Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Attn: Victoria Winchester, Adult SPOA Coordinator
Sullivan County Department of Community Services
20 Community Lane
Liberty, New York 12754
Phone number (845) 513-2008
Fax number (845) 513-2110

2. Please review REQUIRED DOCUMENTATION FORM below.
   Referrals will NOT be considered complete without:
   Complete SPOA Application
   Clinical Information as specified below.

3. Upon receipt, application will be reviewed by SCDCS for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 845 513-2008.

REQUIRED DOCUMENTATION

Required Documents	**Care Management**	**CR**	**TX APT**	**SH**
Eligibility Determination	X	X	X	X
Referral Form	X	X	X	X
Psychiatric Evaluation (Including DSM VI and Current within 90 days)	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X
Physical Exam & Immunization Record		X	X	
Authorization for Restorative Services **(MUST BE ORIGINAL)**		X	X	

Eligibility Determination

In order to be eligible for services through SCDS, applicants for Housing or Case Management Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, B, C, **or** D must be met:

Yes ____ No ______ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions.

Yes ____ No ______ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI ***DUE TO A DESIGNATED MENTAL ILLNESS***.

Yes ____ No ______ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant must meet 1 or 2 below:

1. The individual has experienced two of the following four functional limitations *due to a designated mental illness over the past 12 months on a continuous or intermittent basis.* (Documentation in psychosocial assessment required.)

Yes ___ No ___ a. **Marked difficulties in self-care.**
Yes ___ No ___ b. **Marked restrictions of activities of daily living.**
Yes ___ No ___ c. **Marked difficulties in maintaining social functioning.**
Yes ___ No ___ d. **Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home of school setting.**

Yes ____ No ______ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)
Yes ____ No ______ One six month stay in an inpatient psychiatric unit
Yes ____ No ______ Two stays of any length in an inpatient psychiatric unit in the preceding two years.
Yes ____ No ______ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.
Yes ____ No ______ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.
Yes ____ No ______ Six months consecutive residency in a designated Adult Home.
Yes ____ No ______ Six months consecutive residency in a Residential Care Center for Adults (RCCA)
Yes ____ No ______ Six months consecutive residency in a Residential Treatment Facility (RTF)

Applicant Information

Name: ______________________________ Date of Birth: ____________________

Social Security #: ______________________________ Medicaid #: ____________________

Address: ______________________________ Apt. #: ______________

City: ____________________ State: ______________ Zip: ______________

County of residence: ____________________

Telephone ______________ Male __ Female __ Citizenship: Yes ____ No (if no, immigration status): ____________________

Ethnicity

____ White (Non-Hispanic)
____ Latino/Hispanic
____ Native American
____ Other ____________________

____ Black (Non-Hispanic)
____ Asian/Asian American
____ Pacific Islander

Primary Language

___English ___Spanish ___Chinese ___French
___Italian ___Russian ___German ___Japanese
___Other

Custody Status of Children

____ No children
____ Children are all above 18 years of age
____ Minor children currently in client's custody
____ Number of children:______ Gender: ________
____ Minor children not in client's custody but have access
____ Minor children not in client's custody – no access

Current Living Situation

____ Room
____ Own apt
____ Supervised Living
____ Supported Housing
____ Lives with spouse
____ Correctional facility

____ Homeless (shelter)
____ Homeless (streets)
____ Nursing Home
____ Psychiatric Hospital
____ Lives with Parents
Other ______________

Insurance and financial information: Currently receives

Social Security ☐
SSI/SSD ☐
Public Assistance ☐
Medicaid ☐
Medicare ☐

Earned Income/Wages ☐
Food Stamps ☐
VA Benefits ☐
Representative Payee ☐
Other ______________

Referral source (including RPC Long Stay)

Name: ______________________________ Phone: ____________________

Agency: ______________________________ Fax: ____________________

Address: ____

Program: ______________________________ Relationship: ____________________

Email address: ______________________________

Current diagnosis:

____
____
____

Current medical conditions:

____
____
____

Psychosocial and environmental problems:

____
____
____

Current medications:

____

Outpatient Treatment Provider:

Agency: ______________________ **Program:** ______________________

Contact: ______________________ **Telephone:** ______________________

Substance Abuse History **: Please List Drugs of Choice**

____

Length of Time Recipient Has Been Substance Free: ______________________

Criminal Justice – Current Status

___ None ____ Incarcerated-Jail ____ Incarcerated-Prison _____ CPL 330.20/730

___ Probation ____ Parole ____ _____ Other:______________

P.O. Name: ______________________ Telephone: ______________________

Number of arrests/incarcerations in past year _________ **Number of lifetime arrests** __________

Reason for Arrest:______________________ _________ **Date:** __________

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law? _______ **Yes** _____ **No**

Is an AOT under Kendra's Law currently being pursued? _______ **Yes** _____ **No**

Case Management Service Requested

_____ Health Home Care Management _____ CSS Care Management

Is there a specific case management program requested? ______________________

Residential Services Requested

_____Supervised Community Residence
_____Supportive Apartments
____ Treatment Apartment Programs
_____ RSS Supported Housing
_____ Chestnut Street Apartments
_____Invisible Children's Program (for families with children under the age of 18).
____ Family Care
____Golden Ridge Supported Housing
____COC Housing
_____ Scattered Sites Housing Program

Geographical Preference/Community: ______________________

Recipient Requests:

____

Recipient Signature: ______________________ **Date:** __________

Referring Party Signature: ______________________ **Date:** __________

Rehabilitation Support Services, Inc.

Service Authorization for Adult Community Residences and Treatment Apartment Programs

A. Type of Authorization: ☐ Initial Authorization
☐ Re-Authorization

B. Client's Name: ______________________________

C. Client's Medicaid Number: ______________________________

I, the undersigned licensed physician/practitioner, based on either:
a) **INITIAL AUTHORIZATION:** Must be signed by a physician ONLY and based upon clinical information **and** a face to face assessment of the individual

OR

b) **RE-AUTHORIZATION:** Must be signed by a Physician, Physician Assistant or Nurse Practitioner in Psychiatry.

D. have determined that ______________________ would benefit from the provision
(client's name)
of community rehabilitation services as known to me and defined pursuant to 14 NYCRR Part 593.

E. This determination is in effect for the period __________ to __________, at which time there will be an evaluation of continued stay.

F. ICD.10 Primary Mental Health Diagnosis Code F ☐☐ . ☐☐
ICD.10 Diagnosis______________________________
____

Name of Practitioner (Please Print): ☐ Physician ☐Physician Asst. ☐ Nurse Practitioner in Psychiatry		Practitioner's License#
G. Signature of Practitioner	Date	Practitioner's NPI #

INSTRUCTIONS:
Initial Authorization: Must be a Face to Face visit with a PHYSICIAN: Residents, PA's or NPP's cannot sign for the physician. Complete sections F and G.
Re-Authorization: PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTIONER IN PSYCHIATRY
Complete Section F and G
RSS Staff: Complete Sections A, B, C, D and E and NPI # if blank
RSS MBP 3 Revised 8.15

SULLIVAN COUNTY SINGLE POINT OF ACCESS

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: This release cannot be used for the release of HIV- related information nor for the re-disclosure of confidential information provided to the agencies listed below except as allowable by law.

Applicant's Name:________________________ **DOB:**____________________________

Extent or Nature of Information to be Disclosed:

Contents of the SPOA Referral Packet including but not limited to:

Psychiatric Assessment/Core Evaluation

Psychosocial Assessment/Core History

Hospital Admission and Discharge Plan (if appropriate)

Physical Examination and TB Test Results

List of Medications

Physician's Authorization

Other:__________________________________

Purpose or Need for Information

To facilitate a referral for residential and/or care coordination services, determine eligibility for such services, and assess appropriateness of applicant for the various programs available.

Information Being Disclosed From: (Name, Address, and Title of Person/Organization/Facility/Program)

All referrals go directly to SPOA Coordinator, who then distributes relevant information to the SPOA Committee including:

Access: Supports for Living, Inc. (Devon Mgmt./Golden Ridge)
Action Toward Independence
A-SPOA Referral Source
Garnet Health Medical Center (formerly Catskill Regional Medical Center)
EESHI Scattered Sites Program
Hudson Valley Community Services
Independent Living, Inc.
NYS Office of Mental Health
Rehabilitation Support Services, Inc.
Rockland Psychiatric Center/Rockland Psychiatric Center MTR
Sullivan County Center for Workforce Development
Sullivan County Department of Community Services
Sullivan County Department of Family Services
Kearney Realty and Development Group (Chestnut Street Apartments)
Sara Watson, ODTA (Office of Temporary and Disability) Program Manager
Unite Us

I hereby authorize the release of the above information to the persons/organizations/facilities/programs identified above. I understand that the information is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time in writing. This authorization will expire when I am no longer receiving SPOA services.

____

Signature of Applicant **Date Signed**

____

Signature of Witness **Relationship to Applicant** **Date Signed**