OFFICE OF COMMUNITY SERVICES **REVISED 1/20**
FOR WARREN AND WASHINGTON COUNTIES
230 Maple Street, Suite 1, Glens Falls, NY 12801
Telephone: (518) 792-7143
FAX: (518) 792-7166

SINGLE POINT OF ACCESS REFERRAL PACKET
Services for Adults with a Serious Mental Health Condition

This referral packet is to be used to refer people for the following mental health services: housing, case management, East Side Center psychosocial club, and the Assertive Community Treatment Team. It can also be used to refer someone to the Dual Recovery Program.

Eligibility criteria
In order to be eligible for mental health housing, case management, East Side Center psychosocial club, and the Assertive Community Treatment Team, a person must meet the criteria for a serious and persistent mental illness, which are:

1. Diagnosed Mental Illness
The individual is 18 or older and currently has a mental illness diagnosis. Diagnoses of Alcohol or Substance Use Disorder, Organic Brain Syndrome, and Developmental Disabilities are excluded.

AND

2a. Extended Impairment in Functioning Due To Mental Illness
The individual has experienced functional limitations in at least two of the following areas over the past year: self-care, activities of daily living, maintaining social functioning, basic day-today tasks.

OR

2b. SSI or SSDI Due To Mental Illness

Check the service(s) you are referring the individual to:

☐**Psychiatric Rehabilitation Residential Programs**

☐**Community Residence (Group Home)**
Offers a group home environment with a high level of support, including 24/7 staffing, for people in the earliest stages of recovery. The overall goal is to provide short-term, focused skill development in a home-like setting. Skill development can include but is not limited to: managing symptoms through medication and therapy, improving daily living skills, pursuing educational, vocational, and employment goals, solving transportation needs, and increasing one's comfort with broader social interaction.

or

☐**Community Living Apartment Programs:**

☐**Maple Street Apartments *or* ☐Satellite Apartments**
The Community Living Apartment Programs are a less intensive level of treatment housing than Community Residence. Staff meet with recipients from one to seven days each week to provide direct services and supportive counseling. Maple Street Apartments is a single-site apartment building with nine units and 24-hour staffing. Residents maintain separate addresses and telephone numbers, and take responsibility for the upkeep of their living space. Satellite Apartments are individual apartments throughout the community. Staff provides services through regular visits and an on-call system is utilized in case of an emergency.

To make a referral to one of the Psychiatric Rehabilitation Residential Programs, please complete/submit all of the following:

- Consent for Release of Information
- Functional Assessment Survey
- Authorization for Restorative Services
- Referral Form
- Additional required documentation:
    1. Psychiatric/psychosocial evaluation completed within the past year*
    2. Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year
    3. Physical exam and negative T.B. test

*If there is an evaluation but it is older than one year, it can be submitted along with a recent progress note or treatment plan.

☐**Independent Living (Supportive Housing)**

Helps people find quality, permanent, independent housing. People are assisted in locating and moving into a new home by finding an apartment, evaluating a lease, selecting furniture, etc., all while receiving financial assistance throughout the process based on the individual's needs. After having settled into a new home, clients regularly work with the staff to maintain stable living in the community.

To make this referral, please complete/submit all of the following:

- Consent for Release of Information
- Functional Assessment Survey
- Referral Form
- Additional required documentation:
    1. Psychiatric/psychosocial evaluation completed within the past year*
    2. Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year

*If there is an evaluation but it is older than one year, it can be submitted along with a recent progress note or treatment plan.

☐**Case Management**

Links people to services specific to their needs, providing coordination of services, personalized for each individual's health and social needs. This includes linkage to behavioral health, medical care, and community resources, as well as advocacy to address any barriers to recovery.

To make this referral, please complete/submit all of the following:

- Consent for Release of Information
- Functional Assessment Survey
- Referral Form
- Additional required documentation:
    1. Psychiatric/psychosocial evaluation completed within the past year*
    2. Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year

*If there is an evaluation but it is older than one year, it can be submitted along with a recent progress note or treatment plan.

☐**Assertive Community Treatment**

An intensive and highly integrated team approach for community mental health service delivery serving people whose symptoms of mental illness lead to serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness.

To make this referral, please complete/submit all of the following:

- Consent for Release of Information
- Functional Assessment Survey
- Referral Form
- Additional required documentation:
    1. Psychiatric/psychosocial evaluation completed within the past year*
    2. Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year

*If there is an evaluation but it is older than one year, it can be submitted along with a recent progress note or treatment plan.

☐I have explained the ACT Team services to the person being referred and s/he is interested in receiving the service.

☐I have discussed this referral with all current mental health providers, including case manager, and they are in agreement with services being transferred to the ACT Team.

The person I am referring has continuous high service needs demonstrated by one or more of the following:

☐ Inability to participate or succeed in traditional, office-based services or case management.

☐ High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).

☐ High use of psychiatric emergency or crisis services.

☐ Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).

☐ Co-existing substance abuse disorder (duration greater than 6 months).

☐ Current high risk or recent history of criminal justice involvement.

☐ On an Assisted Outpatient Treatment order

☐ Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.

☐ Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.

☐ Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.

☐East Side Center

A psychiatric rehabilitation program which supports personal growth and wellness through social, recreational, creative, learning, volunteerism, employment, and community participation opportunities.

To make this referral, please complete/submit all of the following:

- Consent for Release of Information
- Functional Assessment Survey
- Referral Form
- Additional required documentation:

1. Psychiatric/psychosocial evaluation completed within the past year*
2. Admission note and/or discharge summary if there has been an inpatient mental health admission within the past year
3. Physical exam and negative T.B. test

*If there is an evaluation but it is older than one year, it can be submitted along with a recent progress note or treatment plan.

☐**Dual Recovery Program**

Support for those who are in recovery from mental health and substance use conditions. Services include:
- Support meetings: every Monday, Wednesday, and Friday 4:00 PM – 5:00 PM
- Social night: select Fridays each month, 4:00 PM – 6:00 PM
- Open Access/Walk-In hours: every first and third Tuesday of the month, 200 PM – 4:00 PM

Individuals need not have a diagnosis or serious mental health condition to participate in this program.

To make this referral, please complete/submit the following:
- Consent for Release of Information
- Referral Form

I AM UNABLE TO ACCEPT INCOMPLETE REFERRALS.

Please be sure that you have completely filled out and included all required forms and supporting documentation.

SINGLE POINT OF ACCESS
CONSENT FOR RELEASE OF INFORMATION

Name: _____ DOB: _____

The Single Point of Access Committee (SPOA) is comprised of representatives of community agencies including, but not limited to, the Office of Community Services for Warren and Washington Counties, the Warren-Washington Association for Mental Health, Glens Falls Hospital, Capital District Psychiatric Center, Liberty House Foundation, PEOPLe USA, Northern Rivers, Transitional Services Association, Adirondack Health Institute, Citizen Advocates, and the Departments of Social Services for Warren and Washington Counties. In order to determine the most appropriate level of service based on strengths, needs, and program openings, I give my permission for members of the SPOA Committee to exchange information amongst each other, and to exchange information with the following Person, Organization, Facility or Program:

Name and Title of Person/Organization/Facility/Program releasing information: _____

_____

Address of Person/Organization/Facility/Program: _____

Phone and Fax Number of Person/Organization/Facility/Program: Phone:_____ Fax: _____

The extent or nature of information to be disclosed includes:

☐ Clinical summaries (i.e. psychiatric evaluations) ☐ Treatment plans and treatment plan reviews
☐ Admission and/or discharge summaries ☐ Notes of psychiatric or other clinic visits
☐ Medication records and laboratory results ☐ Other: _____

I understand that the above information is protected by Mental Hygiene Law 33.13 governing confidentiality of clinical records and/or by Federal Regulation 42 CFR governing confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in law or regulations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on my consent. Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The duration of this authorization is one year, unless I specify a date, event or condition upon which it will expire sooner. The date, even or condition upon which consent will expire sooner than noted above is: _____.

The following is a brief description of what I would find most helpful for myself:

_____

_____

_____

_____ _____

Applicant (Print Name) Date Witness (Print Name) Date

_____ _____

Applicant Signature Date Witness Signature Date

SINGLE POINT OF ACCESS
SYMPTOMS AND FUNCTIONING SURVEY

Information is based upon (*check all that apply*):

☐ Direct observation
☐ Client's own report
☐ Other *(please specify)*: _____

Please use the following scale for Parts I and II:

1 = no problem 2 = minor problem 3 = moderate problem 4 = severe problem

I. PSYCHIATRIC SYMTOMS

IN THE LAST YEAR HAS THIS PERSON EXHIBITED:	1	2	3	4
Preoccupation with physical health or fear of physical illness	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Emotional withdrawal	☐	☐	☐	☐
Odd, disorganized, or confused thinking	☐	☐	☐	☐
Restlessness or hyperactivity	☐	☐	☐	☐
Unusual mannerisms or postures	☐	☐	☐	☐
Hostility	☐	☐	☐	☐
Suspiciousness	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Reduction in normal intensity of feelings	☐	☐	☐	☐
Heightened emotional tone, agitation, and/or increased reactivity	☐	☐	☐	☐
Confusion	☐	☐	☐	☐
Guardedness	☐	☐	☐	☐

II. BEHAVIOR

WITHIN THE LAST YEAR, DID THIS PERSON:				
React poorly to criticism, stress, or frustration	☐	☐	☐	☐
Respect limits set by others	☐	☐	☐	☐

	1	2	3	4
Threaten physical violence to others	☐	☐	☐	☐
Damage property to others	☐	☐	☐	☐
Damage own property	☐	☐	☐	☐
Require one to one supervision	☐	☐	☐	☐
Miss or arrive late for appointments	☐	☐	☐	☐
Wander or run away	☐	☐	☐	☐
Behave inappropriately in a group setting	☐	☐	☐	☐
Take or use other's property without permission	☐	☐	☐	☐
Shown inappropriate sexual behavior	☐	☐	☐	☐
Threaten harm to self	☐	☐	☐	☐
Do harm to self	☐	☐	☐	☐

Please use the following scale for Parts III and IV, circling appropriate number:

1 = independently 2 = reminders/assistance 3 = requires 1:1 supervision 4 = can't or will not

III. DAILY LIVING SKILLS

DOES THIS PERSON:	1	2	3	4
Shop for personal necessities	☐	☐	☐	☐
Manage personal money	☐	☐	☐	☐
Use social service agencies appropriately	☐	☐	☐	☐
Use social supports/community resources	☐	☐	☐	☐
Devote proper time to tasks	☐	☐	☐	☐
Engage in individual leisure activities	☐	☐	☐	☐
Dress appropriately	☐	☐	☐	☐
Do own laundry	☐	☐	☐	☐
Take medication as prescribed	☐	☐	☐	☐
Keep clinic or other appointments	☐	☐	☐	☐

	1	2	3	4
Use money correctly for purchases	☐	☐	☐	☐
Perform home maintenance/cleaning	☐	☐	☐	☐
Maintain an adequate diet	☐	☐	☐	☐
Use public transportation	☐	☐	☐	☐
Maintain adequate personal hygiene	☐	☐	☐	☐
Use telephone correctly	☐	☐	☐	☐
Smoke in a safe manner	☐	☐	☐	☐
Wake up promptly	☐	☐	☐	☐
Attend a day program	☐	☐	☐	☐
Demonstrate basic cooking skills	☐	☐	☐	☐

IV. PROBLEM SOLVING AND INTERPERSONAL SKILLS

1 =can do independently 2 = needs reminders/assistance 3 = requires one-on-one supervision 4 = can't or won't

DOES THIS PERSON:	1	2	3	4
Apologize when appropriate	☐	☐	☐	☐
Respect personal space of others	☐	☐	☐	☐
Act assertively when appropriate	☐	☐	☐	☐
Listen and understand	☐	☐	☐	☐
Resolve conflicts appropriately	☐	☐	☐	☐
Exercise good judgment	☐	☐	☐	☐
Plan in cooperation with others	☐	☐	☐	☐
Treat own minor physical problems	☐	☐	☐	☐
Obtain help for physical problems	☐	☐	☐	☐
Follow through on advice of doctor	☐	☐	☐	☐
Socialize with others	☐	☐	☐	☐
Take initiative or seek assistance with problems	☐	☐	☐	☐

SINGLE POINT OF ACCESS
AUTHORIZATION FOR RESTORATIVE SERVICES IN REHABILITATION HOUSING PROGRAMS

Client's name: _____

Client's Medicaid number: _____
(if client is applying for Medicaid, please indicate by writing "PENDING")

Please indicate what type of authorization this is:

☐ Initial Authorization **(Must be completed by a PHYSICIAN only and requires a face-to-face meeting between the authorizing Physician and the Client.)**

For initial authorization only: Date of required face-to-face meeting between the authorizing physician and the client: _____

☐ Re-Authorization **(May be completed by a PHYSICIAN, PHYSICIAN'S ASSISTANT, OR PSYCHIATRIC NURSE PRACTITIONER)**

I, the undersigned, have determined that the above-named person would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR, which include:

* Assertiveness/self-advocacy
* Community integration
* Skill development
* Socialization
* Daily living skills
* Medication management
* Rehabilitation counseling
*Symptom management

This authorization is for the following type of Mental Health Service within the noted time frame (please check the type of residential service for which the client is seeking admission and document the Effective Date and End Date of this authorization within the noted parameters):

☐ Community Residence
Effective Date: _____
End Date: _____ (no more than six months from Effective Date)

☐ Apartment Program:
Effective Date: _____
End Date: _____ (no more than one year from Effective Date)

Name (*please print*): _____

License number: _____ National Provider Identifier: _____

Signature: _____ Date: _____

SINGLE POINT OF ACCESS
REFERRAL FORM

Name of person being referred: _____ Date of Birth: _____

Age: _____ Gender: ☐Female ☐Male ☐Transgender

Address: _____ Phone number: _____

Insurance: ☐Managed Medicaid ☐Straight Medicaid Medicaid CIN #: _____
☐Medicare ☐Commercial Insurance ☐None

Income: ☐ Supplemental Security Income (SSI) ☐ Social Security Disability (SSD) ☐ Temporary Assistance
☐ None ☐ Other *Please list:* _____

Diagnosis: _____

Psychiatrist/Psychiatric Nurse Practitioner: ☐None *or* Name: _____
Phone number: _____

Therapist: Name: ☐None *or* Name: _____ Phone number: _____

Psychiatric hospitalization(s): ☐History ☐Current *Explain*: _____
_____ *or* ☐None

Substance Abuse: ☐History ☐Current *Explain*: _____
_____ *or* ☐None

Legal Involvement: ☐History ☐Current *Explain*: _____
_____ *or* ☐None

Current living arrangements: _____

Other providers involved: _____

Reason for referral: _____

Person making referral: _____ Agency: _____

Phone number: _____ Fax number: _____

Date of referral: _____

Please send completed referral packet and supporting documentation to:

Single Point of Access Coordinator, Office of Community Services
Fax: (518) 792-7166 Mail: 230 Maple Street, Glens Falls, NY 12801

If you have questions, please call the Single Point of Access Coordinator at (518) 792-7143.