ANTHONY J. PICENTE, JR.
County Executive

ASHLEE THOMPSON
Commissioner

ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH
120 Airline Street, Suite 200, Oriskany, NY 13424
Phone: (315) 768-3660
Fax: (315) 768-3670

Adult Single Point of Access and Accountability (ASPOAA) Referral Form

Care Management and Residential Services

NAME: _____ DOB: _____

Before completing this referral, please ensure (and mark) the following:

☐ This individual is 18+ years old

☐ This individual has a primary DSM-5 diagnosis of a severe mental illness <u>other</u> than alcohol/substance use disorders, developmental disabilities, dementias, or mental disorders due to a general medical condition.
Diagnosis Codes: _____

Before submitting this referral, please ensure (and mark) the following:

☐ There is an attached psychiatric evaluation, mental health assessment, or other documentation indicating the individual meets the criteria for a <u>primary</u> mental illness diagnosis, signed by a Psychiatrist, Medical Doctor, Nurse Practitioner, LMSW, LCSW, LMHC, or LMFT dated within the last 12 months.

Mail, Fax or Email to:
Attention: Rebeccah Philipson
Adult SPOAA Coordinator
Phone: (315) 768-3669
Fax: (315) 768-3670
rphilipson@ocgov.net

~~For OCDMH Only~~

SPOAA received: _____
SMI date received: _____
SMI expiration date: _____
Requested services: _____

Services referred to: _____
Distribution date#1: _____ OCDMH staff: _____

Services referred to: _____
Distribution date#2: _____ OCDMH staff: _____

OCDMH referral return date: _____ Reason: _____

Revised December 2021

Oneida County Department of Mental Health
Adult SPOAA Referral

Required: A Mental Health Assessment – Completed by a Mental Health Professional

Date of referral: _____ Referring Person _____

Referring Agency: _____ Referent Phone #: _____

Email: _____ Referent Fax #: _____

DEMOGRAPHIC INFORMATION: For Individual Being Referred

Last Name: _____ **First Name:** _____ AKA _____

DOB: _____ Phone: _____ Gender: Male☐ Female☐ (T☐)

SSN: _____

Medicaid Number: __ __ __ __ __ __ __ __ __ Medicare Number: _____

Other Health Insurance Name & ID: _____

Outpatient Address: _____ City/State: _____Zip: _____

Temporary Address: _____City/State: _____Zip: _____

State Hospital☐ Article 28 Hospital☐ Correctional Facility☐ Halfway House ☐ Shelter☐

(Admission Date: _____Anticipated Discharge/Release Date: _____)

Homeless☐ Homelessness start date: _____

Address Prior to Homelessness: _____City/State: _____Zip: _____

Ethnicity:	Race: (check all that apply)	Primary Language:
□ Hispanic □ Non-Hispanic	□ Caucasian □ African American □ Native American-Alaska □ Asian □ Native Hawaiian/other Pacific Islander □ Other _____	□ English □ Other: _____ Can individual understand English? □ Yes □ No, interpreter needed

Educational/Vocational:
Highest level of education: _____
Currently in school? ☐
Currently employed? ☐ Employer name: _____
Currently volunteering? ☐ Vocational services? ☐

INCOME SOURCES (with amounts):

□ SSI _____
□ SSDI _____
□ Temporary Assistance _____
□ Food Stamps (SNAP) _____
□ TANF _____
□ Veteran's Benefits _____
□ Employment/Wages _____
□ Family/Spouse _____
□ Support _____
□ Pension _____
□ None _____
□ Other Income _____

REPRESENTATIVE PAYEE:

□ Self
□ Other:

Name/Agency: _____
Address: _____
Phone: _____
Relationship: _____

Describe individual's money management skills:
_____
_____
_____

FUNCTIONAL/MEDICAL PROBLEMS:

□ Special Dietary Needs
□ Impaired Vision
□ Requires Special Medical Equipment
□ Impaired Ability to Walk
□ Impaired Hearing
□ Other _____

COGNITIVE IMPAIRMENT:

□ Developmental Disability
□ Learning Disability
□ Traumatic Brain Injury
□ Other _____

ALLERGIES:

_____
_____

COMMUNITY SURVIVAL SKILLS:

	Circle	
➢ Evacuate a building within 3 minutes: _____	Yes	No
➢ Bathe/dress: _____	Yes	No
➢ Hygiene/grooming: _____	Yes	No
➢ Eating/cooking: _____	Yes	No
➢ Risk of falling: _____	Yes	No
➢ Risk of wandering: _____	Yes	No
➢ Coordinate their own transportation:_____	Yes	No

CURRENT MEDICAL CONDITIONS:

_____
_____
_____
_____
_____
_____

CURRENT MEDICAL MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

CURRENT PSYCHIATRIC MEDICATIONS:

□ Long-acting injectable? (dosage and most recent administration) _____

_____ _____ _____
_____ _____ _____
_____ _____ _____

CAPABILITY TO ADMINISTER MEDICATIONS (select multiple if applicable):

□ Independently □ With supervision □ With assistance □ Unable □ Refuses

INDIVIDUAL'S TREATMENT TEAM:

Mental Health Agency: _____ Phone: _____

Therapist: _____ Prescriber: _____

Care Manager: _____ Agency _____ Phone: _____

Addiction Services Counselor/Agency: _____ Phone: _____

Probation/Parole Officer: _____ Phone: _____

Residential Agency: _____Phone: _____

Primary Care Provider: _____ Phone: _____

Other: _____Phone: _____

INPATIENT MENTAL HEALTH ADMISSIONS:
(include facility name and dates**)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please note: ICM and ACT referrals are based on the above information.

OUTPATIENT MENTAL HEALTH HISTORY:
(include facility name and dates**)**

_____

_____

_____

_____

_____

_____

HISTORY OF ASSISTED OUTPATIENT TREATMENT (AOT)?

■ No

□ Yes □ County: _____

SUBSTANCE ABUSE HISTORY

Substance	Frequency of Use	Date of Last Use	Drug of Choice	Do Not Know
Alcohol				
Marijuana				
Synthetic marijuana				
Cocaine				
Opiates				
Benzodiazepines				
Hallucinogens				
Methadone				
Suboxone				
Other:				

INPATIENT SUBSTANCE USE ADMISSIONS:
(include facility name and dates**)**

_____

_____

_____

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_____

_____

_____

OUTPATIENT SUBSTANCE USE HISTORY:
(include facility name and dates**)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FORENSIC HISTORY (please mark as applicable):

☐ History of criminal behavior?

☐ Pending charges? If yes, please explain: _____

☐ History of sexual offence? If yes, what level? _____ If so, what dates? _____

☐ History of arson? If yes, what dates? _____

☐ History of violent felony? If yes, what dates? _____

☐ Other forensic history? If yes, please explain:

_____

_____

_____

DANGEROUSNESS TO SELF/OTHERS/PROPERTY:
(if yes, please give most recent date & explain**)**

☐ Sexual assault (victim): _____

☐ Sexual assault (perpetrator): _____

☐ Physical assault (victim): _____

☐ Physical assault (perpetrator): _____

☐ Suicidal ideation: _____

☐ Suicide attempt: _____

_____

☐ Self-abusiveness: _____

☐ Homicidal ideation: _____

☐ Homicidal ideation (attempt): _____

☐ Homicidal ideation (success): _____

☐ Property damage: _____

REQUIRED ELIGIBILITY

IMPORTANT: All ASPOAA referrals MUST have an attached psychiatric evaluation, mental health assessment, or other documentation indicating the individual meets the criteria for a **primary** mental illness diagnosis, signed by a Psychiatrist, Medical Doctor, Nurse Practitioner, LMSW, LCSW, LMHC, or LMFT dated within the last 12 months.

In order to be considered an adult with a serious mental illness (SMI), the following requirements must be met:

☐ The individual is 18+ years old

☐ The individual has a primary DSM-5 diagnosis of a severe mental illness other than alcohol/substance use disorders, developmental disabilities, dementias, or mental disorders due to a general medical condition.

Primary diagnosis: _____ **ICD-10 Code:** _____
Secondary diagnosis: _____ **ICD-10 Code:** _____
_____ **ICD-10 Code:** _____
_____ **ICD-10 Code:** _____

AND

☐ The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

OR

☐ The individual must have documentation that 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:

- ☐ Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing health care or complying with medical advice).
- ☐ Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
- ☐ Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
- ☐ Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete errors in tasks, or require assistance in the completion of tasks).

OR

☐ Reliance on Psychiatric Treatment, Rehabilitation and Supports

A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

CERTIFICATION:

I certify that this individual, _____, who is eighteen years or older, is functionally disabled due to mental health needs, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the eligibility requirements.

_____ _____
Print Name of Person Completing Form **Title**

_____ _____
Signature of Person Completing Form **Date**

REASON FOR REFERRAL (to be completed by referent):

- Individual's current symptoms:

- Baseline functioning:

- Desired Outcome:

- Required level of supervision:

- Functional limitations (such as cooking, cleaning, hygiene):

- Interactions with others:

- Adherence to mental health treatment:

- Overall strengths:

- Overall weaknesses:

- Other information:

RESIDENTIAL SERVICES

Please note, it is not required to choose both a residential and case management agency to refer.

☐ **Catholic Charities – Community Residence (CR):**

A community residence is an OMH certified program in a 24-hour supervised residential setting, designed for individuals in need of training and experience in the activities of daily living. The Community Residence Program provides a comfortable, furnished environment with access to support on-site services. There are specialized houses such as MICA, MI/MR, and Geriatric. Residents are expected to participate in daily activities to maintain the residence, like cleaning, shopping, cooking, etc. They are also expected to engage in activities outside of the residence. Individuals must be able to ambulate and complete stairs independently, be able to complete a self-preservation test in less than 3 minutes, and be able to administer medications independently (with the supervision of staff). Individuals usually share a room and are expected to transition out within approximately 2 years. (315) 724-2158 x7013

☐ **Utica Rescue Mission – The Enriched Living Center (ELC):**

The Enriched Living Center is an OMH licensed, 52 single room residential facility that provides 24-hour staff supervision, 7 days a week. The goal of the ELC is to assist and empower individuals to live as independently as possible in a stable, community-based supportive housing environment. Services include medication supervision and management, transportation to appointments, representative payee services, coordination of health services, and support and monitoring with activities of daily living. The ELC offers cafeteria-style dining and meals are included in the program fee. Residents should be willing to engage in mental health treatment and are expected to participate in activities that promote psychiatric rehabilitation and community integration. Residents should be independent with daily living skills; able to walk up and down stairs; and able to complete a self-preservation test in less than 3 minutes. The average length of stay is 4 years. (315) 735-1645 x2120.

☐ **Mohawk Valley Psychiatric Center – State Operated Community Residences (SOCR) and Transitional Living Center (TLC):**

There are two, 12-bed each, State Operated Community Residences (SOCR) located in Whitesboro, NY and Yorkville, NY. The Transitional Living Center (TLC) is a 10-bed residence and is located in Utica, NY on the MVPC grounds. Programs include 24-hour, 7 days a week staff supervision. MVPC functions on a person-centered approach to engage individuals during their recovery from mental illness in the development of skills necessary for successful reintegration into the community. Individuals typically share a room. The anticipated length of stay within these programs are three to nine months. TLC (315) 738-2669, Whitesboro Community Residence (315) 736-8575, and Yorkville Community Residence (315) 768-4710. **Please note: referral priority is given to individuals being discharged from a state psychiatric facility.**

☐ **Catholic Charities – Pathways to Independent Living (APT):**

Pathways to Independent Living is an OMH certified program that provides services to clients in an apartment setting. Counselors are available Monday-Friday to meet with clients and support them with basic skills such as tracking appointments, coordinating transportation, cleaning, and grocery shopping. Individuals in the program will be seen at a minimum of once a week. During their stay, clients are encouraged and supported in their efforts to become part of the greater community. Individuals must be able to ambulate and complete stairs independently, to complete a self-preservation test in less than 3 minutes, and able to administer medications independently. Some apartments are double occupancy and individual are expected to transition out within approximately 2 years. (315) 724-2158 x7013

Catholic Charities – Supported Housing Apartments:

Supported Housing offers rental stipends, start-up resources (as the budget allows), and a minimum of 1 visit each month to discuss housing. Individuals need to be self-sufficient and have the ability to live independently. (315) 724-2158 x7018.

☐ **Supported Housing (SH):** Must be homeless or living in a transitional setting

☐ **Long-Term Supported Housing (LTSH):** Must have a 6-month continuous stay in an OMH psychiatric center, OMH residential program, or state correctional facility.

☐ **Medicaid Re-Design Team (MRT):** Must be a high utilizer or Medicaid services, Health Homes eligible (to include discharges from Article 28 or 31 hospitals and/or adult nursing homes).

☐ **Transformation Supported Housing (TSH):** Must meet one of the following (being discharged from a state psychiatric center or residential program; being discharged from an Article 28 or 31 hospital; high user of Medicaid and referred by Health Home; verified 4+ ER visits or admissions over 12 months; admission to a CR greater than 2 years; admission to apartment program greater than 3 years, or currently homeless/living in a shelter).

☐ **DePaul Single-Site Supported Housing: Please specify Utica or Rome _____**

A Single-Site Supportive Housing Program, is a non-licensed New York State Office of Mental Health program that provides long-term or permanent housing where residents can access the support services they require to live successfully in the community. Each unit is fully furnished and include start-up items such as linens, dishes, silverware, and pots and pans. Heat, air conditioning, hot water and electric are included in the rent. Rent for tenants is thirty percent of one's income or the Department of Human Services (DHS) shelter rate. The security deposit is paid by DePaul. On-site services are available, such as Housing Specialists to teach skills and assist tenants in linking to community services. There is a limited number of Hearing and Visually Accessible (HVA) units. Units located in both Rome and Utica. (855) 348-4452.

CARE COORDINATION SERVICES

☐ **Health Home Care Management (HHCM)**

Health Home Care Management is a system of care coordination. Care Managers provide a single point of contact for clients and their families for all mental, healthcare and social service needs. Clients are seen a minimum of once per month or as needed. Care Managers can assist with medical needs, appointments, and support, as well as identifying goals to improve health and wellbeing. Unlimited Capacity. Client must have Medicaid or be Medicaid eligible although services are also available for those without Medicaid (Medicare, Commercial).

☐ **Intensive Case Management (ICM) Adult Services**

Services are targeted to individuals with a primary diagnosis of SMI and high service/support needs. Services include assertive outreach and support to coordinate and monitor treatment, advocacy and linkages to community based and other natural support systems and work toward the goal of reducing reliance on emergency and inpatient services. **Consider HHCM (see above) if there is no prior case management history.** Case load size is typically 1:12 but can be 1:15. ICM serves Health Home Plus members and are seen between 2-4 times per month. Frequency of visits are reduced as the individual transitions towards stepping down to Health Home Care Management. ICM also provides services to individuals who are court ordered (pursuant to MHL 9.60) to participate in Assisted Outpatient Treatment. **Please note: eligibility requirements include 3 inpatient stays within the last 24 months, or are considered 1S, 1SV or 2S designee by a correctional facility.**

☐ **Assertive Community Treatment Team (ACT)**

ACT is a mobile, clinical mental health treatment team which includes a prescriber, mental health professionals, an administrative assistant and a team leader. The team's mission is to provide short-term (1-2 years) treatment, rehabilitation, and intensive supports to people in the community to help them re-connect to traditional clinic services. Program capacity is 65 and the staff to client ratio is 1:10. ACT also provides services to individuals who are court ordered (pursuant to MHL 9.60) to participate in Assisted Outpatient Treatment. **Please note: eligibility requirements include 2 inpatient stays within the last 12 months or a single 60-day stay.**

INDIVIDUAL STATEMENT:

Please mark the following that you need assistance with or that you wish to improve *(mark all that apply)*:

- ☐ Advocacy
- ☐ Assertiveness/saying "no"
- ☐ Social skills
- ☐ Compliance with medication
- ☐ Compliance with treatment (mental health, substance abuse, medical)
- ☐ Job skills
- ☐ Hygiene
- ☐ Cooking/Cleaning
- ☐ Money management/budgeting
- ☐ Communication
- ☐ Transportation skills
- ☐ Compliance with medical recommendations
- ☐ Access to community resources
- ☐ Parenting issues/skills
- ☐ Other: _____

This section is for the use of the individual who is being referred for services. They can provide any information relevant to the services he/she is requesting, including special needs or preferences.

_____

_____

_____

_____

_____

_____

_____

This statement is completed by: □ Individual □ Family Member □ Advocate

Individual being referred

Print name: _____

Signature: _____ Date: _____

Referent:

Print name: _____

Signature: _____ Date: _____

Authorization for the Use and/or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), the Oneida County Department of Mental Health may not use or disclose your protected health information (PHI) except as provided in our Notice of Privacy Practices without your prior authorization. Your signature on this form indicates you give Oneida County Department of Mental Health permission to use and/or disclose your PHI identified below with authorized individual(s) and/or agency. Disclosure of PHI can be written, electronic, or verbal. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

SUBJECT OF PROTECTED HEALTH INFORMATION (CLIENT)

Name _____ Date of Birth _____ Telephone _____

Address _____ City _____ State _____ Zip _____

RECIPIENT OF PROTECTED HEALTH INFORMATION

Oneida County Department of Mental Health
120 Airline Street, Suite 200
Oriskany, NY 13424

INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

Name of Individual / Agency _____ Telephone _____

Address _____ City _____ State _____ Zip _____

☐ **Two Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

DOCUMENTS AUTHORIZED FOR USE / DISCLOSURE *(Please Check All That Apply):*

☐ A-SPOA/A Referral	☐ Core History	☐ Admission / Intake information
☐ Psychiatric Evaluations	☐ Housing History	☐ Discharge Summary
☐ Psychological Evaluations	☐ Hospitalization History	☐ Case Management History
☐ Mental Status Exams	☐ Forensic History	☐ Case Management Service Plans
☐ Risk Assessment Forms	☐ Treatment History	☐ Current Svc Plan / IEP
☐ Medical History	☐ Most Recent Medical Exam	☐ Educational Reports
☐ AOT History	☐ Current Medications	☐ Medication History
☐ Recommendations	☐ Recommendations	☐ Other (please specify):

PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION *(Check all that apply):*

☐ Expedite access to care	☐ A-SPOA/A Referral
☐ Coordinate care	☐ Establish Program Eligibility
☐ Referral for mental health services	☐ Cross System Case Conference
☐ AOT coordination of services	☐ Other _____

Authorization:

I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties who are also subject to the requirements of federal law to protect this information. I understand that this authorization will automatically expire:

- ☐ One Year from the date of this form
- ☐ This is a One-time release
- ☐ 30 days after discharge from this sequence of treatment**.**

_____ _____
Signature of Client **Date**

_____ _____ _____
Signature of person legally authorized to consent to disclosure **Title or Relationship to Client** **Date**

_____ _____
Witness **Date**

Revocation Section:

I understand that I may revoke this authorization at any time by signing the revocation section and returning it to Oneida County Department of Mental Health. I further understand that any such revocation does not apply to the extent that persons authorized to use/disclose my health information have already acted in reliance on this authorization.

I hereby revoke this authorization

_____ _____ _____ _____
Signature Date Witness Date