COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

ADULT CARE COORDINATION AND RESIDENTIAL SERVICES

Applicant Information

Applicant Name:

Address:

City: State: Zip Code:

Home Phone: Cell:

Email:

Date of Birth: Social Security Number:

Driver's License: Yes No State: Identification Number:

Legal Status: sex offender; if so, level ___ incarcerated restraining/order of protection AOT

probation/parole; officer _____ Contact Information: _____

Primary Insurance: Group #:

Secondary Insurance: Group #:

Emergency Contact: Phone:

Relationship:

Applying for:
Care Management/Coordination
Please Choose Appropriate Level of Housing:
Comprehensive Apartment Program - CAP (*apartment settings, staff visits 3x per week min. /daily visits maximum)*
Supported Apartment SHUD (*apartment settings, staff visits 1-4x per month)*
24-hr Supervised Community Residence: High Cliff Terrace
Gateway Programs

Psychiatric History

Diagnostic Impression

Code:

Code:

Code:

Trauma History: sexual physicalemotional domestic violence other
Use this space to provide details on age, frequency, duration, perpetrator, etc.

Other Pertinent Psychiatric Information:

To accompany my referral, **I have attached the following: psychosocial assessment AND physical health examination or other professional health evaluation** with relevant treatment information, completed within the past year.

Revised 5/2021

I have reviewed this information and understand that this and other information will be given to the program(s) to which I am applying.

_____ _____

Applicant Signature Date

To be completed by the Referral Source

Referring Agency:

Contact:

Address:

City: State: Zip Code:

Phone: Ext. Fax:

Email:

Reason for Referral:

How long have you been working with the applicant?

To the best of your knowledge, what types of services will continue to be provided or have been requested for this individual?

Therapy Psychiatry Adult Day/PROS Health Monitoring (WillCare)
Aging Services (Office for the Aging, Meals on Wheels)

How frequently?

Other Agencies Providing Support (name, type of service, contact information):

_____ _____

Referral Source Signature Date

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RELEASE OF INFORMATION

Applicant Name: DOB:

I hereby authorize the following agencies to release and exchange the following information:

Coordinated Entry/HUD Program
Capital District Psychiatric Center
Columbia Memorial Hospital
Greene Dept. of Social Srvs.
Greene County Mental Health Ctn
Greene County Probation
Mental Health Association
Gateway
Office for People with Developmental Disabilities (OPWDD)
Twin County Recovery Services, Inc
WillCare
Other:
Other:

Current residential address and phone
Evaluation results
Employment records
Diagnosis, prognosis, treatment status
Discharge summaries
DSS assessments
DSS case type and grant amount
DSS case status
Medical records
Presence in treatment
Psychological/social assessments
Treatment plans
Other:
Other:

The purpose of this authorization is to assist with care management or residential housing services, or both, provide ongoing communication between the above agencies, fulfill court and DSS mandates, and coordinate care services. The information and/or documents obtained with this consent may be redisclosed only with my expressed written consent. I have read and understand the above and authorize the disclosure of such information as herein contained. I understand that this consent is subject to revocation at any time except to the extent that the person or agency, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon termination of services.

NOTE: CRIMINAL JUSTICE CONSENTS ARE IRREVOCABLE. THEY ARE VALID UNTIL THE DISPOSITION IN QUESTION HAS BEEN TERMINATED. THEREFORE, PROBATION CONSENTS MAY NOT BE REVOKED.

I also understand that any disclosure of the information and/or documentation is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information and/or documentation to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

_____	_____	_____
Signature	Witness	Date

PHYSICIAN AUTHORIZATION FOR

RESTORATIVE SERVICES

LICENSED COMMUNITY RESIDENCE PROGRAMS

- ☐ Initial Authorization
- ☐ Semi-Annual Authorization (HCT)Community Residence
  The Philmont Hearth
- ☐ Annual Authorization (CAP, HCA, CSA, Gateway)
  Transitional Apartment Programs

CLIENT NAME: _____

CLIENT MEDICAID NUMBER: _____

ICD.10 DIAGNOSIS: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me have determined that _____ would benefit from the
(Consumer Name)

provision of Mental Health Restorative services defined pursuant to Part 593 of 14 NYCRR. If this is a renewal, a copy of the most recent residential service plan review is attached.

** IF this is an **Initial Authorization,** the prescribing physician must see the consumer **face-to-face** prior to authorizing services.

_____/_____/_____ _____ _____ _

Mo Day Year Physician Name (Please Print) Licensure #

_____ _____

NPI # Physician Signature

To be completed by the Referral Source for Residential Admission

Day Program Recommendation

As this Residential Program maintains a rehabilitation focus, it is expected that all residents will engage in gainful activities during the weekday. This activity should be tailored to the individual, addressing his or her individual needs, strengths, goals, etc. Options for day activities include: attending PROS, school, Supported Employment, Supported Education, volunteer work, Sheltered Employment, or any other type of service program offered by COARC or a competitive employment placement. Our goal is to promote independence to the highest degree that the individual is able to attain. We value working collaboratively with the individual consumer, as well as with all collateral services providers in reaching this end.

The recommended day activity for _____ is

_____.

This document will become part of the residential service plan.

_____ _____
Resident Primary Clinician

_____ _____
Program Director Date

SINGLE POINT OF ACCESS (SPOA)

FUNCTIONAL ASSESSMENT

To be completed by or with the applicant

Living arrangement at time of application:

- ☐ Independent
- ☐ Family/Friends
- ☐ Homeless
- ☐ Homebound
- ☐ Community Residence (24 hr. Supervised)
- ☐ Residential Program or Apartment

Does the applicant have a housing subsidy: ☐ Yes ☐ No Amount: _____

*Please list all **living arrangements** starting with the most recent:*

Description (location/with whom)	From	To	Outcome (Successful/Unsuccessful)

Use this space to describe living situations other than above:

_____

_____

Activities of Daily Living

*… please provide a general picture of **daily activities** or **schedule** of the applicant*

_____

_____

Will your schedule change if admitted into this program? ☐ Yes ☐ No

Please describe how your schedule may change:

_____

Personal Effectiveness				
Please the check box to indicate issues within the **past 30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe	Severity 1	2	3	4
Arises promptly	☐	☐	☐	☐
Attends a day program	☐	☐	☐	☐
Demonstrates basic cooking skills	☐	☐	☐	☐
Keeps clinic or other appointments as scheduled	☐	☐	☐	☐
Maintain adequate personal hygiene	☐	☐	☐	☐

Maintains an adequate diet	☐	☐	☐	☐
Performs home maintenance, cleaning tasks	☐	☐	☐	☐
Smokes in a safe manner	☐	☐	☐	☐
Uses money correctly for purchases	☐	☐	☐	☐
Uses public transportation	☐	☐	☐	☐
Uses telephone correctly	☐	☐	☐	☐
Problem Solving and Interpersonal Skills				
Please the check box to indicate issues within the **past 30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe	Severity 1	2	3	4
Acts assertively when appropriate	☐	☐	☐	☐
Apologize when appropriate	☐	☐	☐	☐
Exercise good judgment	☐	☐	☐	☐
Follow through on advice of doctor	☐	☐	☐	☐
Listen and understand	☐	☐	☐	☐
Obtain help for physical problems	☐	☐	☐	☐
Plan in cooperation with others	☐	☐	☐	☐
Resolve conflicts appropriately	☐	☐	☐	☐
Socialize with others	☐	☐	☐	☐
Take initiative or seek assistance with problems	☐	☐	☐	☐
Treat own minor physical problems	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Functional Assessment				
Hygiene				**Any additional Comments:**
Monitors on own	☐			
Needs assistance	☐			
Shopping				
Shops independently	☐			
Needs assistance to shop	☐			
Ability to maintain residence				
Manages on own	☐			
Needs assistance	☐			
Economic Self Sufficiency				
Manages own money	☐			
Needs assistance	☐			
Has a representative payee	☐			
Ability to Self-Direct Activities				
Can initiate plans	☐			

Can follow through with plans	☐			
Needs Assistance	☐			

What do you expect to gain by working with this program?

_____

_____

What are your strengths and positive qualities?

_____

_____

What are your hobbies and interests?

_____

_____

In what areas of your life do you **want or need** to make changes?

Educational	☐	Transportation	☐
Employment	☐	Social/Recreational	☐
Financial/Economical	☐	Family	☐
Housing	☐	Legal/Probation	☐
Medical Wellness	☐	Other:	☐
Mental Health Recovery	☐		
Self care	☐		
Substance Abuse	☐		

What do you see as your role in making these changes?

_____

_____

What generally gets in your way of making changes in your life?

_____

_____

How do you think this service can assist you in making changes in your life?

_____

_____

Do you take your mental health medications as prescribed? ☐ Yes ☐ No

I have answered the above questions to the best of my ability. I understand that this and other information contained in this referral will be presented at the next Care Management and Housing SPOA meeting to make a determination as to my eligibility and readiness for the services requested.

_____ _____

Applicant Signature Date

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FINANCIAL ASSESSMENT

Sources of Income:

Monthly Amount:	If Pending….
SS Disability: _____	Date of application_____
SSI Income: _____	Date of application_____
Public Assistance: _____	Date of application_____

Employment: _____

Retirement benefits (specify): _____

Worker's Compensation, unemployment ins. (specify): _____

Other (specify)_____

Expenses:

- ☐ Child support
- ☐ wage garnishment
- ☐ fines/restitution

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PSYCHIATRIC ASSESSMENT (To be completed if no psychosocial within the last year is attached)

*Please list all **psychiatric inpatient admissions** starting with the most recent*

Inpatient Provider	Admission	Discharge	Reason

Use this space to describe treatment related obstacles or outcomes of above:

_____

_____

*Please list all **psychiatric outpatient admissions** starting with the most recent*

Outpatient Provider	Admission	Discharge	Reason

Use this space to describe treatment related obstacles or outcomes of the above:

_____

_____

History of suicide ideation (dates, methods, triggers): _____

_____

Family/friend history of suicide attempts or completion (who, when, method): _____

_____

What generally occurs when this person decompensates?

_____

_____

Is the person usually a danger to self or others when decompensating? ☐ Yes ☐ No

Does the person seek help when decompensating? ☐ Yes ☐ No

Please explain:

_____

_____

Psychiatric Symptoms Assessment				
Please the check box to indicate issues occurring in the **past 30 days**: 1 = none or no issue 2 = minor 3 = moderate 4 = severe	Severity 1	2	3	4
Anxiety (worry, fear, over-concern for present or future	☐	☐	☐	☐
Blunted Affect (reduced emotional tone, reduction in normal intensity of feeling, flatness)	☐	☐	☐	☐
Disorientation (confusion or lack of association for person, place or time)	☐	☐	☐	☐
Emotional Withdrawal (lack of spontaneous interaction, isolation, deficit in relating to others	☐	☐	☐	☐
Excitement (heightened emotional tone, agitation, increased reactivity)	☐	☐	☐	☐
Hallucinatory Behavior (perceptions without normal external stimuli)	☐	☐	☐	☐
Hostility (animosity, contempt, belligerence)	☐	☐	☐	☐
Mannerisms, posturing (bizarre motor behavior)	☐	☐	☐	☐
Motor Retardation (slowed, weakened movements or speech)	☐	☐	☐	☐
Somatic Concerns (preoccupation or fear of physical health and illness)	☐	☐	☐	☐
Suspiciousness (mistrust, believes others harbor malicious or discriminatory intent)	☐	☐	☐	☐
Tension (motor manifestations, nervousness, hyperactivity)	☐	☐	☐	☐
Uncooperativeness (resistance, guardedness, rejection of authority)	☐	☐	☐	☐
Unusual thought content or conceptual disorganization (odd, disorganized, bizarre or confused thoughts)	☐	☐	☐	☐

Risk Assessment			
BEHAVIOR	YES	NO	Description (dates, injuries, legal status, etc)
Arson	☐	☐	
Assaultive Behavior	☐	☐	
Criminal Offenses	☐	☐	
Medication Compliance	☐	☐	
Sex Offender (status and level)	☐	☐	
Driving/Traffic Violations	☐	☐	

Other:	☐	☐	

**please note that positive responses to the above questions does not rule out admission to the program*

Other Alerts:

Presently at risk of psychiatric admission	☐ Yes	☐ No
Cycles in and out of the hospital with less than 90 days between admissions	☐ Yes	☐ No
History of long length of inpatient admissions (90 days +)	☐ Yes	☐ No
Frequent crisis related contacts	☐ Yes	☐ No
Reluctance to use traditional programs	☐ Yes	☐ No
Inadequate social support and/or difficulty in self monitoring	☐ Yes	☐ No
Current mental health services are deemed inadequate	☐ Yes	☐ No
Current suicidal ideations?	☐ Yes	☐ No
Current homicidal ideations?	☐ Yes	☐ No

_____ _____

Referral Source Signature Date

_____ _____

Optional Physicians Notes:

_____