

ONONDAGA COUNTY SINGLE PORTAL OF ACCESS FOR CASE MANAGEMENT AND MENTAL HEALTH RESIDENTIAL SERVICES REFERRAL FORM - ADULT

FOR HOUSING/ RESIDENTIALAPPLICATIONS, SEND DIRECTLY TO THE HOUSING PROVIDER (S)
FOR **HIGH-NEED APPLICANTS**, SEND COPY TO: SPOA and RESIDENTIAL COORDINATOR, FAX 472-0084

FOR CASE MANAGEMENT/ ASSERTIVE COMMUNITY TREATMENT APPLICATIONS (pp.1-5), SEND DIRECTLY TO:
ATTN: SPOA SPECIALIST • ONONDAGA CASE MANAGEMENT SERVICES, INC.
220 HERALD PLACE, 3rd FLOOR • SYRACUSE, NEW YORK 13202
PHONE (315) 472-7363 • FAX (315) 472-0084

Name of Person being referred: _____ Phone #: _____
Address: _____
Emergency Contact: _____ Phone #: _____
Emergency Contact address: _____

REFERRAL SOURCE

- Self, family, or friend
- State Psychiatric Center (inpt.)
- Certified or general psych inpt.
- Mental Health Residential
- Mental Health Outpatient
- Emergency nonresidential program
- CSP mental health program
- Local MH practitioner
- General hospital ER
- AOT Coordinator
- MR/DD facility
- Substance abuse program
- Other Medical Provider
- Family Court
- Jail, penitentiary etc.
- Probation
- Parole
- Police
- Shelter for homeless
- Other: _____

Referring Agency: _____ Address _____
Referring Person: _____ Phone _____

DEMOGRAPHICS: DOB: ___/___/___ Age: _____ Gender: _____ Soc. Sec.#: _____-____-_____

Race/Ethnicity

- White (non-Hispanic)
- African-American (non-Hispanic)
- Spanish, Hispanic, Latino
- Asian, Asian American
- American Indian, Alaskan Native
- Pacific Islander
- Other, Specify: _____

Employment

- No Employment
- Competitive empl. W/no formal supports
- Competitive empl. W/ongoing supports
- Community-integrated empl. (State or local)
- Sheltered empl.-non integrated workshop
- Sporadic or casual empl. For pay (odd jobs)
- Non-paid work experience (volunteer)
- Other: _____

Current Living Situation

- Private Residence alone
- Private Res. w/ spouse or domestic partner
- Private Res. w/ parent, child, or other family
- MH Supported Housing (housing or SRO)
- MH Supported Program (Congregated)
- MH Apartment Treatment Program
- MH Congregate Treatment Program
- MH Crisis Residence
- Inpatient, state psychiatric center
- DOH Adult Home
- Drug or Alcohol abuse residence or inpt.
- Correctional facility
- Nursing Home or other medical facility
- Homeless shelter or emergency housing
- Homeless street, parks drop in center, other
- Other: _____

Primary Language: _____

Average # of hours per week
Of employment or volunteering

English Proficiency

- Does not speak English
- Poor
- Fair
- Good
- Excellent

Marital Status

- Single, never married
- Currently married
- Cohabiting w/ signif. Other/Domestic Partner
- Divorced/Separated

Education Level

- No formal education
- Grammar school K-9
- Junior high school (grades 7-9)
- High School (grades 10-12 or GED)
- Business, vocational, or technical training
- Some college, but no degree
- Associates Degree
- Bachelors Degree
- Graduate Degree
- Unknown
- Other: _____ read & write? _____

Veteran Status

- Yes
- No
- 100% service connected

Custody of Children

- No Children
- Have Children all >18 yrs old
- Minor Children currently in client's custody
- Minor Children not in client's custody but have access
- Minor Children not in client's custody – no access
- Unknown

ENTITLEMENTS AND INCOME:

Benefits or Insurance	Now Receives	Amount	Benefits or Insurance	Now Receives	Amount
Social Security Retirement	<input type="checkbox"/>		Wages/earned income	<input type="checkbox"/>	
SSI	<input type="checkbox"/>		Worker's Comp	<input type="checkbox"/>	
SSD	<input type="checkbox"/>		Unemployment	<input type="checkbox"/>	
Public Assistance	<input type="checkbox"/>		Private insurance/third party payor	<input type="checkbox"/>	
Veterans	<input type="checkbox"/>		Trust fund	<input type="checkbox"/>	
Medicare	<input type="checkbox"/>		Medication Grant	<input type="checkbox"/>	
Medicaid	<input type="checkbox"/>		Section 8	<input type="checkbox"/>	
Food Stamps	<input type="checkbox"/>		Railroad Retirement	<input type="checkbox"/>	
Pension	<input type="checkbox"/>		Other	<input type="checkbox"/>	

Medicaid number _____ Effective date: _____

If Medicaid is pending, specify application date: _____

Representative payee? Name: _____ Phone: _____

Agency _____ Address: _____

CLINICAL INFORMATION:

Primary Treatment Agency/ Program _____

Therapist: _____ Phone# _____

Psychiatrist: _____ Phone# _____

If no current services: Specify Last Treatment Program: _____
Specify Date of Last service: _____

Age of onset of illness: _____

Diagnoses: Axis I: _____ Code# _____
Secondary Axis I: _____ Code# _____
Axis II: _____ Code# _____
Axis III: _____ Code# _____
Axis IV: _____ Code# _____
Axis V: _____ Code# _____

List all Medications: _____

CURRENT SERVICES

	Currently receives	Received during last 12 months
State Psychiatric Center inpatient unit	<input type="checkbox"/>	<input type="checkbox"/>
General hospital psychiatric unit or certified psychiatric hospital	<input type="checkbox"/>	<input type="checkbox"/>
Mental health housing and housing support	<input type="checkbox"/>	<input type="checkbox"/>
MH outpatient: clinic, continuing day treatment, partial hospital, IPRT	<input type="checkbox"/>	<input type="checkbox"/>
CSP nonresidential mental health program (eg, clubhouse, vocational svcs.)	<input type="checkbox"/>	<input type="checkbox"/>
ACT, ICM, SCM, or other Case Management	<input type="checkbox"/>	<input type="checkbox"/>
Emergency mental health (nonresidential)	<input type="checkbox"/>	<input type="checkbox"/>
Prison, jail, or court mental health services	<input type="checkbox"/>	<input type="checkbox"/>
Local MH practitioner	<input type="checkbox"/>	<input type="checkbox"/>
Assisted outpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>
Self help/peer support services	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse inpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse outpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

CLINICAL INFORMATION: (continued)

NUMBER OF ER VISITS FOR PSYCHIATRIC REASONS IN THE LAST 12 MONTHS: _____ IN LAST 6 MONTHS: _____

NUMBER OF PSYCHIATRIC HOSPITALIZATIONS IN THE LAST 12 MONTHS: _____ IN LAST 6 MONTHS: _____

List any psychiatric hospitalizations during the last 24 MONTHS:

Date	Hospital	Length of Stay
1.		
2.		
3.		

CO-OCCURRING DISORDERS: (select all that apply)

- Cognitive Impairment
- Mental Retardation or Developmental Disorder
- Drug or Alcohol Abuse
- Impaired ability to walk
- Hearing Impairment
- Blindness
- Speech Impairment
- Other medical problem/condition: _____
(Ex. Diabetes, Incontinence)

Cognitive Disorder:

- Developmental Disability Yes No specify IQ _____
- Traumatic Brain Injury Yes No specify _____
- Learning Disability Yes No specify _____

SUBSTANCE USE

Drugs of Choice:

- None
- Crack
- Cocaine
- Prescription drugs
- Other: _____
- Any IV Drug Use
- Heroin/Opiates
- Sedative/Hypnotic
- Amphetamines
- Alcohol
- PCP
- Benzodiazapines
- Inhalant: Sniffing glue, other household product
- Marijuana/Cannabis
- Hallucinogens

Frequency of Use*:

- Not in the last 6 months
- Not in the last 3 months
- Not in the last month
- 1 or more in the last month
- 1 or more in the last week
- Daily
- *Age at Onset of Use _____
- *Longest Period of Sobriety _____

Substance Abuse Treatment	Current/ Past	Number of treatment episodes	Agency/Facility
Inpatient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No			

AREAS OF SPECIAL CONCERN:

	Yes	No	Date of most recent episode
History of Homelessness _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Victim of Physical/ Sexual Abuse _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current Domestic Violence in home _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic self-harm/ self-mutilation _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of Suicidal Ideation _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of Suicide Attempts / Self Harm _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Method used in most recent suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Elaborate on other serious attempts</i> _____			
Arson _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physically abusive and/or assaultive of another _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually assaultive behavior _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

AREAS OF SPECIAL CONCERN (continued)

- Destruction of Property _____ _____
- Current Access to Firearms _____ _____
- Criminal Justice Involvement _____ _____

Describe current Criminal Justice status:

- Recipient is not a criminal justice recipient
- Under arrest, in jail, lockup, or court detention
- In NYS Dept. of Correctional Services (state prison)
- Released from jail/prison in the last 30 days
- Other: _____
- Under Probation Supervision
- Under Parole Supervision
- CPL 330.20
- On bail, released on own recognizance (ROR) or conditional discharge
- Unknown whether or not recipient has a criminal justice record

NUMBER OF ARRESTS IN THE LAST 6 MONTHS: _____

NUMBER OF INCARCERATIONS IN THE LAST 6 MONTHS: _____

PLEASE ELABORATE ON ANY SPECIAL CONCERNS:

COMMUNITY SURVIVAL SKILLS: (circle specific areas of major concern)

ADL's (eating, hygiene, grooming, dressing, toileting)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

Personal Safety (crossing streets, not getting lost, keeping oneself out of violent or threatening situations, smoking safety if applicable)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

Community Living (using public transportation, cooking, cleaning, shopping, social skills)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

Economic Self-Sufficiency (obtain and retain entitlements, budgeting money, finding housing, vocational skills)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

Use/engagement with mental health services (taking medications, making appointments, adherence to regimen/programs)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

Use/engagement in medical services (annual physical, taking medications, making appointments, adherence to special diets, etc.)

- Independent – requires no assistance
- Can do with help
- Requires significant assistance

STRENGTHS/SUPPORTS:

Please list this individual's skills and strengths _____

Leisure Time Activities _____

Natural Supports _____

Family Involvement _____

Support Groups/Peer Programs _____

LAST PAGE FOR CASE MANAGEMENT/ASSERTIVE COMMUNITY TREATMENT REFERRALS
(This section is required in order to be considered for services)

REASON FOR REFERRAL:

Recovery goals that the individual wants CM or ACT to assist with: _____

Please describe this person's ability to: 1) Set realistic goals and 2) Follow through on agreed upon plan _____

Has person received case management services in the past? Yes No

Please indicate date, agency, case manager: _____

Is individual aware of this referral? Yes No

Is individual interested in case management /ACT services? Yes No

Referrals from inpatient units: Anticipated discharge date: ____/____/____

SERVICE DESIRED (PLEASE CHECK ONE):

_____ **Assertive Community Treatment (ACT)**

-Self-contained clinical treatment team including psychiatrist, psychiatric nurses, and other specialists. Individual is seen multiple times per week in community. Individuals with serious Axis I psychiatric disorders, history of treatment non-compliance, and co-occurring substance disorders are prioritized. Usually, if individual has not had Intensive Case Management services in the past, an attempt is made to engage individual within the ICM program before the person is considered for ACT services.

_____ **Intensive Case Management (ICM)**

-Case manager uses outreach to engage individuals who are at risk in the community. Case manager provides linkage and coordination of multiple services, crisis prevention and intervention. Individual is seen a minimum of 4X per month, case manager caseload is 1:12. Individual must have serious psychiatric disorder. Individuals who are homeless, frequent users of emergency services, and/or hospitalized for more than 90 days are prioritized.

_____ **Supportive Case Management (SCM)**

-Case manager coordinates and monitors community services. Individual is seen a minimum of 2X per month, case manager caseload is 1:20. Individual must have serious psychiatric disorder. In addition, person must have functional impairments in planning, organizing, personal care and safety, and/or economic self-sufficiency.

_____ **Forensic Case Management (FICM)**

- Person must be currently transitioning out of Onondaga County Correctional facilities
- Person must also have serious psychiatric disorder

_____ **Homeless Case Management (HCM)**

- Person must be living on streets, in shelter, or have 72-hour eviction notice in hand
- Psychiatric diagnosis is NOT required for this program

ADD THIS PAGE FOR HOUSING/RESIDENTIAL REFERRALS

REASON FOR REFERRAL:

Recovery goals that the person wants residential services to assist with: _____

Please describe this person's ability to: 1) Set realistic goals, and 2) Follow through on agreed upon plan _____

Is individual aware of this referral? Yes No

Is individual interested in residential services? Yes No

HOUSING/ RESIDENTIAL SERVICE DESIRED, see Residential description & contacts

- | | |
|--|--|
| <input type="checkbox"/> Supervised Community Residence (Congregate Treatment) | <input type="checkbox"/> Family Care |
| <input type="checkbox"/> Supervised Community Residence Apartments | <input type="checkbox"/> Supported Housing |
| <input type="checkbox"/> Treatment Apartment Programs | <input type="checkbox"/> Young Adult Program |
| <input type="checkbox"/> Enriched Services Single Room Occupancy (SRO) | <input type="checkbox"/> Rooming House |
| <input type="checkbox"/> Adult Residence/Adult Care Facility | <input type="checkbox"/> Apartment |

PLEASE INDICATE AGENCY (S) DESIRED; send application directly to them*

- Hutchings Psychiatric Center (State Operated Community Residences, Family Care)
- Transitional Living Services (Community Residences, Supervised Community Apts, Treatment Apts, Supported Independent Housing)
- St. Joseph's Hospital Residential Services (Supervised Community Residences, Treatment Apartments)
- Central New York Services (MICA Supervised Community Residence and Treatment Apartments, Supported Housing Apartments)
- Central New York Services SRO (Enriched Services Single Room Occupancy Program)
- Loretto Community Residences, Inc. (Geriatric Supervised Community Residences)
- Lincoln Elms I and II Adult Residences
- Rescue Mission – Crossroads Adult Home
- Kalet's Adult Residence
- Salvation Army Women's Shelter Supported Housing Program
- Salvation Army State Street Apartments (Young Adult Supported Housing)

Additional Documentation Required For Residential Referral (Office of Mental Health-licensed programs):

- Psychosocial/CORE history, clinical summary
- Authorization for Restorative Services of Community residence programs (Medicaid billing)
- Physical and PPD/Mantoux within 90 days
- Consent for Release of Information forms for all agencies selected and for any confidential information sent with application

Additional Documentation Required For Adult Home/Adult Residence (Dept of Health-licensed programs) Kalet's, Lincoln Elms, Crossroads:

- DSS 3122 Medical Evaluation, PPD/Mantoux
- Psychosocial/Core History
- Mental Health Evaluation on approved form
- Consent for Release of Information forms for all agencies selected and for any confidential information sent with application

*See description of Residential Services and listing of Residential Service contacts.

FAX COPIES OF HIGH NEED and PRIORITY HOUSING APPLICATIONS, with OCM Consent form to: SPOA AND RESIDENTIAL COORDINATOR, Jan Moag, phone 472-7363, fax 472-0084. Check below if access issues are anticipated.

Send original of application to Housing Providers directly. (Coordinator does not forward or re-release applications.)

SPOA and Residential Coordinator alert: questions about access