Community Referral Application

Serving: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida and St. Lawrence Counties

Oneida County Department of Mental Health
Application for Care Management

Identifying Information

Last Name: **First Name**:	**Date of Birth**: ____/____/____	☐ Male ☐ Female
Address:	**Medicaid CIN#**:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	**Social Security #:**	
Cell Phone:		
Indicate any current health care providers (clinic, therapist, psychiatrist):		
Indicate any need for language/interpretation services; specify language spoken if other than English:		

I participated in the completion of this form and agree to participate in services:

______________________________ ______________________________________

Individual (Print Name) **Signature** **Date**

______________________________ ______________________________________

Witness (Print Name) **Signature** **Date**

Eligibility Category Information – Must meet Category A to be eligible for mental health care management services through ASPOAA. Check any others that apply:

Check		Category	Specify Diagnosis; Provide Available Detail
	A	**Serious Mental Illness**	
	B	HIV/AIDS and the risk of developing another chronic condition	
	C	Mental Health Condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (specify)	

Risk Factors – Check All That Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
	Lack of or inadequate connectivity with healthcare system.	
	Non-adherence to treatments or medication(s) or difficulty managing medications.	
	Recent release from incarceration.	
	Recent release from psychiatric hospitalization. (List hospitals and dates within last 2 years)	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues.	
	History of violent behavior.	

Narrative

Please specify the individual's needs and how you would like the program to help them.
Supporting documentation of Mental Health Diagnosis must be attached.

Contact Information for Person Completing Referral

Name:	**Title:**
Organization:	
Phone:	**Email:**

MAIL, FAX OR EMAIL TO:
Carole Flinn, ASPOAA Coordinator
120 Airline Street, Suite 200
Oriskany, NY 13424
FAX: 315-768-3670 PHONE: 315-768-3663
cflinn@ocgov.net

IMPORTANT: All Health Home Care Management referrals must be accompanied by separate documentation of Serious Mental Illness, dated within a year of the application and signed by an MD, LMSW, LCSW, Psychologist, PA, RN, LPN, NPP, LMHC, LMFT or LCAT.