

**APPLICATION FOR ADULT SERVICES**

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**PROGRAMS REQUESTED (Check all that apply):**

**Residential Programs**

- Group Homes (Genesis/Pearl Street)
- Intensive Supportive Apartments
- Supportive Apartments
- Supported Housing

**Case Management**

- Intensive Case Management
- Supportive Case Management
- Dual Recovery Case Management

**Psychosocial Club/Vocational Rehabilitation**

- East Side Center
  - Project C.H.O.I.C.E.
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**CLIENT INFORMATION:**

Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security: \_\_\_\_\_ Medicaid/Medicare #: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check all that apply:

- Functionally Disabled due to a Mental Illness
- SSI or SSDI Enrollment due to a Mental Illness
- Functionally Disabled in the Areas Indicated:
  - Self-Care                       Activities of Daily Living                       Social Functioning
  - Inability to Complete Tasks    Self-Direction                                       Economic Self-Sufficiency
- Regular and Ongoing Reliance on Psychiatric Treatment, Rehabilitation, and Supports

Referral Source: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for referral at this time (please state specifically how these services will benefit the applicant): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**PSYCHIATRIC INFORMATION:**

Clinical Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_

Diagnosis: Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Medications (please list dosage and attach additional sheets if necessary): \_\_\_\_\_

Does the applicant take medications as prescribed? Yes  No

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**SUICIDE/HOMICIDE RISK:** Yes  No  Unknown

Please describe recent suicidal ideation, suicide attempts or homicidal ideation: \_\_\_\_\_

Please describe past history of suicidal ideation, suicide attempts or homicidal ideation: \_\_\_\_\_

Early warning signs of decompensation: \_\_\_\_\_

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**PSYCHIATRIC HOSPITALIZATION:** Unmet Needs  Needs Met  Unknown

Currently inpatient? Yes  No  Admit date: \_\_\_\_\_ Anticipated D/C date: \_\_\_\_\_

Please list any previous psychiatric hospitalizations: \_\_\_\_\_

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**MENTAL HEALTH TREATMENT:** Unmet Needs  Needs Met  Unknown

Please list any previous outpatient treatment, including current: \_\_\_\_\_

Brief history of illness: \_\_\_\_\_

Does the applicant have a history of violence towards self or others? Yes  No  If yes, please explain.

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**HEALTH CARE:** Unmet Needs  Needs Met  Unknown

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Has a health care proxy been executed: Yes  No

Has an advance directive been executed: Yes  No

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**SUBSTANCE ABUSE:** Unmet Needs  Needs Met  Unknown

Please list past and present use and treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Length of sobriety: \_\_\_\_\_ Substance of choice: \_\_\_\_\_

Treatment provider: \_\_\_\_\_ Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_

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**LEGAL INVOLVEMENT:** Unmet Needs  Needs Met  Unknown

History of arson, legal or criminal involvement? Yes  No  Current charges pending? Yes  No

Currently on probation? Yes  No  Currently on parole? Yes  No

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Probation or Parole Officer: \_\_\_\_\_ Phone: \_\_\_\_\_

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**FINANCIAL MANAGEMENT:** Unmet Needs  Needs Met  Unknown

Check if applicable: Medicaid  SSI  SSD  PA

Application pending for: Medicaid  SSI  SSD  PA

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Other Insurance: \_\_\_\_\_

Please list any financial management needs, including rep payee status and income source: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**LIVING ARRANGEMENT:** Unmet Needs  Needs Met  Unknown

Homeless, or at risk of homelessness? Yes  No

Please list current living arrangement, including any current or pending subsidies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Many programs require group living and/or group participation. Please assess applicant's ability to tolerate such a structure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**VOCATIONAL/EDUCATIONAL FUNCTIONING:** Unmet Needs  Needs Met  Unknown

Please list vocational/educational goals, strengths, barriers to employment/school participation and work history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**TRANSPORTATION:**Unmet Needs  Needs Met  Unknown Please list current transportation needs: \_\_\_\_\_  
\_\_\_\_\_

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**SOCIAL SUPPORTS:**Unmet Needs  Needs Met  Unknown 

Natural supports: \_\_\_\_\_

Leisure time activities: \_\_\_\_\_

Social clubs/support groups: \_\_\_\_\_

Identified needs: \_\_\_\_\_

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Is individual aware of this referral? Yes  No Is individual interested in services? Yes  No Please list client strengths and skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SERVICE NEEDS:**

Yes No High Priority Low Priority

Psychiatric Services:    Medication Management:    Substance Abuse Services:    Living Arrangements:    Self-Care:    Legal:    Benefits/Financial:    Transportation:    Medical Services:    Work/School:    Social/Family Relationships:    Crisis/Safety Planning:    

Other (describe): \_\_\_\_\_

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**ADDITIONAL COMMENTS:**Please add any additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Required information:**

- Consent for release of information
- Psychiatric evaluation (most recent; for Residential, within 1 year)
- Treatment plan (most recent)
- Admission/discharge summaries (most recent)
- Physical exam with T.B. (Residential, South Street Center only)
- Functional assessment survey (Residential only)
- Signed physician authorization for restorative services (Residential only)

**Please send form and information to:**SPOE Coordinator  
Office of Community Services  
230 Maple Street  
Glens Falls, NY 12801  
Phone: (518) 792-7143  
Fax: (518) 792-7166

## APPLICATION FOR ADULT SERVICES

This application is for use in referring individuals to residential, 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.

*Group Homes* are targeted for those in the earliest stage of recovery 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 provide services through regular visits and an on-call system. *Supported Housing* helps individuals with finding and maintaining permanent independent housing.

*Intensive Case Management* and *Supportive Case Management* assist adults with severe mental illness to access care and function in the community. *Dual Recovery Case Management* assists adults with severe mental illness, who have alcohol and/or drug problems, and who may be involved with the criminal justice system.

*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 attached application should be filled out completely. In addition, please attach the following:

1. **Signed release(s) of information (including, if possible, releases of information covering other services with which the applicant is already involved)**
2. **Psychiatric evaluation (most recent; for Residential Programs, must be within one year)**
3. **Current treatment plans (most recent)**
4. **Relevant admission and discharge summaries (most recent)**
5. **Physical exam with Mantoux T.B. test (Residential Programs and South Street Center Only)**
6. **Functional assessment survey (Residential Programs Only)**
7. **Signed physician authorization for restorative services (Residential Programs Only)**

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 should be forwarded to:

SPOE Coordinator  
Office of Community Services  
230 Maple Street  
Glens Falls, NY 12801  
Telephone: (518) 792-7143  
Fax: (518) 792-7166

After receiving the completed application, we will contact you as soon as possible regarding the next steps in the process. Thank you for your interest in our programs.

