

## Warren and Washington Counties Single Point of Access Referral Form Services for Adults with a Serious Mental Health Condition

- Psychiatric Rehabilitation Residential Program**     **Independent Living** (Supportive Housing)  
     ↳  Community Residence (Group Home)  
     ↳  Community Living Apartment Program:     Maple Street Apartments     Satellite Apartments  
 **Care Coordination**         **East Side Center**         **Assertive Community Treatment team**

Name:		Date of Birth:	
		Age:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender			
Address:		Phone number:	
Insurance: <input type="checkbox"/> Managed Medicaid <input type="checkbox"/> Straight Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial Insurance			
Medicaid CIN #:		Name of Insurance Company:	
Income: <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Social Security Disability (SSD) <input type="checkbox"/> Temporary Assistance <input type="checkbox"/> None <input type="checkbox"/> Other <i>Please list:</i>			
Primary Care Provider			
Name:		Phone number:	
Psychiatrist/Psychiatric Nurse Practitioner			
Name :		Phone number:	
Therapist			
Name:		Phone number:	
Diagnosis:			
Psychiatric hospitalization(s): <input type="checkbox"/> History <input type="checkbox"/> Current Explain:		Substance abuse: <input type="checkbox"/> History <input type="checkbox"/> Current Explain:	
		Legal involvement: <input type="checkbox"/> History <input type="checkbox"/> Current Explain:	
Current living arrangements:			
Other providers who are involved:			
Please describe what services this person needs the care coordinator to connect him/her to:			
Person making referral: Agency:		Date of referral:	
Phone number of referral source:		Fax number of referral source:	



**\*\*MUST BE COMPLETED FOR ALL REFERRALS\*\***

**SYMPTOMS AND FUNCTIONING SURVEY**

Information is based upon *(please specify by circling)*:

1. Direct observation
2. Client's own report
3. Other *(please specify)*: \_\_\_\_\_

Please use the following scale for Parts I and II, circling appropriate number:

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

**I. PSYCHIATRIC SYMPTOMS**

IN THE LAST YEAR HAS THIS PERSON EXHIBITED:	1	2	3	4
Preoccupation with physical health or fear of physical illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Odd, disorganized, or confused thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness or hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual mannerisms or postures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspiciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduction in normal intensity of feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heightened emotional tone, agitation, and/or increased reactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guardedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**II. BEHAVIOR**

WITHIN THE LAST YEAR, DID THIS PERSON:

React poorly to criticism, stress, or frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respect limits set by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threaten physical violence to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Damage property to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage own property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Require one to one supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miss or arrive late for appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wander or run away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behave inappropriately in a group setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take or use other's property without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shown inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threaten harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following scale for Parts III and IV, 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:	1	2	3	4
Shop for personal necessities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage personal money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use social service agencies appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use social supports/community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devote proper time to tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in individual leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do own laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take medication as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep clinic or other appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use money correctly for purchases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform home maintenance/cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Maintain an adequate diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain adequate personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use telephone correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke in a safe manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up promptly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend a day program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrate basic cooking skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### IV. PROBLEM SOLVING AND INTERPERSONAL SKILLS

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

DOES THIS PERSON:	1	2	3	4
Apologize when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respect personal space of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Act assertively when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen and understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resolve conflicts appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise good judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan in cooperation with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treat own minor physical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtain help for physical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow through on advice of doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialize with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take initiative or seek assistance with problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*COMPLETE THIS FORM FOR REFERRALS TO  
COMMUNITY RESIDENCE 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 | * Socialization      | * Rehabilitation counseling |
| * Community integration       | * Health services    | * Substance abuse services  |
| * Daily living skills         | * Symptom management | * Skill development         |
| * Medication management       | * Parenting training |                             |

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)

NAME (please print): \_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_ NATIONAL PROVIDER IDENTIFIER: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**PLEASE MAKE SURE YOUR REFERRAL PACKET IS COMPLETE:**

- Referral Form
- Signed Consent for Release of Information
- Symptoms and Functioning Survey
- Signed Authorization for Restorative Services (Community Residence and Supportive Apt. Programs only)
- Additional required documentation:
  - Psychiatric/psychosocial evaluation completed within the past year
  - Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year
  - Physical exam and negative T.B. test (Community Residence, Supportive Apt. Programs, and East Side Center only)

Please send referral packet and supporting documentation to:  
Single Point of Access Coordinator, Office of Community Services  
Fax: (518) 792-7166 Mail: 230 Maple Street, Glens Falls, NY 12801

If you have questions, please call the Single Point of Access Coordinator at (518) 792-7143.