WARREN AND WASHINGTON COUNTIES *REVISED 1/21*
SINGLE POINT OF ACCESS REFERRAL PACKET
Services for Adults with a Serious Mental Health Condition

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.)*

☐ Copy of a psychiatric evaluation or psychosocial assessment completed within the past year *(If there hasn't been a recent evaluation, an older one can be submitted but it must be accompanied by a recent progress note and/or treatment plan.)*

REFERRALS FOR THE PSYCHIATRIC REHABILITATION RESIDENTIAL PROGRAMS ALSO REQUIRE:

☐ Authorization for Restorative Services form completed by a physician

☐ Copy of a physical exam completed within the past year

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

REFERRALS FOR THE PSYCHOSOCIAL CLUB ALSO REQUIRE:

☐ Copy of a physical exam completed within the past year

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

Name of person being referred: Date of referral:

Person making referral: Agency:

Phone number: Fax number:

CHECK THE SERVICE(S) YOU ARE REFERRING THE INDIVIDUAL TO:

☐ **Psychiatric Rehabilitation Residential Programs**

☐ **Comunity 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

☐ **Independent Living (Supportive Housing)**

- Helps people locate and move into an apartment, evaluate a lease, select furniture, etc. and provides financial assistance as well
- After having settled into a new home, clients work with staff to maintain stable living in the community.

☐ **Case 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.

1. The person I am referring is unable to participate or succeed in traditional, office-based mental health treatment because:

2. The person I am referring has continuous high service needs demonstrated by one or more of the following:

☐ 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.

3. ☐ 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 are in agreement with the services being transferred from them to the ACT Team.

☐ **East Side Center**

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

☐ **Dual Recovery Program**

Support for those who are in recovery from mental health and substance use conditions. Support includes meetings, social nights, and walk-in hours.

Note: Individuals need not have a serious mental health condition to participate in this program.

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 *(check all that apply)*:

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. ☐ Extended impairment in functioning due to a mental health condition

The individual has experienced functional limitations in at least two of the following areas over the past year:

- ☐ Self-Care *(check all that apply)*:
  - ☐ marked difficulties in personal hygiene
  - ☐ marked difficulties in securing health care or complying with medical advice
  - ☐ marked difficulties in avoiding injuries
  - ☐ marked difficulties in maintaining a healthy diet

- ☐ Activities of Daily Living *(check all that apply)*:
  - ☐ marked difficulties in maintaining a residence
  - ☐ marked difficulties in using transportation
  - ☐ marked difficulties in day-to-day money management
  - ☐ marked difficulties in accessing community services

- ☐ Maintaining Social Functioning *(check all that apply)*:
  - ☐ marked difficulties in interpersonal interactions with family members, friends, neighbors
  - ☐ marked difficulties in compliance with social norms
  - ☐ marked difficulties in appropriate use of leisure time

- ☐ Marked difficulties with basic day-today tasks *(check all that apply)*:
  - ☐ marked difficulties in completing tasks on time
  - ☐ marked difficulties in completing tasks without numerous errors
  - ☐ marked difficulties in completing tasks without assistance

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

Name: Agency:

OR

D. ☐ Reliance on mental health treatment, rehabilitation, or supports

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)*

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 Warren-Washington Association for Mental Health, Glens Falls Hospital, Capital District Psychiatric Center, Liberty House Foundation, PEOPLe USA, Northern Rivers, Adirondack Health Institute, Behavioral Health Services North, Alliance for Positive Health, 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

SINGLE POINT OF ACCESS
AUTHORIZATION FOR RESTORATIVE SERVICES IN REHABILITATION HOUSING PROGRAMS

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 <u>only</u> and requires a <u>face-to-face</u> 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'S ASSISTANT, OR PSYCHIATRIC NURSE PRACTITIONER**)

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:

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

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
Effective Date:
End Date: (no more than six months from Effective Date)

☐ Apartment Program:
Effective Date:
End Date: (no more than six months from Effective Date)

Name (*please print*): License number:

National Provider Identifier:

Signature: Date:

REFERRAL FORM

Name of person being referred: Date of Birth:

Age: Gender: ☐Female ☐Male ☐Transgender

Address: Phone number:

Insurance: ☐Managed Medicaid ☐Straight Medicaid Medicaid CIN #:
☐Medicare ☐Commercial Insurance ☐None

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

Diagnosis:

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

Therapist: ☐Does not have one *or*
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*:

Current living situation:
Note: if this is a housing referral, please include reason the person is unable to remain in current living situation.

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

Reason for referral:

<u>I AM UNABLE TO ACCEPT INCOMPLETE REFERRALS.</u>

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

Please send completed 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