Fulton, Montgomery and Hamilton Counties
Single Point of Access
Adult Referral Packet

Thank you for your interest in the Single Point of Access (SPOA) Program for Fulton, Montgomery and Hamilton Counties. This referral should be completed if you are referring an **adult** (age 18 and above) with a **significant mental illness** for **OMH residential based housing programs (Community Residence, Treatment Apartment/Apartment Treatment Program, Supportive Housing/Scattered Site, Crisis or Respite).** The SPOA referral also provides access to the **ACT Team, AOT or Health Homes Care Coordination services.** This referral may also be completed if you are referring an adult with a substance use diagnosis to the **OASAS Recovery Supported Housing Program.**

The referral agent completes the referral packet.
Attaches a signed Consent to Release Information Form.
Provides all supporting documentation as requested in the referral packet.

Please complete the referral form thoroughly. The referral form may be returned if these items are missing. Please ensure that the Consent to Release Information Form is signed by the client. The signed consent form must accompany the referral packet in order for the client is considered for services.

Required Supporting Documentation

See Individual Program Requirement - attached to the end of this referral packet.

Psychiatric Assessment that includes ICD-10 codes/DSM V Diagnosis Codes
Comprehensive Assessment
Current List of Medication
Authorization for Restorative Services (OMH – CR and ATP/TAP residential placement only)
Face to Face Form (OMH – CR and TAP/ATP residential placement only)
Hospital Admission/Discharge Summaries (if available)
Reference Letter (OASAS Recovery Supported Housing only)

This information needed to determine eligibility and to ascertain the appropriate level of care the client may require. **Please attach all the supporting documentation** that you are legally able to release. The SPOA Coordinator will attempt to obtain information if the Consent to Release Information Form allows information to be obtained.

The referral packet is incomplete and will not be sent, to any provider of services until all required documentation has been obtained.

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Once the packet is complete and reviewed for eligibility, the SPOA Coordinator, in collaboration with the SPOA Committee Members, will determine whether the client is appropriate for the requested services. The referral packets may be sent to housing providers at that time. If the client is not eligible for services, the referral agent will be notified by the SPOA Coordinator as to the reason for denial of services. **Denial's can be appealed, by contacting the SPOA Coordinator.**

Gwenn Gyldenvand, SPOA Coordinator, 57 East Fulton Street, Gloversville, NY 12078
Telephone # (518)-773-3559 Fax # (518)-773-3561 ggyldenvand@fultoncountyny.gov

Fulton, Montgomery and Hamilton Counties
Single Point of Access (SPOA)
Request for Adult Services

Services Requesting

Check housing level of care needed:

_____ CCFMC -Perry Street Community Residence (MICA-CR – 24-hour supervised for Mentally Ill / Chemically Addicted)

_____ Congregate/Supervised Community Residence (CR – 24-hour supervised)
_____ MHA -CR (Montgomery County) _____ CCFMC –CR (Fulton County)

_____ Treatment Apartment Program /Apartment Treatment Program (TAP/ATP)
_____ Helio Health -TA at Lodge (Fulton County) _____ MHA- ATP Scattered Sites in (Fulton County)
_____ Helio Health -TA Congregate (Scattered Sites in Fulton County) _____ MHA- ATP Scattered Sites (Montgomery County)

_____ Supportive Housing/Scattered Sites in Apartment Complex (SHP/SP SRO)
_____ Helio Health -SP SRO at the Lodge (Fulton County)
_____ DePaul -Veddersburg SHP Apartments (Montgomery County)

_____ Supportive/Supported Housing/Scattered Sites support service
_____ MHA-SH (Montgomery County) _____ Helio Health -SH (Fulton County)

_____ Respite/Crisis Program
_____ MHA Crisis/Respite

_____ OASAS Recovery Supported Housing (RSH)
_____ HFM Prevention (Fulton County) _____ HFM Prevention (Montgomery County) _____ Both

Check case management level of care needed:

_____ Bassett -Lead HH agency - Health Home Care Coordination/Case Management
_____ CHC –Lead HH agency – Health Home Care Coordination/Case Management

_____ ACT Team (Assertive Community Treatment)
_____ AOT (Assisted Outpatient Treatment)

Mandatory- please complete and provide details – such as services needed, skill deficits, etc.
Housing/Care Coordination Needs: _____
_____
_____
_____

Section A: Demographics

1. Name:
First: _____ **MI:** _____ **Last:** _____

2. D.O.B.: _____/____/_____

3. Sex/Gender: O **Male O Female O Other**
Explanation:_____

4. **Medicaid #:** _____ **County of Medicaid Reimbursement:** _____

Fidelis Medicaid #:_____ **CDPHP Medicaid #:**_____

5. **Social Security Number:** _____-_____-_____

6. **Address:** **(If applicant hospitalized, please give address prior to admission.)**

_____

_____

Telephone: _____

7. **Race/Ethnicity: (Check all that apply)**

O 1. White, European American **O 3. Hispanic, Puerto Rican**

O 2. Black, African American **O 4. Other, specify:** _____

8. **English Proficiency: (Check one)**

O Does not speak English **O Poor**

O Fair **O Good** **O Excellent** **(1)**

Section B: Characteristics

List all Current Treatment Providers (Including this hospitalization/admission/contact):

Program Name	Date of Admission	Length of Stay	Contact Name	Telephone Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you in a Health Home? ____Yes ____No **Care Coordination/Case Manager Name/Agency:**_____

1. **Current Living Situation: (Check one)**

O 1. Private Residence, alone, partner or family
O 2. Homeless, Emergency Shelter
O 3. Inpatient Hospital, Mental Health
O 4. Inpatient Hospital, Substance Use
O 5. MH Supportive Housing, SRO
O 6. MH Apartment Treatment Program
O 7. MH Congregate Treatment Program
O 8. Substance Use Halfway House
O 9. Correctional Facility
O 10. Other (specify): _____

2. **Marital and Parental Status: (Check One)**

O Single, never married O Married Do you have children? O Yes O No Do you have custody? O Yes O No

O Divorced/Separated/Widow Do they reside with you? O Yes O No Do you have visitation? O Yes O No

3. **Length of occupancy (In Months):**_____ **4.** **Reason for Leaving:** _____

5. **Current Employment Status: (Check one)**

O 1. No employment of any kind O 2. Employment, specify: _____

6. **Income or Benefits Currently Receiving Status: (Check all that apply and provide amounts)**

O 1. Wages, salary or self employed, $_____
O 2. Supplemental security incomes (SSI), $_____
O 3. Social Security disability income (SSD), $_____
O 4. SSP, $_____
O 5. Medicaid, PA, TANF $_____
O 6. Food Stamps (SNAP),_____
O 7. Veteran benefits, $_____
O 8 Worker's compensation or disability ins., $_____
O 9. SSI, SSD pending, $_____
O 10. Medicaid pending, $_____
O 11. Other funding source, specify $_____

7. **Representative Payee Status:**

O Rep Payee for self O Currently receiving Rep Payee services O A Rep Payee is needed

Name and Address of Rep Payee:

_____

Section C. Forensic (Check all that apply)

1. AOT – Current or Past? Status: _____

O Yes O No O Pending (Court Date: _____)
O AOT/Diversion
Date AOT Effective: _____Date of Expiration: _____
Name of AOT Coordinator/Care Manager: _____ Phone Number:_____

2. Criminal Justice Status (Check all that apply)

O 1. Applicant is not under Criminal Justice Supervision
O 2. Under arrest in jail, lockup,
O 3. In NYS Dept of Correctional Services (State Prison)
O 4. Alternative to incarceration (Mental Health Court, Drug Court)
O 5. Under Probation supervision
O 6. Under Parole supervision
O 7. Sex Offender Status; specify level: _____
O 8. Other (specify): _____

Name of Probation/ Parole Officer: _____ County: _____
Telephone number: _ _____ Date Released/Date Prob/Parole to end: _____

Current /Past Charges: _____
_____

Section E: Clinical/Medical

1. Psychiatric/Substance Use Information F10 Code and DSM-V Diagnosis: (Most recent - List all)

ICD.10 Code: _____

ICD.10 Code: _____

ICD.10 Code: _____

ICD.10 Code: _____

2. Applicant Adherence to Medication Regime: (Check one)

O 1. Takes medication exactly as prescribed
O 2. Rarely or never takes medication as prescribed
O 3. Takes medication as prescribed most of the time
O 4. Sometimes takes medication as prescribed

3. Physical Functioning Level: (Check all that apply)

O 1. Fully ambulatory
O 2. Needs help with toileting
O 3. Incontinent
O 4. Climbs one flight of stairs
O 5. Can feed self
O 6. Can dress self
O 7. Can bathe self
O 8. Unknown
O 9. Other (specify): _____

. Does applicant have a medical condition that requires special services/ equipment or supplies? O Yes O No
Identify: _____

Section F: Utilization

1. Mental Health/ Substance Use Services within the past 18 months: (Check all that apply)

O 1. None
O 2. Inpatient Psychiatric Hospitalization
O 3. Mental Health Outpatient Clinic
O 4. Mental Health Housing Program
O 5. Substance Use Inpatient Treatment
O 6. Substance Use Outpatient Treatment
O 7. Open Access
O 8. Self help / Peer support services
O 9. Private psychiatrist or therapist
O 10. AOT, Care Coordination, Case Management
O 11. Unknown
O 12. Other (specify): _____

2. Service Utilization (Indicate the number of each)

1. Psychiatric /Substance Use Hospitalizations in the last 24 months: _____
2. Psychiatric /Substance Use Outpatient admissions in the last 24 months: _____
3. Emergency room /mobile crisis psychiatric visits in the last 12 _____
4. Arrests/ Incarcerations in the last 12 months _____
5. Housing/Crisis/ Respite Admission in the last 24 months: _____
6. Substance Use 825 Reintegration Program _____

3. Other co-occurring disabilities, if any: (Check all that apply)

O 1. Drug or Alcohol Abuse O 4. Blindness /Visual Impairment O 6. Mute/Speech Impairment
O 2. Cognitive/TBI Disorder O 5. Impaired ability to Walk O 7. Other,_____
O 3. Development Disorder/Mental Retardation

Section G: Risk Assessment

1. High Risk Behavior: (Check one response for each) 0 = never 1 = history of 2 = recent/past 30 days

	0	1	2	Unknown/comments
A. Does applicant do physical harm to self?				
B. Does applicant attempt suicide?				
C. Does applicant physically abuse another?				
D. Does applicant assault others?				
E. Has applicant been a victim of sexual abuse?				
F. Has applicant been a victim of physical abuse?				
G. Does applicant engage in arson or accidental fire setting?				
I. Does applicant exhibit the following symptoms…… ..Delusions				
Homicidal attempts				
Severe Thought Disorder				
Hallucinations				
Disruptive Behavior				
Other, (specify)				

2. Does applicant have a current or past history of substance abuse? (Check as indicated)

0 = never 1 = history of 2 = recent/past 30 days

	0	1	2	Unknown/ Comments
A. Alcohol				
B. Cocaine				
C. Amphetamines				
D. Crack				
E. PCP				
F. Inhalants				
G. Heroin / Opiates				
H. Marijuana / Cannabis				
I. Hallucinogens				
J. Sedative / Hypnotic / Anxiolytics				
K. Other Prescription Drug Abuse				
L. Tobacco				

Section H: Referral Source

1. Referring Agency Information:

Agency Name: _____

Agency Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Program/Unit Name: _____

Primary Contact: _____

Phone Number: _____ **Fax Number:** _____

Email: _____ **Date Completed:** _____

Send referrals to:

SPOA Coordinator
57 East Fulton Street
Gloversville, N.Y. 12078

(518) 773–3559
FAX (518) 773-3561

Email: ggyldenvand@fultoncountyny.gov

OMH -Supportive Housing Program/Scattered Sites (SH)(SP-SRO) for Helio Health, MHA and DePaul single sites units

This form is MANDATORY if you are requesting OMH Supportive Housing/Scattered Sites (SHP, SP-SRO or MRT) services.

Eligibility: _____ **At least 18 years of age** **DOB:** _____

Primary ICD-10/DSM V Diagnosis:_____

Check all that apply: (1)
_____ one – six month stay in an inpatient psychiatric unit
_____ two –stays of any length in an inpatient psychiatric unit in the preceding two years
_____ three or more admission to an OMH operated or licensed certified mental health outpatient program within the preceding 18 months
_____ three or more contacts with crisis or emergency mental health services with the preceding 18 months
_____ SSI/SSDI recipient due to mental illness
_____ six months consecutive residency in an adult home, CR, RCCA, ATP/TAP, Family Care or RTF or RTC.

Check each area in which the individual considered functionally disabled: (3)
_____ social functioning
_____ self care
_____ daily living skills
_____ self direction
_____ ability to concentrate
_____ economic self-sufficiency

Check all that apply:
_____ In-adequate income to meet ongoing monthly expenses
_____ Ability to identify needs to maintain independent community living
_____ Desire to participate in rehabilitative goal planning to increase independence
_____ Housing crisis without a permanent residence
_____ Low-income housing eligibility required

Check all that apply: (MRT Supportive Housing)
_____ Individual is a high user of Medicaid and on the DOH list
_____ Individual is a high user of Medicaid Services
_____ Resident of NYS OMH Psychiatric Center
_____ Resident in an OMH Operated Residential Program
_____ Discharged from Article 28 Hospital
_____ Discharged from Article 31 Hospital
_____ Discharged from OMH facility within State Prison

Fulton, Montgomery and Hamilton Counties SPOA - Consent to Release Information

Name: _____
First MI Last

Date of Birth: _____ Age: _____ Sex: _____

Consent to Release Information

The extent or nature of the information to be disclosed:

- ☐ Psychiatric Assessment
- ☐ Comprehensive Assessment
- ☐ ICD 10 Codes/Diagnosis Documentation
- ☐ History/Physical Assessment
- ☐ PPD Results
- ☐ Discharge Summaries/Progress Notes
- ☐ Current list of Medications
- ☐ IQ testing Full Scale
- ☐ Other; (specify)_____

The purpose or need for the information:

- ☐ To determine eligibility for SPOA services and to ascertain the appropriate level of care
- ☐ To discuss the referral at the SPOA Committee Meeting.
- ☐ To coordinate services between all of the community based organization who are or will be involved in this clients' care.
- ☐ Other; (specify) _____

I am allowing the information in the SPOA referral to be shared with programs listed below:

Montgomery County Community Service, 200 Clark Ave., Fultonville, NY 12072
Fulton County Community Service, 57 East Fulton St., Gloversville, NY 12078
Hamilton County Community Service, 83 White Birch Lane, Indian Lake, NY 12842
Catholic Charities of Fulton & Montgomery Counties (Residential, Care Coordination) 1 Kimball Street, Amsterdam, NY 12010
Mental Health Association (Residential Services) 11 Mohawk Place, Amsterdam, NY 12010
Helio Health P.O. Box 292 (Residential Services) Argersinger Office Complex, 73 North Main St, Gloversville, NY 12078
St. Mary's Healthcare (Care Coordination, ACT Team, AOT Program, Adult IP and OP Mental Health, Open Access, Substance Abuse IP and OP Services), 427 Guy Park Avenue and 4988 St. Hwy 30, Amsterdam, NY 12010
Mental Health Association (Ombudsman, Children's SPOA) 307-309 Meadow Street, Johnstown, NY 12095
HFM Prevention Council (Recovery Supported Housing, Recovery Community and Outreach Center) 86 Briggs Street, State Hwy 5, Johnstown, NY 12095
DePaul Community Services (Veddersburg Single Site Supportive Housing), 251 East Main Street, Amsterdam, NY 12010.
The Family Counseling Center (OP Mental Health, Domestic Violence Outreach), 11-21 Broadway, Gloversville, NY 12078
Community Health Connections (Lead Health Home, Health Home Navigation) 1300 Massachusetts Avenue, Troy, NY 12180
Bassett Healthcare Network (Lead Health Home, Health Home Navigation) 1 Foxcare Drive, Suite 214, Oneonta, NY 13820
Alliance for Positive Health (Care Coordination) 845 Central Avenue, Suite 202, Albany, NY 12206
Building Blocks (Care Coordination) 26 Century Hill Drive, Latham, NY 12110
ICAN (Care Coordination) 310 Main Street, Utica, NY 13501
Fulton County Department of Social Services (Adult Protective Services), 4 Daisy Lane, Johnstown, NY 12095
Montgomery County Department of Social Services (Adult Protective Services), Fonda, NY 12068
Parent/Family/Friend or other Representative: _____
Other, (specify), _____

I am allowing the specific information requested in this release to be COLLECTED BY, SHARED WITH and PASSED BETWEEN the programs above and with Fulton, Montgomery and Hamilton Counties Single Point of Access (SPOA), 57 East Fulton Street, Gloversville, NY 12078.

Authorization/Signatures

A. I hereby authorize the **one time release** of the above information to the person/organization/facility/program identified above. I understand that the information released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time. My consent to release information will expire when acted upon, or 90 days from this date, whichever occurs first.

_____	_____	_____
Signature of Client/Person acting for Client	Relationship	Date
_____	_____	_____
Signature of Witness	Title	Date

B. I hereby authorize the **periodic release** of the above information to the person/organization/facility program identified above. I understand that the information released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time. My consent to release information to the person organization facility/program identified above will expire when I am no longer receiving services from such person /organization/facility/program or one year from this date, whichever occurs first.

_____	_____	_____
Client/Person acting for Client	Relationship	Date
_____	_____	_____
Signature of Witness	Title	Date

Physician Authorization
(CR) Community Residences/Congregate Treatment
(TAP/APT) Treatment Apartment Program/Apartment Treatment Program

☐ Initial Authorization
☐ Semi-Annual Authorization
☐ Annual Authorization

Client's Name:

_____

Client's Medicaid Number:

_____

F-Code DMS code/ Diagnosis Name:

_____ _____

I, the undersigned **licensed physician,** based on my face to face assessment and my review of the assessments made available to me, have determined that _____ may
(Client's name)
benefit from the provision of the mental health restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period ____/____/_____ to ____/____/_____, at which time there will be an evaluation for continued stay.

____/____/_____ _____ _____
Mo. Day Year Physician Name (please print) Licensure Number

_____
Physician Signature

☐

Face-to-Face Form
Authorization

Date: _____

___ Initial Evaluation
___ Semi-Annual Evaluation
___ Annual Evaluation

Client Name: _____
Date of Birth: _____

To Whom it May Concern:

This letter is to verify that on _____ (Date), I, _____ (Physician) met with the above named client. During this meeting, I reviewed and signed the Restorative Services of Community Residences Physician's Authorization Form. This form was completed with the above named client and has been assessed by me that he/she/they requires: **(Check one)**

_____ Congregate Treatment/ Community Residence (24-hr supervised living)
(Restorative Services Authorization for <u>6-month</u> timeframe)

_____ Treatment Apartment Program/Apartment Treatment Program
(**Restorative Services Authorization for <u>12-month</u> timeframe**)

Sincerely,

Psychiatrist/Physician