

Referral Form: Case Management and Residential Services

Required: A Mental Health Assessment - Completed by a Mental Health Professional
(As defined by § 587.4 of the State of New York Official Compilation of Codes, Rules & Regulations)

Date of Referral _____	Referring Person _____
Relationship _____	Agency _____
Referent Contact Info	Phone _____ Fax _____ Email _____

BASIC CONTACT INFORMATION: For Individual Being Referred

Last Name _____	First Name _____	AKA _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F	DOB _____	Phone _____
SSN _____	Medicaid Number _____	Medicare Number _____

Address/Living Situation

Outpatient Address _____	City/State _____	Zip _____
Individual is Inpatient	<input type="checkbox"/> St. E's <input type="checkbox"/> St. Luke's <input type="checkbox"/> MVPC <input type="checkbox"/> Other _____	

Living Status:

Living Arrangements:

Length of Time in This Living Status:

Less than one month 1-3 months 3-6 months 6-12 months One year or more Unknown

DIAGNOSIS (enter code and description)

Axis I _____	_____	_____	_____
Axis II _____	_____	_____	_____
Axis III _____	_____	_____	_____
Axis IV _____	_____	Axis V (present 0-100 GAF) _____	_____

NOTICE

THE INFORMATION CONTAINED HEREIN CONSTITUTES
CONFIDENTIAL HEALTH DATA PROTECTED BY NEW YORK STATE
AND FEDERAL PRIVACY STATUTES

IF YOU RECEIVE THIS INFORMATION IN ERROR, IMMEDIATELY
CONTACT THE ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH
TO ARRANGE FOR FORWARDING

UNAUTHORIZED VIEWING OF PROTECTED HEALTH INFORMATION IS
PROSECUTABLE UNDER STATE AND FEDERAL STATUTES

SEND TO:

Oneida County Department of Mental Health
235 Elizabeth Street, 3rd Fl.
Utica, New York 13501

Email: adultspoa@ocgov.net
Phone: (315) 798-5439
Fax: (315) 798-6445
Attn: Adult SPOA/A Coordinator

For OCDMH Use Only						
<input type="checkbox"/> OUTREACH	<input type="checkbox"/> AOT INVESTIGATION	RISK LEVEL				
<input type="checkbox"/> OFA	<input type="checkbox"/> AOT SERVICE ENHANCEMENT	1	2	3	4	5
<input type="checkbox"/> FORENSIC	<input type="checkbox"/> AOT COURT ORDER					
<input type="checkbox"/> DRUG COURT	<input type="checkbox"/> AOT STEP-DOWN	OCDMH Review _____				
Date Referral Rec'd: _____	MHA _____	Core History _____	ROI/AU _____			
Request for Missing Information: 1 st Attempt _____		2 nd Attempt _____	3 rd Attempt _____	Date Distributed _____		

RESIDENTIAL SERVICES

(CR) Community Residence- CR, MICA, MI/MR, Low Demand	(315) 735-7541 x260
(SOCR) State-Operated Community Residence <i>(Generally restricted to those discharged from MVPC)</i>	(Whitesboro) (315) 736-8575 (Yorkville) (315) 768-4710
(APT) Pathways Apartment Program	(315) 735-7541 x240
(ESRO) Enriched Single Room Occupancy	(315) 735-1645 x120
(FC) Family Care <i>(Occasionally available through MVPC)</i>	(315) 738-6194

First Residential Choice _____

Second Residential Choice _____

*Referent is responsible for recommending appropriate level of care. Interviews will be held and determinations made in order of stated preference.

CASE MANAGEMENT/CARE COORDINATION SERVICES

These programs are targeted to individuals with diagnosable mental health needs, which are severe and marked by an impairment that seriously interferes with the ability to function independently, appropriately and effectively.

(SCM) Supportive Case Management (272-2700)

Individuals with primary diagnosis of SMI, seen a minimum of 2 times per month, case manager caseload is 1:20. Individuals have functional impairments in planning, organizing, personal care, safety, and/or economic self-sufficiency. Services include Outreach & Support, Coordinate and Monitor Treatment.

(CCM) Clinic Case Management / for Individuals connected to an MVPC clinic (738-2645)

Individuals with primary diagnosis of SMI, seen a minimum of 2 times per month, case manager caseload is 1:20. Individuals have functional impairments in planning, organizing, personal care, safety, and/or economic self-sufficiency. Outreach & Support, Coordination and Treatment Monitoring are provided.

(ICM) Intensive Case Management (738-4446)

Individuals with primary diagnosis of SMI, seen a minimum of 4 times per month, case manager caseload is 1:12. Individuals have high service/support needs. Services include assertive outreach & support to coordinate & monitor treatment, reducing reliance on emergency/inpatient service. **If individuals have not had less-intensive services through (SCM/CCM), they will be considered for that program prior to consideration for ICM.**

(DRN) Dual Recovery Network (737-9012)

Individuals must be age 18 or older, be homeless, or at a significant risk of homelessness. Have, or be scheduled for an evaluation for a diagnosis of both mental illness and alcohol or substance use. Individuals are seen as often as necessary.

(ACT) Assertive Community Treatment (738-4056)

Self-contained Clinical Treatment team, which consists of a psychiatrist and a variety of mental health professionals who deliver mental health treatment, rehabilitation, self-help & and intensive supports to individuals in the community. Assertive outreach at least 1 and up to 7 days week for individuals unable to succeed with traditional clinic and case management models, who have high service needs, multiple or long-term inpatient admissions, a primary diagnosis of SMI, & who desire to live independently. Staff ratio is 1:9, but all staff serve all individuals enrolled rather than carry a discrete caseload. **If individuals have not had other less-intensive services (SCM/CCM, ICM), they will be considered for those programs prior to consideration for ACT.**

First Program Choice _____

Second Program Choice _____

🌀 Please see brochures or contact the providers for details about their programs. 🌀

SERVICES ONLY

(SO) Services Only (OCDMH 798-5439): This category is for individuals who are self-sufficient/do not require a case manager, but who wish to access the following services: Legal Aid Transportation Social Recreation

REASON FOR REFERRAL

[It is **Mandatory** to complete the following - Please Write Legibly]

☞ Please specify the areas in which the individual is experiencing functional limitations and explain the individual's needs. Areas of functional limitation include: Self-care, Social Functioning, Activities of Daily Living, Economic Self sufficiency, Self Direction, Concentration, and Employment. ☞

Specify How You Would Like the Program to Help the Individual

Current Symptoms Prompting Referral

Most Recent Use of Acute Services

CURRENT TREATMENT TEAM:

Case Manager	_____	Phone	_____
Psychiatrist	_____	Phone	_____
Primary Therapist	_____	Agency	_____ Phone _____
Primary Care Provider	_____	Phone	_____
Addiction Services	_____	Phone	_____
Probation/Parole Officer	_____	Phone	_____
Residential	_____	Phone	_____
Support Groups	_____	Other	_____

Individual Has:	Mental Health Advanced Directive	YES	NO	Unknown
	Health Care Proxy	YES	NO	Unknown

(If you answered YES to the above questions, please attach a copy to this referral)

CURRENT MEDICAL CONDITIONS		
SPECIFY CONDITION	PROVIDER	PRESCRIBED MEDICATIONS
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

LIST MEDICATIONS

CAPABILITY TO SELF-ADMINISTER CURRENT MEDICATIONS (select one)

Independently
 With Supervision
 With assistance
 Unable
 Refuses

LIST SIGNIFICANT ALLERGIES

DEMOGRAPHICS		
Race/Ethnicity (may check two)	Primary Language	Does individual speak/understand English?
<input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Hispanic (White) <input type="checkbox"/> Black <input type="checkbox"/> Native American-Alaska <input type="checkbox"/> Hispanic (Non-White) <input type="checkbox"/> Asian <input type="checkbox"/> India (Hindu) <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Bosnian <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> Limited <input type="checkbox"/> Very Limited <input type="checkbox"/> No Individual is Fully Acculturated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Religious Affiliation		
<input type="checkbox"/> Christian <input type="checkbox"/> Catholic <input type="checkbox"/> Baptist <input type="checkbox"/> Church of Christ <input type="checkbox"/> Jehovah's Witness	<input type="checkbox"/> Lutheran <input type="checkbox"/> Methodist <input type="checkbox"/> Presbyterian <input type="checkbox"/> Latter Day Saints <input type="checkbox"/> Hinduism	<input type="checkbox"/> Islamic/Muslim <input type="checkbox"/> Judaism <input type="checkbox"/> Buddhism <input type="checkbox"/> None <input type="checkbox"/> Other _____

FUNCTIONAL/MEDICAL/ADL PROBLEMS					
Functional Medical Problems	Cognitive Impairment				
<input type="checkbox"/> Special Dietary Needs <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Require Special Medical Equipment	<input type="checkbox"/> Impaired Ability to Walk <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Other _____	<input type="checkbox"/> Developmental Disability/LD <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other _____			
Community Survival Skills	Independent:	YES	NO	UNKNOWN	Please describe how individual gets to appointments
Can Bathe / Dress Self		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hygiene / Grooming		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating / Cooking		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can access emergency services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can recognize/avoid common dangers (traffic, fire, weather)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At risk of falling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At risk of wandering		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

DANGEROUS TO SELF, OTHERS, PROPERTY		
	Most Recent Date	Explanation/Notes
<input type="checkbox"/> Sexual Assault - Victim	_____	_____
<input type="checkbox"/> Sexual Assault - Perpetrator	_____	_____
<input type="checkbox"/> Physical Assault - Victim	_____	_____
<input type="checkbox"/> Physical Assault - Perpetrator	_____	_____
<input type="checkbox"/> Substance Abuse - Alcohol	_____	_____
<input type="checkbox"/> Substance Abuse - Drugs	_____	_____
<input type="checkbox"/> Homicidal Ideation - Attempt	_____	_____
<input type="checkbox"/> Homicidal Ideation - Success	_____	_____
<input type="checkbox"/> Suicidal Ideation - Attempt	_____	_____
<input type="checkbox"/> Suicidal Ideation - Success	_____	_____
<input type="checkbox"/> Arson	_____	_____
<input type="checkbox"/> Self Injury	_____	_____
<input type="checkbox"/> Property Damage	_____	_____
<input type="checkbox"/> Frequent Crisis	_____	_____

RESIDENTIAL HISTORY / STABILITY		
Previous Residence (address/ city/ state)	Type (Independent Living, Boarding Home)	Reason Moved
_____	_____	_____
_____	_____	_____
Factors to be considered in finding placement (geographic location, first floor only etc): _____		
Marital Status		
<input type="checkbox"/> Single – never married <input type="checkbox"/> Single – living as married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		

FINANCIAL: Benefits / Entitlements / Financial Status		
Income Sources (specify source and amount)		
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Food Stamps _____	<input type="checkbox"/> Employment / Wages _____
<input type="checkbox"/> SSDI _____	<input type="checkbox"/> TANF _____	<input type="checkbox"/> Family / Spouse _____
<input type="checkbox"/> Public Assistance _____	<input type="checkbox"/> Safety Net _____	<input type="checkbox"/> None _____
<input type="checkbox"/> Pension _____	<input type="checkbox"/> Support _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Veteran's Benefits _____		
Representative Payee Information <input type="checkbox"/> Self <input type="checkbox"/> Other (If other, fill out info below)		
Name _____	Relation _____	
Address _____	Phone _____	
Describe individual's money management skills: _____ _____		

HEALTH INSURANCE STATUS			
Insurance Type	Policy ID #	Insurance Type	Policy ID #
<input type="checkbox"/> Medicaid enrolled	_____	<input type="checkbox"/> Medicare	_____
<input type="checkbox"/> Medicaid application filed	_____	<input type="checkbox"/> Private Health Insurance	_____
<input type="checkbox"/> PMHP enrolled	_____	<input type="checkbox"/> Not Insured	_____
<input type="checkbox"/> Veteran's Insurance	_____		

VOCATIONAL / EDUCATIONAL

Highest level of school completed _____

Currently in school? Yes No School name _____

School address _____ City/State _____ Phone _____

Currently employed? Yes No Employer name _____

Employer address _____ City/State _____ Phone _____

Currently volunteering? Yes No

Current vocational or employment services? Yes No (If yes, please describe)

VETERAN STATUS

Is individual a veteran? Yes No If yes, status: _____

INCARCERATION / LEGAL

Does individual have a history of criminal activity or any legal charges pending? If yes, please explain.

ADDICTION

Substance	Age First Used	Frequency of Use	Date Last Use	Drug of Choice	Do Not Know

Inpatient Treatment History

Addiction Treatment Center	Dates	Type/Completed

Outpatient Treatment History

Addiction Treatment Center	Dates	Type/Completed

RISK ASSESSMENT

~ Mandatory ~

Individual's Name _____ Date of Assessment _____

Referent/Person Completing Assessment _____ Relationship to Individual _____

- | | | |
|--|---|---|
| <p>1 Danger to SELF</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> | <p>2 Danger to OTHERS</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> | <p>3 Destruction of PROPERTY</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> |
| <p>4 Inpatient Psychiatric Stays</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> | <p>5 Contact with Law Enforcement</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> | <p>6 Incarcerations</p> <p>0 Never
1 Unknown
2 Once in past 2 years
3 2 or more times in past 2 years
4 Other Low Risk
5 Other High Risk</p> |
| <p>7 Impact of Mental Health on Risk</p> <p>0 None
1 Unknown
2 Mild
3 Severe
4 Other Low Risk
5 Other High Risk</p> | <p>8 Impact of Trauma on Risk</p> <p>0 None
1 Unknown
2 Mild
3 Severe
4 Other Low Risk
5 Other High Risk</p> | <p>9 Impact of Phys Condition on Risk</p> <p>0 None
1 Unknown
2 Mild
3 Severe
4 Other Low Risk
5 Other High Risk</p> |
| <p>10 Impact of Addiction on Risk</p> <p>0 None
1 Unknown
2 Mild
3 Severe
4 Other Low Risk
5 Other High Risk</p> | <p>11 Residential</p> <p>0 Needs Met
1 Unknown
2 Some Needs
3 Homeless
4 Other Low Risk
5 Other High Risk</p> | <p>12 Treatment Utilization</p> <p>0 Consistent
1 Unknown
2 Sporadic
3 Resistant
4 Other Low Risk
5 Other High Risk</p> |
| <p>13 ADL Functioning</p> <p>0 Functions Independently
1 Unknown
2 Needs Occasional Help
3 Needs Frequent Help
4 Other Low Risk
5 Other High Risk</p> | <p>14 Literacy (English)</p> <p>0 Can Read and Write
1 Unknown
2 Has Minimal Skills
3 Can Not Read/Write
4 Other Low Risk
5 Other High Risk</p> | <p>15 Vocational</p> <p>0 Employed
1 Unknown
2 Unemployed more than 1 yr
3 Unemployed less than 1 yr
4 Other Low Risk
5 Other High Risk</p> |
| <p>16 Transportation</p> <p>0 Independent
1 Unknown
2 Needs Occasional Help
3 Needs Frequent Help
4 Other Low Risk
5 Other High Risk</p> | <p>17 Income</p> <p>0 Sufficient Income
1 Unknown
2 Insufficient Income
3 No Income
4 Other Low Risk
5 Other High Risk</p> | <p>18 Management of Finances</p> <p>0 Manages Independently
1 Unknown
2 Needs Occasional Help
3 Needs Frequent Help
4 Other Low Risk
5 Other High Risk</p> |
| <p>19 Personal Coping Skills</p> <p>0 Adequate Coping Skills
1 Unknown
2 Minimal Coping Skills
3 No Coping Skills
4 Other Low Risk
5 Other High Risk</p> | <p>20 Supports</p> <p>0 Adequate Supports
1 Unknown
2 Minimal Supports
3 No Supports
4 Other Low Risk
5 Other High Risk</p> | |

For OCDMH Use

1	2	3	4	5	6	7	8	9	10	
11	12	13	14	15	16	17	18	19	20	

INDIVIDUAL'S STATEMENT

This section is provided to the individual who is being referred for services. The individual can provide any information relevant to the services s/he is requesting, including special needs and preferences.

Large empty rectangular box with horizontal lines for writing.

THIS STATEMENT COMPLETED BY:		Individual	Family Member	Advocate
I participated in completing this form.		I agree with the assessment.		
Individual would not participate.		I do not agree with the assessment.		
Referral completed without the individual present.				
_____	_____	_____	_____	_____
Individual – Print Name	Signature			Date
_____	_____	_____	_____	_____
Witness – Print Name	Signature			Date

ADULT SINGLE POINT OF ACCESS/ACCOUNTABILITY – INDIVIDUAL’S SELF-ASSESSMENT

This section is to be completed by the individual who is being referred for services.

Please circle the answer that explains how often you think or feel the following ways:

1. I FEEL HOPELESS

Always Most of the time Sometimes Rarely Never

2. I HAVE SOMEONE TO TALK TO

Always Most of the time Sometimes Rarely Never

3. I FEEL UNDERSTOOD

Always Most of the time Sometimes Rarely Never

4. I FEEL ALONE

Always Most of the time Sometimes Rarely Never

5. I FEEL LIKE LIFE IS NOT FAIR

Always Most of the time Sometimes Rarely Never

6. I THINK PEOPLE DESERVE TO PAY FOR WHAT I AM GOING THROUGH

Always Most of the time Sometimes Rarely Never

7. I THINK I DESERVE TO LIVE

Always Most of the time Sometimes Rarely Never

8. I BELIEVE I AM A GOOD PERSON

Always Most of the time Sometimes Rarely Never

9. I THINK KILLING MYSELF IS THE ONLY WAY TO END MY PAIN AND SUFFERING

Always Most of the time Sometimes Rarely Never

10. I FEEL VIOLENT

Always Most of the time Sometimes Rarely Never

11. I FEEL LIKE HURTING MYSELF

Always Most of the time Sometimes Rarely Never

12. I FEEL HELPLESS

Always Most of the time Sometimes Rarely Never

13. I DON'T CARE ABOUT ANYTHING

Always Most of the time Sometimes Rarely Never

14. I BELIEVE I HAVE THE RIGHT TO BE HAPPY

Always Most of the time Sometimes Rarely Never

15. I BELIEVE I HAVE THE ABILITY TO CHANGE MY LIFE

Always Most of the time Sometimes Rarely Never

THOUGHTS / COMMENTS:

Signature of Individual

Print Name

Date

For OCDMH Use

1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	