Jefferson County
Single Point of Access (SPOA) Committee

UNIVERSAL REFERRAL FORM
FOR CARE MANAGEMENT AND RESIDENTIAL SERVICES

Name of Individual: _____ DOB: _____

Current Address: _____

I agree to be considered for one of the following adult case management and/or housing services: Care Management, Supported Housing Case Management, THRIVE Wellness and Recovery Community Residence and/or Apartment Program. I have been informed as to the nature of these services and understand that participation in any of these programs is voluntary.

I understand that with my agreement, acceptance into one of the above programs is decided by Jefferson County's Single Point of Access Committee. I understand that this committee is comprised of representatives from community agencies as well as consumer advocates. Community agencies represented include, but are not limited to: St. Lawrence Psychiatric Center, Jefferson County Community Services, Jefferson County Department of Social Services, Adult Protective, Office for the Aging, Jefferson County Probation, Children's Home of Jefferson County (CHJC), THRIVE Wellness and Recovery, Community Clinic, Family Counseling Services, Samaritan Medical Center: Behavioral Health/Addiction Services/Inpatient Mental Health Unit, Watertown Vet Center, Jefferson County Veteran Administration, Mental Health Association of Jefferson County, Disabled Person's Action Organization, Jefferson Rehabilitation Center, Northern Regional Center for Independent Living, Fort Drum Behavioral Health and Exceptional Family Member Program, Carthage Behavioral Health, North Country Family Health Center, ACR Health, Planned Parenthood of the North Country, River Community Wellness, Citizen Advocates, Points North Housing Coalition.

I understand that the members of this committee are bound to maintain the highest standards of confidentiality defined by law and are not to disclose information that identifies me personally, outside of the SPOA Committee process. I understand that it is the role of the committee to oversee the use of adult case management/housing services in Jefferson County and to decide which level of service, depending upon availability and program eligibility requirements, is most appropriate for each individual based on their needs and desires. In making its decision, the committee will use and possibly discuss all information provided by the individual agency representatives regarding my circumstances. I understand that I may request that an agency which possesses my protected health information, exclude or hold private specific information from SPOA Committee consideration.

By signing this authorization I give my permission for members of the Single Point of Access Committee to share information necessary to describe my situation, and to determine the most appropriate service or services based on my needs and desires. I understand that upon my written request, I may withdraw my permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future applications for these services. Unless my permission is withdrawn I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Withdrawal of Request/Authorization

I voluntarily withdraw my request for case management and housing services and in doing so withdraw my authorization for the Single Point of Access Committee to continue to share information regarding my circumstances. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Referred to: (Please refer to Level of Care Guide, Appendix 1)	
Care Management	**Residential Services**
☐ Care Management	☐ THRIVE Community Residence
☐ Supported Housing Case Management (SHCM)	☐ THRIVE Apartment Program
Eligible for Long Term Stay Funding: ◯ Y ◯ N	**Eligible for RCE Funding: ◯ Y ◯ N**

Individual Being Referred			
Name:	**Sex:**	**DOB:**	**Age:**
Address:			**County:**
Phone:	**Social Security #:**		**Marital Status:**
Religion:	**Legal Status:**		**Veteran: ◯ Y ◯ N**
Current Living Arrangement:			

Health Insurance		
Medicare:	**Medicaid:**	**Private:**

Financial Information/sources of income (If applied and not yet receiving a potential source of income, please describe & give date of application)			
Monthly Income:		**Employer:**	
SSI:	**SSD:**	**PA:**	**VA:**
Alimony:	**Child Support:**	**Retirement:**	**Other:**
Existing Rep. Payee? ◯ Y ◯ N (Name, phone #)			

Emergency Contact		
Name:	**Relationship:**	**Phone:**
Address:		

Referred By		
Name:	**Title:**	**Agency:**
Address:		**Phone:**
Email:		**Fax:**

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Psychiatric Data		
Diagnosis:		
Current Mental Health Services **(Include Name and Phone Number of Clinic, Primary Therapist, Psychiatrist And/or Relevant Providers)**		
Other Agencies Involved With This Individual		
Psychiatric Hospitalizations		
Currently Hospitalized: ◯Y ◯N	**Admission Date:**	**Anticipated/Actual Discharge Date:**
Where will the individual be referred upon discharge, if not already linked to outpatient mental health services?		

Psychiatric Hospitalizations within the LAST YEAR (Dates, Locations, Reasons)		
Date	**Location**	**Reason**

Current Medications (Dosage and Frequency) (Psychiatric and Medical)		
Medication Name	**Dosage**	**Frequency**

Risk Factors	**Yes**	**No**	**Comments**
Drug/Alcohol Abuse/Use	☐	☐	
Non-Compliance With Treatment	☐	☐	

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AOT Referred	☐	☐	
Mild or Moderate Stress Creates Exacerbation of Symptoms	☐	☐	
Difficulty Coping with Major or Multiple Medical Problems	☐	☐	
Suicide Attempts	☐	☐	
Self-Injurious Behavior	☐	☐	
Trauma	☐	☐	
Sexual Misconduct	☐	☐	
Sexual Offender	☐	☐	Level:
Problems with Self Direction/Concentration	☐	☐	
Difficulty With Self Care	☐	☐	
Difficulty with ADL's	☐	☐	
Lack of Support System	☐	☐	
Frequent Crisis Contacts	☐	☐	
Parent/Child Problems	☐	☐	
Chronic Vocational/Economic Problems	☐	☐	
Property Damage	☐	☐	
History of Violence	☐	☐	
Temper Outbursts	☐	☐	
Incarceration	☐	☐	
Chronic Housing Problems	☐	☐	
Chronic Legal Problems	☐	☐	
Nighttime Agitation (Housing Only)	☐	☐	
Incontinence (Housing Only)	☐	☐	
Elopement (Housing Only)	☐	☐	
Smoke with Supervision (Housing Only)	☐	☐	

Criminal History

Offense	Outcome	Date

Safety Concerns
Safety concerns are addressed to assure that case managers can safely go into the home

Safety issues around this person or others in the household? ◯ Y ◯ N (Explain)

Firearms, swords, weapons in the home? ◯ Y ◯ N (Explain)

Animals in the home (dogs that are dangerous? ◯ Y ◯ N (Explain)

Medical Information (Housing Only)	Yes	No	Comments
Physical Exam (Within 1 year)	◯	◯	
Mantoux Test (Within 1 year)	◯	◯	

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Medical Information (Housing Only)	Yes	No	Comments
Cardiac/COPD Problems	◯	◯	
Diabetes	◯	◯	
Seizure Disorder (Indicate Date of Last Seizure)	◯	◯	
Allergies	◯	◯	
Special Diet	◯	◯	
Limited Ambulation	◯	◯	Able to do stairs?
Any Restriction of Activities	◯	◯	

Social Data	
Current Day/Social Programs:	
VESID:	Employment/Training Hx:
Any Previous Supervised Living (date/location):	
Family Care ____◯__ Y ____◯__N Date:	
Gateway ____◯__ Y ____◯__N Date:	
Northwood ____◯__ Y ____◯__N Date:	
SRO ____◯__ Y ____◯__N Date:	
THRIVE CR ____◯__ Y ____◯__N Date:	
Independent Living ____◯__ Y ____◯__N Date:	
Other	

Statement of Need **(Describe what the person sees as his/her concrete case management needs in terms of advocacy, linkage, monitoring or state the reason(s) individual needs requested level of housing.)**

Signature of Individual Making the Referral: _____ Date: _____

Signature of Individual Being Referred: _____ Date: _____

SEND OR FAX REFERRAL FORM TO:
Diane Zikowitz
PO Box 6550
Watertown, New York 13601
Phone: (315) 200-8575
Fax: (315) 779-1184
Email: dzikowitz@chjc.org

******TO PROCESS THIS REFERRAL WE NEED ALL INFORMATION ON FORMS TO BE COMPLETE AND REQUIRED DOCUMENTS RECEIVED******

PLEASE SEE APPENDIX 1 FOR REQUIRED DOCUMENTS

Authorization for Restorative Services of Community Residences and Apartment Treatment

Authorization for the receipt of Restorative Services not to exceed:

☐ 6 months for Congregate Residences **(Check One Only)**

☐ 12 months for Apartment Residences **(Check One Only)**

Individual's Name:_____

Individual's Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, and having conducted a face-to-face assessment with said client as required pursuant to Part 593 of Title 14 NYCRR, have determined that _____ would benefit from the
(Individual's Name)
provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR.

_____ _____

Physician's Signature **Month/Day/Year of Signature**

_____ _____

Type or Print Physician's Name **License Number & State**

_____

NPI Number

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Statement of Ability to Self-Medicate

Resident's Name: _____ C#: _____

	Yes	No
Independently	○	○
With Supervision	○	○

Comments:_____
_____
_____
_____
_____

_____ _____
Physician's Signature **Date**

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Appendix 1: Level of Care Guide and Document Checklist for Adult Referrals

CARE MANAGEMENT PROGRAMS:

CARE MANAGEMENT PROGRAM:

Description: Care Management services assist individuals with a serious mental health diagnosis to access needed medical, social, psychosocial, educational, financial, and other services to support the consumer's maximum independent functioning in the community. Consumers do not need to be receiving Medicaid to qualify.

Required Documents:

- ☐ SPOA Application (Complete in full. Pages 1 and 5 signed.)
- ☐ Copy of most recent evaluation with core history and documentation of psychiatric diagnosis *****

***Evaluation must be current within the last 12-months**

SUPPORTIVE HOUSING PROGRAM:

Description: Supportive Housing enables individuals who are homeless or are at imminent risk of becoming homeless to live more independently in the community. Supportive Housing recipients must be able to live in the community with minimum staff intervention. Supportive Housing can provide start-up costs to include a security deposit and rental assistance.

Required Documents:

- ☐ SPOA Application (Complete in full. Pages 1 and 5 signed.)
- ☐ Copy of the most recent evaluation with core history and documentation of psychiatric diagnosis *****

***Evaluation must be current within the last 12-months**

When applicable, the following documentation will prioritize the case:

- ☐ Legal Eviction Notice (processed through a court)
- ☐ DSS Emergency Housing paperwork
- ☐ Legal Custody/Guardianship paperwork

****SEE NEXT PAGE FOR RESIDENTIAL PROGRAMS****
(Apartment Program, Community Residence)

NOTE: Referrals that are missing required documents will remain pending until documentation is received or until 90-days from receipt of referral. Referrals pending after 90-days will be closed.

RESIDENTIAL PROGRAMS:

APARTMENT PROGRAM:

Description: The Apartment Program provides a less intensely supervised living arrangement for individuals with a persistent mental health diagnosis who do not need the 24/7 staff support of a Community Residence (see below) but would benefit from developing the skills to live more independently. Clients are assigned a Care Manager who they meet with at least three times per week to develop the skills to transition to a less structured, more independent setting.

Required Documents:

- ☐ SPOA Application (Complete in full. Pages 1 and 5 signed.)
- ☐ Authorization for Restorative Services form (Page 6 of SPOA Application) *****
- ☐ Statement of Ability to Self-Medicate form (Page 7 of SPOA Application) *****

***Forms must be completed and signed by a <u>permanently licensed NYS Physician (MD)</u>**

- ☐ Copy of most recent evaluation with core history and documentation of psychiatric diagnosis *****

***Evaluation must be current within the last 12-months**

COMMUNITY RESIDENCE PROGRAM:

Description: The Community Residence program (also called **Congregate Residence**) provide a supportive, home-like structured environment enabling individuals with a serious persistent mental health diagnosis to learn skills necessary for independent community living. Community Residences are staffed 24/7 and provide the highest level of support. Jefferson County locations include two residences in Watertown and one location in Clayton. As individuals increase their independence and acquire needed skills, they are expected to transition to a less structured, more independent setting.

Required Documents:

- ☐ SPOA Application (Complete in full and sign Pages 1 and 5)
- ☐ Authorization for Restorative Services form (Page 6 of SPOA Application) *****
- ☐ Statement of Ability to Self-Medicate form (Page 7 of SPOA Application) *****

***Forms must be completed and signed by a <u>permanently licensed NYS Physician (MD)</u>**

- ☐ Copy of the most recent evaluation with core history and documentation of psychiatric diagnosis *****

***Evaluation must be current within the last 12-months**

NOTE: Referrals that are missing required documents will remain <u>pending</u> until documentation is received or until 90-days from receipt of referral. Referrals pending after 90-days will be closed.