so, when does your lease expire? _____

Who is your current landlord? _____

What is the rent for this location? _____ /month

Are you getting any help to pay your rent? Yes No

- If so, please list person or agency helping you _____

How many bedrooms are there? _____

Do you need assistance with any of the following:

Paying a security deposit?	Yes	No
Furnishing an apartment?	Yes	No
Rental subsidy?	Yes	No
Dealing with housing issues?	Yes	No

If yes, please explain_____

Describe the physical living space (e.g. apartment, house, etc.) and any problems with living conditions.

Has the client ever had problems in past housing (e.g. eviction, inability to live alone, failure to pay rent?)
__No __ Yes, describe.

Has the client ever been homeless?
__No __Yes, describe

Current Living Arrangements

Household Composition (name)	Age	Relationship to client

Medical information: Describe any significant current physical health conditions and treatment being received, including medications and treatment provider and compliance with treatment.

Current medical provider: _____ Date of last visit: _____

Legal Concerns: (Describe all past and current arrests and convictions)

Sex Offender Status: __No __ Yes _____Level

Other agency involvement: (Describe any current or past involvement with other agencies. e.g. DDSO, ARC, Child protective / preventive services, etc.)

Education (Last grade completed? GED? Additional training e.g. VESID)

Employment history Describe the kind of work done and success at maintaining employment. List all past & current known employers

Strengths/Needs & Problems

Client Strengths / Interests (What can professional interventions build upon?)

Client Needs (Areas affected by psychiatric illness)	None	Low	Med-ium	High	Explanation
Self care (ADL's, hygiene, grooming, hygiene, nutrition, shopping, cooking, completing chores)					
Money management					
Housing (obtaining adequate housing, furniture, appliances)					
Home management (cleaning, use of appliances, household organization)					
Transportation					
Psychiatric services (getting access, keeping appointments, appropriate use)					
Medical services (getting access, keeping appointments, appropriate use)					

Medication management					
Legal (help dealing with the legal system)					
Social security (obtaining, keeping)					
DSS (Medicaid, PA, food stamps, etc.)					
Work / School (attendance, ability to function in the work / learning environment and complete assigned tasks)					
Social Relationships (Establishing or maintaining satisfactory & appropriate relationships with peers)					
Handling emergencies / solving problems					
Other (describe)					

Housing applications only: Describe any special condition that would have a bearing on the client's ability to live in a community residence or supportive apartment

Goals: (What do you expect the client to accomplish by virtue of his/her receiving care management or housing services?)

Request for
Intensive Mental Health Services
And
Information Release Authorization
To
Single Point of Access Committee

Name: _____ DOB: _____

I request that I be considered for the following intensive mental health services:

__ Care management **__ Community residence program**

__ Supported Housing **__ Apartment Treatment Program**

I am knowledgeable of what the above named services consist.

I understand that acceptance into one of the above programs is decided by Clinton County's Single Point of Access Committee. I understand that this committee is composed of representatives of community agencies and consumer advocates. Community agencies represented include, but are not limited to, Clinton County Mental Health and Addiction Services, Behavioral Health Services North, CVPH Medical Center, Department of Social Services, Department of Probation, Office for People with Developmental Disabilities (OPWDD), Office for the Aging , ETC Housing Corp., Champlain Valley Health Network and National Alliance on Mental Illness (NAMI). I understand that the members of this committee have agreed in various signed agreements to be bound by the highest standards defined by law (42 C.F.R. Part 2) to maintain the confidentiality of the information presented to the committee and to not discuss that information outside the scope of the committee.

I understand that it is the role of the committee to oversee the use of the above named services in Clinton County and to decide what level of service is most appropriate for each client in light of the demands for those services. The committee's decision will be based on information about me from a variety of sources available to the committee.

With this understanding, I give my permission for members of the Clinton County Single Point of Access Committee to share information regarding me in order to determine my eligibility for the services named above. I further understand that I may withdraw this request and permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future application for these services. Unless my permission is withdrawn I understand that this request / authorization will remain in effect as long as I continue to receive the services covered by this committee.

Signature: _____ Date: _____

Witness: _____ Date: _____

Withdrawal of Request / Authorization

I voluntarily withdraw my request for case management or housing services and in so doing withdraw my authorization for the Clinton County Single Point of Access Committee to continue to share information regarding me. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Signature: _____ Date: _____

Witness : _____ Date:_____

Initial Authorization For
Restorative Services
Of Breakthrough II Community Residence Programs

(Community Residence & Apartment Treatment Program Applications Only)

(To be signed by a licensed physician and the individual requesting consideration for housing services on the same date)

I have **met with my physician on this date** and discussed the Breakthrough II Residence Program and the services and supports it has to offer. By signing this form I have consulted with my physician and I am asking for consideration to have my application reviewed by the SPOA committee for admission to the program.

Applicants Name: _____

Applicants' Signature_____ _____ Date_____

Applicants Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me and having **met face to face on this date with this individual** to discuss the Breakthrough II Residential Program, have determined that the above named person would benefit from the provision of mental health restorative services* as known to me and defined pursuant to Part 593 of 14 NYCRR.

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

License #: _____

* Mental Health Restorative Services include:

- Assertive / Self Advocacy Training
- Community Integration Services
- Daily Living Skills Training
- Medication Management / Training
- Parenting Training
- Skill Development Services
- Rehabilitation Counseling
- Socialization
- Health Services
- Symptom Management
- Substance Abuse Management