WARREN AND WASHINGTON COUNTIES
SINGLE POINT OF ACCESS REFERRAL PACKET
Services for Adults with a Serious Mental Health Condition

Name of person being referred: **Date of referral:**

Current Status: **INPATIENT** **HOME** **REHAB CENTER** **HOMELESS**

Person making referral:
Agency:

Phone number:
Fax number:

Check the service(s) you are referring the individual to:
Psychiatric Restorative Residential Programs

Community Residence:

☐Group Home

- Offers a high level of support, including 24-hour staffing, for people in the earliest stages of recovery
- Overall goal is to provide short-term, focused skill development in a home-like setting
- Skill development includes symptom management, daily living skills, pursuing educational, vocational, and employment goals, solving transportation needs, and increasing one's comfort with broader social interaction

Or

Community Living Apartment Programs:

☐Maple Street Apartments ***or*** **☐ Satellite Apartments**

- Less intensive level of treatment housing than Community Residence
- Staff meet with recipients from one to seven days each week to provide support
- Maple Street Apartments is a single-site apartment building with nine units and 24-hour staffing
- Satellite Apartments are individual apartments throughout the community; staff provides regular visits and there is an on-call system in case of an emergency

ALL REFERRALS REQUIRE:

☐ Referral form ***(Please do not skip any fields – all fields must be completed.)***

☐ Consent for Release of Information form **(*Note: any HIV or HIV-related information requires a separate release.)***

☐ Eligibility/ Psychiatric Symptoms & Functional Behavioral Checklist

☐ Copy of a comprehensive psychiatric evaluation or psychosocial assessment completed within the past year

☐ Authorization for Restorative Services form **completed by a physician** *********(Last page in packet)*

☐ Copy of a physical exam completed within the past year

☐ Copy of a negative TB screening completed within the past year

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Supported Housing

☐ **Scattered Site Apartments**

- Helps people locate and move into an apartment, evaluate a lease, obtain furniture, etc. and provides a rental stipend.
- Assists in obtaining resources for self-sufficiency.
- After having settled into a new home, clients work with staff to maintain stable living in the community.

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Case Management

☐ **Care Management (Non-Medicaid)**

- Links people to services specific to their needs and provides coordination of services
- Includes linkage to behavioral health, medical care, and other community resources
- provides advocacy to address any barriers to recovery

☐**Health Home Care Management**

- Links people to services specific to their needs and provides coordination of services
- Includes linkage to behavioral health, medical care, and other community resources
- provides advocacy to address any barriers to recovery

☐**Assertive Community Treatment**

- An intensive and integrated team approach to community mental health service delivery serving people who are unable to participate or succeed in traditional, office-based mental health treatment.
- The person I am referring is unable to participate or succeed in traditional, office-based mental health treatment **because:**
- The person I am referring has continuous high service needs demonstrated by one or more of the following: **(Check all that apply)**
  - ☐ Two or more psychiatric hospitalizations in the past year
  - ☐ One psychiatric hospitalization of 60 days or longer
  - ☐ Two or more visits to hospital Emergency Department in the past year
  - ☐ Two or more stays on the Crisis Stabilization Unit in the past year
  - ☐ Persistent severe major symptoms *(e.g., psychosis, disorganized thinking)*
  - ☐ Co-existing substance use disorder *(Note: substance use disorder cannot be the primary diagnosis)*
  - ☐ Current high risk of or recent history of criminal justice involvement
  - ☐ Active Assisted Outpatient Treatment order
  - ☐ Inability to meet basic survival needs ***(please explain)***
  - ☐ Homeless or at imminent risk of becoming homeless
  - ☐ Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services were provided
  - ☐ Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation *(e.g. community residence or psychiatric hospital)* without intensive community services

☐ I have explained the ACT Team services to the person being referred and s/he wants to receive the service.

☐ I have discussed this referral with all current mental health providers, including the case manager and they agree with the services being transferred from them to the ACT Team.

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Psycho-Social Clubs

☐ **East Side Center**

- A psychiatric rehabilitation program which supports personal growth and wellness through social, recreational, creative, learning, volunteerism, employment, and community participation opportunities.
- Operational Weekdays

☐**Dual Recovery Program**

- Support for those who are in recovery from mental health and substance use conditions, including: Various Locations: Hope & Healing, Eastside Center, Cooper Street
- Support meetings: every Monday, Wednesday, and Friday 4:00 PM – 5:00 PM
- Social night: select Fridays each month, 4:00 PM – 6:00 PM
- Open Access/Walk-In hours: every first and third Tuesday of the month, 200 PM – 4:00 PM

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☐ Copy of a comprehensive psychiatric evaluation or psychosocial assessment completed within the past year

☐ Copy of a physical exam completed within the past year

☐ Copy of a negative TB screening completed within the past year

REFERRAL

Name: **Date of Birth:**

Age: **Gender: ☐Female ☐Male ☐Transgender**

Address: **Phone number:**

Insurance: *☐Managed Medicaid ☐Straight Medicaid / Medicaid CIN #-*(example: AA12345A)*:* *Click here* to enter text.

☐Medicare ☐Commercial Insurance ☐None

Income: ☐ Supplemental Security Income (SSI) ☐ Social Security Disability (SSD) ☐ Temporary Assistance ☐ None ☐ Other *Please list:*

Diagnosis: **Date Diagnosed**
History:
Current:

Psychiatrist/Psychiatric Nurse Practitioner: ☐ Does not have one *or* ☐ Referred to:
Name: Agency: Phone number:

Therapist: ☐ Does not have one *or* ☐ Referred to:

Name: Agency: Phone number:

Psychiatric Hospitalization(s): ☐None ☐History *Explain*: ☐Current Explain:

Substance Abuse: ☐None ☐History *Explain*: ☐Current Explain:

Legal Involvement: ☐None ☐History *Explain*: ☐Current Explain:

Other agencies involved *(e.g. probation, DSS)*:

INCOMPLETE REFERRALS WILL NOT BE REVIEWED UNTIL ALL NECESSASRY PAPERWORK IS SUBMITTED

Please be sure that you have completely filled out and included all required forms and supporting documentation.

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

CONSENT FOR RELEASE OF INFORMATION

Name: **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 ASCEND Mental Wellness, Glens Falls Hospital, Capital District Psychiatric Center, Liberty House Foundation, PEOPLE USA, Northern Rivers, Addiction Care Center Agency, Baywood, SUNY Adirondack Peer-to-Peer Veteran Program, RISE, Adirondack Health Institute, Behavioral Health Services North, Alliance for Positive Health, Fort Hudson HHCM, 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 releasing information:

Address of Person/Organization/Facility/Program:

Phone and Fax Number of Person/Organization/Facility/Program:
Phone: **Fax:**

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 *(must be completed)*:

_____

_____

_____

_____ _____ _____

Applicant Name **Applicant Signature** **Date**

ELIGIBILITY/ PSYCHIATRIC SYMPTOMS & FUNCTIONAL BEHAVIORAL

CHECK LIST

(Must be completed to determine SPMI eligibility)

In order to be eligible for Single Point of Access services, an individual must have a serious and persistent mental illness (SPMI) as evidenced by A, plus B, C, or D:

A. ☐ Diagnosed mental health condition

The individual is at least 18 years old and currently has a primary DSM-IV diagnosis other than an alcohol or drug disorder, organic brain syndrome, or developmental disability.

AND

B. ☐ SSI or SSDI due to mental health condition

The individual is currently receiving SSI or SSDI due to a diagnosed mental illness.

OR

C. ☐ Reliance on mental health treatment, rehabilitation, or supports: (If applicable)

A documented history that shows that the individual, at some prior time, met the threshold for C (above) but medication and/or other treatment and supports have diminished the symptoms and/or functional impairments *(i.e.. medication may control certain primary symptoms such as hallucinations, and highly structured settings may greatly reduce the demands placed on an individual, thereby minimizing functional impairments)*

Information is based upon either direct observation, client report or treatment team.
Please use the following scale for Part 1 & 2.

1 (No Problems) **2 (Minor Problems)** **3 (Moderate Problems)** **4 (Severe Problems)**

1. Psychiatric Symptoms

Psychiatric Symptoms	1	2	3	4
Preoccupation with physical health or fear of physical illness				
Anxiety				
Emotional Withdrawal				
Odd, disorganized, or confused thinking				
Restlessness or hyperactivity				
Unusual mannerisms or postures				
Hostility				
Suspiciousness				
Hallucinations (visual or auditory)				
Reduction in normal intensity of feelings				
Heightened emotional tone, agitation, and /or increased reactivity				
Confusion				
Guardedness				

2. Behavior

Behavior	1	2	3	4
React poorly to criticism, stress, or frustration				
Respect limits set by others				
Threaten physical violence towards others				
Damage own property				
Damage another person's property				
Require one to one supervision				
Miss or arrive late for appointments				
Wander or run away				
Behave inappropriately in a group setting				
Take or use other's property without permission				
Displayed inappropriate sexual behavior				

Threaten or cause harm to self				
Threaten or cause harm to other				

Please use the following scale for Part 3 & 4.

1 (Independent) 2 (Reminders/Assistance) 3 (Requires 1 : 1 Supervision) 4 (Can't or Will not do)

3. Daily Living Skills

Daily Living Skills	1	2	3	4
Shop for personal necessities				
Manage personal money				
Use social service agencies appropriately				
Use social supports/community resources				
Devote proper time to tasks				
Engage in individual leisure activities				
Dress appropriately				
Do own laundry				
Take medication as prescribed				
Keeping clinical and medical appointments				
Using money correctly for purchases				
Performing home maintenance/cleaning				
Maintaining an adequate diet				
Using public transportation or personal transportation as needed				
Maintaining adequate personal hygiene				
Attending day program or job regularly				
Demonstrating basic cooking skills				
Demonstrating basic shopping skills				

4. Problem Solving and Interpersonal Skills

Problem Solving and Interpersonal Skills	1	2	3	4
Apologize when appropriate				
Respect personal space of others				
Act assertively when appropriate				
Listen and understands information				
Resolves conflict appropriately				
Exercises good judgment				
Plans in cooperation with others				
Treats own minor physical injuries				
Obtains help for physical injuries and concerns				
Follows through on advice of doctor				
Socializes with others				
Takes initiative or seeks assistance with problems				

Mental health professional who has determined that these criteria are met:

_____ _____

Name **Credentials (QHHCM, LMSW, BA, MA, LMHC, etc.)**

SINGLE POINT OF ACCESS
AUTHORIZATION FOR PSYCHIATRIC
RESTORATIVE RESIDENTIAL SERVICES HOUSING PROGRAMS

Client's name:

Client's Medicaid number (example: AA12345A):
(if client is applying for Medicaid, please indicate by writing "PENDING")

Please indicate what type of authorization this is:

I, the undersigned, 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, which include:

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

* Assertiveness/self-advocacy
* Community integration
* Skill development
* Socialization
* Daily living skills
* Medication management
* Rehabilitation counseling
*Symptom management

For initial authorization only: Date of required face-to-face meeting between the authorizing physician and the client: _____

☐ **Community Residence**
Effective Date: _____
End Date: _____ (no more than six months from Effective Date)

☐ **Community Living Apartment Programs:**
Effective Date: _____
End Date: _____ (no more than one year from Effective Date)

Name (*please print*):

_____Credentials: (MD)

License number: _____ National Provider Identifier: _____

Signature: _____ Date: _____