

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 or 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) _____ Black (Non-Hispanic)
____ Latino/Hispanic _____ Asian/Asian American
____ Native American _____ Pacific Islander
____ Other _____

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 _____ Homeless (shelter)
____ Own apt _____ Homeless (streets)
____ Supervised Living _____ Nursing Home
____ Supported Housing _____ Psychiatric Hospital
____ Lives with spouse _____ Lives with Parents
____ Correctional facility _____ Other _____

Insurance and financial information: Currently receives

Social Security _____ Earned Income/Wages _____
SSI/SSD _____ Food Stamps _____
Public Assistance _____ VA Benefits _____
Medicaid _____ Representative Payee _____
Medicare _____ 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
- ___ Supervised MICA Community Residence
- ___ 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

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.

ICD.10 Primary Mental Health Diagnosis Code		F			.		
F. ICD.10 Diagnosis _____							
Name of Practitioner (Please Print):						Practitioner's License#	
<input type="checkbox"/> Physician <input type="checkbox"/> Physician Asst. <input type="checkbox"/> Nurse Practitioner in Psychiatry							
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 PRACTITIONER IN PSYCHIATRY
 Complete Section F and G

RSS Staff: Complete Sections A, B, C, D and E and NPI # if blank

**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.
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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 but not limited to the following service providers: 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 Department of Community Services Sullivan County Department of Family Services Kearney Realty and Development Group (Chestnut Street Apartments)
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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.
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_____	_____
Signature of Applicant	Date Signed

_____	_____	_____
Signature of Witness	Relationship to Applicant	Date Signed