

Single Point of Entry

Rich Shaw, SPOE Coordinator
201 E. Green St, Ithaca, NY 14850
607-274-6215 | Fax: 607-274-6316
rshaw@tompkins-co.org

Tammy Hulburt, Casework Assistant
201 E. Green St, Ithaca, NY 14850
607-274-6286 | Fax: 607-274-6316
thulburt@tompkins-co.org

The following documents need to be completed in order to present this application to the SPOE Committee:

- Signed, dated, and witnessed Release of Information
- Completed and signed SMI form
- Clinical information supporting the SMI criteria
- Identified source of income

ACT Referral

- Prior Authorization from Managed Medicaid

———— **Incomplete applications will be returned for completion** ————

For internal use only:

- This application has been reviewed and is complete
- This application has been reviewed and is missing the following required items:

Referral for:

- Housing
 - Community Residence
 - Horizon Apartment Program
- ACT (Assertive Community Treatment)
- Supported Housing
- SRO (Single Room Occupancy)

Referral Source			
Contact Person:		Date of Referral:	
Agency:		Phone:	

Client Identification			
Client Name:		DOB:	
Ethnicity:		Marital Status:	Gender:
Address:			
Telephone:		SS#:	
Medicaid #:		NYS ID# (OMH):	
Emergency Contact:		Relationship to Client:	
		Telephone:	

Type of Current Residence			
<input type="checkbox"/> Room	<input type="checkbox"/> Family Home	<input type="checkbox"/> Community Residence:	
<input type="checkbox"/> Adult Home	<input type="checkbox"/> Own Apartment	<input type="checkbox"/> Shelter:	
<input type="checkbox"/> Family Care	<input type="checkbox"/> None	<input type="checkbox"/> Other (Specify):	

Insurance and Financial Information	
<input type="checkbox"/> Public Assistance (includes Medicaid) <input type="checkbox"/> Medicaid (without Public Assistance) <input type="checkbox"/> If a Spend Down, enter amount: \$ _____ <input type="checkbox"/> Medicaid Managed Care (company name: _____) <input type="checkbox"/> Medicaid Denied (reason: _____) <input type="checkbox"/> Medicaid Dependent on Hospitalization <input type="checkbox"/> Private Third Party; Name of Insurer: _____	<input type="checkbox"/> Medicare#: _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> Earned Income <input type="checkbox"/> SSI <input type="checkbox"/> Social Security /SSD <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Other

Social Support Resources			
Household Composition:			
Last Name	First Name	Relationship	Age
Client is a dependent: <input type="checkbox"/> yes <input type="checkbox"/> no	Client has dependents: <input type="checkbox"/> yes <input type="checkbox"/> no	Client has rep. payee: <input type="checkbox"/> yes <input type="checkbox"/> no Name: _____	
Significant Relationships:			
Name	Relationship	Supportive / Problematic	Telephone

Community Supports: (Probation Officer, Clergy, Attorney, Mental Health Providers, Care Management, etc.)			
Organization / Person	Type of Service / Relationship	Contact Person (if organization)	Telephone

Medical Information				
Primary Care Physician				
Name	Address	Phone number		
Pharmacy				
Name	Address	Phone number		
Medical dx/problems		Allergies		
Current Medications:				
Medication:	Prescribed For:	Dose/Frequency:	Date Started:	Prescribed By:
What level of support does the applicant require to achieve medication compliance?	<input type="checkbox"/> Dispensing	<input type="checkbox"/> None (Independent)		
	<input type="checkbox"/> Supervision	<input type="checkbox"/> Refuses / Non-Compliant		
	<input type="checkbox"/> Reminders	<input type="checkbox"/> Not Applicable		

Mental Health and Substance Use Treatment Information	
Psychiatrist	Therapist:
DSM-5 Diagnoses	
Developmental Disability	
General Medical Condition	
Psychosocial and Environmental Problems	
GAF	

Mental Health and Substance Use Treatment History			
Inpatient - Where:	When:	Outpatient - Where:	When:

Behavioral Characteristics					
	Current	History		Current	History
Cruelty to animals			Legal/Criminal Involvement		
Delusions/Paranoia			Obsessive Compulsive Behavior		
Depressed/Manic Moods			Panic/Agoraphobia		
Hallucinations			Property Destruction		
Disruptive/Bizarre Behavior			Substance Use		
Eating Disorder			Suicidal Ideation/Attempts		
Fire Setting/Arson			Thought Disorder		
Homicidal Ideation/Attempts			Trauma/Abuse/Assault Victim		
Interpersonal Difficulties			Traumatic Brain Injury		
Development Disability/Cognitive Impairment			Threatening/Assaultive Behavior		

Functional Strengths/Deficits Assessment					
Physical Functioning (Self Care)					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Vision					
Hearing					
Speech Impairment					
Walking, use of legs					
Use of hands and arms					
Comments:					

Personal Care (Self Care)					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Toileting					
Eating					
Personal hygiene					
Dressing self					
Grooming					
Care of own possessions					
Care of own living space					
Comments:					

Social Interaction					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Accepts contact with others					
Initiates contact with others					
Communicates effectively					
Engages in activities without prompting					
Participates in groups					
Forms and maintains friendships					
Asks for help when needed					
Comments:					

Social Functioning					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Verbally abuses others					
Physically abuses others					
Destroys property					
Physically abuses self					
Is tearful, crying, clinging					
Takes property from others without permission					
Performs repetitive behaviors					
Comments:					

Community Living Skills					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Household responsibilities					
Shopping					
Handling personal finance					
Use of telephone					
Use of public transportation					
Use of leisure time					
Medication					
Use of medical and other community services					
Basic reading, writing and arithmetic					
Is able to sustain work effort					
Appears at appointments on time					
Follows verbal instructions accurately					
Completes assigned tasks					
Traveling from residence without getting lost					
Recognizing and avoiding common dangers					
Comments:					

Narrative

(Include/attach information that would be helpful to this application, reasons for referral, any legal issues, current living situation, A.O.T. status, family court, child support, etc.)

Criteria For Serious Mental Illness

To be considered an adult diagnosed with Serious Mental Illness, A must be met. In addition, B, C, or D must be met. **(please check all that apply):**

A. Designated Mental Illness Diagnosis (the individual is 18 years of age or older and currently meets the criteria for a DSM psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions).

AND ONE OF THE FOLLOWING

B. The individual is currently enrolled in SSI or SSDI – due to a designated mental illness.

OR

C. Extended impairment in functioning due to mental illness (the individual must meet I or II below):

I. The individual has experienced at least two of these functional limitations due to a designated mental illness over the past twelve 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, 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 in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance to complete tasks).

II. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to designated mental illness over the past twelve months on a continuous or intermittent basis.

OR

D. Reliance on Psychiatric Treatment, Rehabilitations, and Supports
Documented history shows that the individual at some prior time. Met with threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medications 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 which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of the underlying mental disorder.

Name of person completing this form

Title

Signature

Date

Multiple Party Release Form

Tompkins County SPOE Assessment Team

Client Name: _____ Date of Birth: _____

PURPOSE OF THE RELEASE:

To Complete and Process Referral for Adult Mental Health Housing & Case Management Services in Tompkins County

I, _____, do hereby consent and authorize information to be obtained from and/or released to the Tompkins County SPOE Assessment Team that includes:

- | | |
|---|---|
| Cayuga Medical Center | Southern Tier Care Coordination |
| Elmira Psychiatric Center/Family Care | Tompkins County Department of Social Services |
| Lakeview Health Services, Inc. | Tompkins County Mental Health Services |
| Mental Health Association of Tompkins County | Unity House |
| Mid Lakes Assertive Community Treatment - ACT | |

The following information pertaining to myself:

- | | |
|----------------------|--|
| Drug/Alcohol History | Mental Health Housing Referral Package |
| Financial Status | Psychiatric Assessment |
| Medical Records | Psychosocial History |

This release will expire: one year from date of signing

_____ Signature of Client	_____ Date	_____ Signature of Parent/Guardian	_____ Date
------------------------------	---------------	---------------------------------------	---------------

_____ Signature of Witness	_____ Date	_____ Relationship to Client
-------------------------------	---------------	---------------------------------

- | |
|---|
| <input type="checkbox"/> Copy of Release Given to Client
<input type="checkbox"/> Client Refused Copy of Release |
|---|

This information has been disclosed to you from confidential records protected by Federal and State confidentiality laws (42 CFR Part 2, NYS MHL 33.13, NYPH Article 27-F). These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of Federal or State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.