REVISED 3/17

Referral Form for Supportive Services for Adults with Mental Illness

☐ Residential Services ☐ Care Coordination ☐ East Side Center

↳ ☐ Community Residences (Group Homes)
↳ ☐ Supportive Apartment Programs - Maple Street Apartments and Satellite Apartments (please circle one)
↳ ☐ Supported Housing (Independent Living)

Name		
Gender	Female ☐ Male ☐ ☐ Transgender	Date of Birth:
Address		Phone number(s)
Insurance	☐ Managed Medicaid ☐ Straight Medicaid ☐ Medicare ☐ Commercial Insurance Medicaid #: **OR** Medicare #: **OR** Name of Commercial Insurance:	
Income	Supplemental Security Income (SSI) ☐ Social Security Disability (SSD) ☐ Temporary Assistance ☐ None ☐ Other ☐ Please list:	
Primary Doctor	Name:	Phone #:
Psychiatrist	Name:	Phone #:
Therapist	Name:	Phone #:

Diagnosis:
Does the referent take medications as prescribed? Yes ☐ No ☐

Risk Factors, including history of psychiatric hospitalizations, legal history, and substance abuse history:

Living Arrangement, including risk of homelessness:

Social Service Needs:

Other providers who are involved:

Please describe what other services this person needs to be linked to:

Person making referral: Agency:	Date of referral:
Phone number of referral source:	Fax number of referral source:

THE FOLLOWING DOCUMENTS ARE REQUIRED FOR ALL REFERRALS:

1. Most recent psychiatric or psychosocial evaluation
2. Most recent inpatient admission/discharge summary (if applicable)

THE FOLLOWING ADDITIONAL DOCUMENT IS REQUIRED FOR HOUSING AND EAST SIDE CENTER REFERRALS:

1. Physical exam with negative T.B. test

Please send referral and supporting documentation to: SPOA Coordinator, Office of Community Services
Fax: (518) 792-7166 Mail: 230 Maple Street, Glens Falls, NY 12801 Questions? Call (518) 792-7143.

REFERRAL FOR ADULT SERVICES

This referral form is for use in referring individuals to housing, case management and psychosocial/vocational programs funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties. Service providers include Warren-Washington Association for Mental Health and Behavioral Health Services of the Glens Falls Hospital.

Community Residences are targeted for those in the earliest stage of recovery from mental illness and who would benefit from short-term, focused skill development in a home-like setting. **Intensive Supportive Apartments** are located in a single site apartment building and provide 24-hour staffing. **Supportive Apartments** are located in the community; staff provides services through regular visits and an on-call system. **Supported Housing** helps individuals with finding and maintaining permanent independent housing.

Health Home Care Coordination assists adults with severe mental illness to access care and function in the community.

East Side Center offers vocational and pre-vocational programs, supportive counseling, recreation and socialization opportunities, educational trainings, and health workshops. *Project Choice* is a 12-week vocational program that helps individuals to make decisions about working.

The referral form must be filled out completely.

IN ADDITION, FOR ALL SERVICES THE FOLLOWING ADDITIONAL DOCUMENTATION MUST BE SUBMITTED WITH THE REFERRAL:

- **most recent psychiatric evaluation (preferably within the past year)**
- **most recent inpt. admission and discharge summaries (if applicable)**

IF REFERRING TO HOUSING PROGRAMS OR EAST SIDE CENTER, THE FOLLOWING DOCUMENTATION MUST BE SUBMITTED WITH THE REFERRAL:

- **physical exam with negative T.B. test**

Availability of services is limited, and there may be a delay in receiving services even after an applicant has been determined to be eligible. If the referring agent or applicant is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and the programs it represents reserve the right to make the final determination.

The New York State Office of Mental Health sets residential program fees. Funding sources such as SSI, SSDI and Public Assistance adjust the recipient's support payment to ensure that the program fee is covered in the monthly payment. In order to process this application, please have the funding in place prior to admission to the residential programs. Other financial arrangements for private pay residents must also be in place prior to admission.

Completed applications and required documentation can be either faxed or mailed to:

SPOA Coordinator, Office of Community Services for Warren and Washington Counties
230 Maple Street, Glens Falls, NY 12801 Fax: (518) 792-7166

SINGLE POINT OF ACCESS COMMITTEE
CONSENT FOR RELEASE OF INFORMATION

Name: _____ Gender: _____ DOB: _____

The Single Point of Access Committee (SPOA) is comprised of representatives of community agencies including, but not limited to, the Office of Community Services for Warren and Washington Counties, the Warren-Washington Association for Mental Health, Glens Falls Hospital, Capital District Psychiatric Center, Liberty House Foundation, PEOPLe, Inc., Warren and Washington County Probation Departments, the Office of People with Developmental Disabilities, Northern Rivers, Transitional Services Association, and the Departments of Social Services for Warren and Washington Counties. In order to determine the most appropriate level of service based on strengths, needs, and program openings, I give my permission for members of the SPOA Committee to exchange information amongst each other, and to exchange information with the following Person, Organization, Facility or Program:

_____
Name and Title of Person/Organization/Facility/Program

_____
Address of Person/Organization/Facility/Program

_____
Phone and/or Fax Number of Person/Organization/Facility/Program

The extent or nature of information to be disclosed includes:

☐ Clinical summaries (i.e. psychiatric evaluations) ☐ Treatment plans and treatment plan reviews
☐ Admission and/or discharge summaries ☐ Notes of psychiatric or other clinic visits
☐ Medication records and laboratory results ☐ Other: _____

I understand that the above information is protected by Mental Hygiene Law 33.13 governing confidentiality of clinical records and/or by Federal Regulation 42 CFR governing confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in law or regulations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on my consent. Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The duration of this authorization is one year, unless I specify a date, event or condition upon which it will expire sooner. The date, even or condition upon which consent will expire sooner than noted above is: _____.

The following is a brief description of what I would find most helpful for myself:

_____

_____

_____ _____
Applicant (Print Name) Date Applicant (Signature) Date

_____ _____
Witness (Signature) Date

**** THIS FORM IS FOR HOUSING REFERRALS ONLY****

FUNCTIONAL ASSESSMENT SURVEY

Information is based upon (please specify by circling):

1. Direct observation
2. Patient's own report
3. Other (please specify): _____

Please use the following for Parts I and II. Rate by circling appropriate number.

1 = no problem 2 = minor problem 3 = moderate problem 4 = severe problem

I. PSYCHIATRIC PROBLEMS

IN THE LAST YEAR HAS THIS PERSON EXHIBITED:

Some concerns (preoccupation with physical health, fear of physical illness)	1	2	3	4
Anxiety (worry, fear, heightened concern for present or future)	1	2	3	4
Emotional withdrawal (lack of spontaneous interaction, isolation, deficiency in relating to others)	1	2	3	4
Unusual thought content or conceptual disorganization (odd, Disorganized, bizarre or confused thoughts)	1	2	3	4
Tension (motor manifestation, nervousness, hyperactivity)	1	2	3	4
Mannerisms, posturing (bizarre motor behavior)	1	2	3	4
Hostility (animosity, contempt or belligerence)	1	2	3	4
Suspiciousness (mistrust, belief that others harbor malicious or discriminatory intent)	1	2	3	4
Hallucinatory behavior (perceptions without normal external stimuli)	1	2	3	4
Motor retardation (slowed, weakened movements or speech)	1	2	3	4
Blunted affect (reduced emotional tone, reduction in normal Intensity of feeling, flatness)	1	2	3	4
Excitement (heightened emotional tone, agitation, increased reactivity)	1	2	3	4
Disorientation (confusion or lack of association for person, place or time)	1	2	3	4
Uncooperativeness (resistance, guardedness, rejection of authority	1	2	3	4

II. BEHAVIOR

WITHIN THE LAST YEAR, DID THIS PERSON:

React poorly to criticism, stress or frustration	◯ 1	◯ 2	◯ 3	◯ 4
Respect limits set by others	◯ 1	◯ 2	◯ 3	◯ 4
Threaten physical violence to others	◯ 1	◯ 2	◯ 3	◯ 4
Damage property to others	◯ 1	◯ 2	◯ 3	◯ 4
Damage own property	◯ 1	◯ 2	◯ 3	◯ 4
Require one to one supervision	◯ 1	◯ 2	◯ 3	◯ 4
Miss or arrive late for assignments	◯ 1	◯ 2	◯ 3	◯ 4
Wander or run away	◯ 1	◯ 2	◯ 3	◯ 4
Behave inappropriately in a group setting	◯ 1	◯ 2	◯ 3	◯ 4
Take or use other's property without permission	◯ 1	◯ 2	◯ 3	◯ 4
Shown antisocial sexual behavior	◯ 1	◯ 2	◯ 3	◯ 4
Threaten harm to self	◯ 1	◯ 2	◯ 3	◯ 4
Do harm to self	◯ 1	◯ 2	◯ 3	◯ 4

Please use the following for Parts III and IV. Rate by circling appropriate number.

1 = independently 2 = reminders/assistance 3 = requires 1:1 supervision 4 = can't or will not

III. DAILY LIVING SKILLS

DOES THIS PERSON:

Shop for personal necessities	◯ 1	◯ 2	◯ 3	◯ 4
Manage personal money	◯ 1	◯ 2	◯ 3	◯ 4
Use social service agencies appropriately	◯ 1	◯ 2	◯ 3	◯ 4
Use social supports/community resources	◯ 1	◯ 2	◯ 3	◯ 4
Devote proper time to tasks	◯ 1	◯ 2	◯ 3	◯ 4
Engage in individual leisure activities	◯ 1	◯ 2	◯ 3	◯ 4
Dress appropriately	◯ 1	◯ 2	◯ 3	◯ 4

Do own laundry	1	2	3	4
Take medication as prescribed	1	2	3	4
Keep clinic or other appointments	1	2	3	4
Use money correctly for purchases	1	2	3	4
Perform home maintenance/cleaning	1	2	3	4
Maintain an adequate diet	1	2	3	4
Use public transportation	1	2	3	4
Maintain adequate personal hygiene	1	2	3	4
Use telephone correctly	1	2	3	4
Smoke in a safe manner	1	2	3	4
Wake up promptly	1	2	3	4
Attend a day program	1	2	3	4
Demonstrate basic cooking skills	1	2	3	4

IV. PROBLEM SOLVING AND INTERPERSONAL SKILLS

DOES THIS PERSON:

Apologize when appropriate	1	2	3	4
Respect personal space of others	1	2	3	4
Act assertively when appropriate	1	2	3	4
Listen and understand	1	2	3	4
Resolve conflicts appropriately	1	2	3	4
Exercise good judgment	1	2	3	4
Plan in cooperation with others	1	2	3	4
Treat own minor physical problems	1	2	3	4
Obtain help for physical problems	1	2	3	4
Follow through on advice of doctor	1	2	3	4
Socialize with others	1	2	3	4
Take initiative or seek assistance with problems	1	2	3	4

**THIS FORM IS FOR REFERRALS TO COMMUNITY RESIDENCES AND SUPPORTIVE APARTMENT PROGRAMS **

AUTHORIZATION FOR RESTORATIVE SERVICES IN COMMUNITY RESIDENCES

CLIENT'S NAME: _____

CLIENT'S MEDICAID NUMBER: _____
(if client is applying for Medicaid, please indicate by writing "PENDING")

PLEASE INDICATE WHAT TYPE OF AUTHORIZATION THIS IS:

☐ **INITIAL AUTHORIZATION** (Must be completed by a PHYSICIAN only and requires a face-to-face meeting between the authorizing Physician and the Client.)

FOR INITIAL AUTHORIZATION ONLY: Date of required face-to-face meeting between the authorizing Physician and the Client: _____

☐ **RE-AUTHORIZATION** (May be completed by a PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER IN PSYCHIATRY only)

I, the undersigned licensed Physician, or Physician Assistant or Nurse Practitioner in Psychiatry in the case of a Re-Authorization, based on my review of the assessments made available to me, have determined that _____ would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR, which include:

* Assertiveness/self-advocacy
* Community integration
* Daily living skills
* Medication management
* Socialization
* Health services
* Symptom management
* Parenting training
* Rehabilitation counseling
* Substance abuse services
* Skill development

This authorization is for the following type of Mental Health Service within the noted time frame (please check the type of residential service for which the client is seeking admission and document the Effective Date and End Date of this authorization within the noted parameters):

☐ **COMMUNITY RESIDENCE:**
Authorization Effective Date: _____ End Date: _____ (no more than 6 months from Effective Date)

☐ **APARTMENT PROGRAM:**
Authorization Effective Date: _____ End Date: _____ (no more than 1 year from Effective Date)

MEDICAL PROFESSIONAL NAME (please print): _____

LICENSE NUMBER: _____ **NATIONAL PROVIDER IDENTIFIER:** _____

MEDICAL PROFESSIONAL SIGNATURE: _____

DATE OF SIGNATURE: _____