

Referral Information

Onondaga County

SPOA - ADULT

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Name: _____
(Last) (First) (MI)*Single Point of Access Application (for Adults)*

PLEASE COMPLETE ENTIRE FORM. PLEASE ATTACH A COPY OF A RECENT PSYCHOSOCIAL EXAM, ANY AVAILABLE ASSESSMENTS OR MENTAL STATUS EXAM, AND THE INDIVIDUAL'S CONSENT FORM.

1 - REFERRAL INFORMATION			
Referral is for:	<input type="checkbox"/> Care Coordination <input type="checkbox"/> Residential <input type="checkbox"/> Independent Housing <input type="checkbox"/> Other: _____		
Date of Referral:		Applicant Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant Name:		Applicant DOB:	
Applicant SSN:			
Applicant Street Address:			
(City, State, Zip)			
Applicant Phone Number:			
Applicant Cell Number:			
Applicant Email Address:			
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Branch: _____	
Service Connected Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Connected _____ %	
Alternate Contact, Address and/or Phone # for Client:		Emergency Contact Name, Address & Phone #:	
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referring person contact information:			
<input type="checkbox"/> Provider <input type="checkbox"/> Non-Provider			
Name: _____			
Agency: _____			
Address: _____			
Phone: _____ Fax: _____			
Email Address: _____			
Primary Referral Organization Affiliation			
Please select one of the following:			
<input type="checkbox"/> Self, Family, Friend	<input type="checkbox"/> State Psychiatric Ctr (inpt)	<input type="checkbox"/> Social Services	
<input type="checkbox"/> Mental Health Outpatient	<input type="checkbox"/> General Hospital ER	<input type="checkbox"/> Family Court	
<input type="checkbox"/> Local MH Practitioner	<input type="checkbox"/> General Hospital (inpt)	<input type="checkbox"/> Criminal Court	
<input type="checkbox"/> Mental Health Residential	<input type="checkbox"/> Substance Use Program	<input type="checkbox"/> Probation/parole	
<input type="checkbox"/> CSP Mental Health Program	<input type="checkbox"/> Other Medical Provider	<input type="checkbox"/> Jail	
<input type="checkbox"/> Emergency Non-residential Program	<input type="checkbox"/> MR/DD Facility	<input type="checkbox"/> Shelter for the homeless	
<input type="checkbox"/> Beacon Health Strategies/WNYCCP	<input type="checkbox"/> Other (specify): _____		

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2 - PERSONAL AND DEMOGRAPHIC INFORMATION		
Race / Ethnicity	Primary Language	English Proficiency (If primary language is not English)
<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Native <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (specify) _____ _____	<input type="checkbox"/> Does Not Speak English. <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good - Does Not Need Translator
Does this individual currently receive case management or care coordination?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		If Yes, Agency Name:
Current Marital Status		Custody Status of Children
<input type="checkbox"/> Single, never married <input type="checkbox"/> Currently married <input type="checkbox"/> Cohabiting with significant other/domestic partner <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed		<input type="checkbox"/> No children <input type="checkbox"/> Have children - all older than 18 years <input type="checkbox"/> Minor children currently in client's custody <input type="checkbox"/> Minor children not in client's custody but have access <input type="checkbox"/> Minor children not in client's custody - no access
Living Situation at Time of Referral		
<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with spouse/partner <input type="checkbox"/> Lives with parents <input type="checkbox"/> Lives with other relatives <input type="checkbox"/> Homeless - streets/parks <input type="checkbox"/> Homeless shelter/emergency housing <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Assisted /supported living (specify) _____ <input type="checkbox"/> Nursing home/medical setting (specify) _____ <input type="checkbox"/> Supervised Apartment Program (specify) _____ <input type="checkbox"/> Supervised group home (specify) _____ <input type="checkbox"/> Psychiatric hospital /Inpt Rehab (specify) _____ <input type="checkbox"/> Correctional setting (specify) _____		
Please List All Other Members of Your House Hold:		
_____ _____ _____		
Current Educational Level		Current Employment Status
<input type="checkbox"/> No formal education <input type="checkbox"/> Some grade school (1-8th grade) <input type="checkbox"/> Completed grade school <input type="checkbox"/> Some HS (9-12th grade, but no diploma) <input type="checkbox"/> HS diploma or GED <input type="checkbox"/> Vocational, business training <input type="checkbox"/> Some college, no degree <input type="checkbox"/> College degree <input type="checkbox"/> Masters degree <input type="checkbox"/> Other: _____		<input type="checkbox"/> No employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Sheltered workshop <input type="checkbox"/> Has job coach <input type="checkbox"/> VESID involvement <input type="checkbox"/> Other: _____

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3 - ENTITLEMENTS AND INCOME:

<i>Benefits or Insurance</i>	<i>Now Receives</i>	<i>Benefits or Insurance</i>	<i>Now Receives</i>
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 payer	<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"/>

Client Medicaid #: _____*Representative payee?* No Yes*Representative Payee Name:* _____*Agency:* _____*Address:* _____*Phone:* _____**4 - CLINICAL INFORMATION:**

<i>AXIS</i>	<i>DIAGNOSES</i>	<i>CODE</i>
AXIS I (MH)		
AXIS I (CD)		
AXIS II		
AXIS III		
AXIS IV		
AXIS V		

Primary Treatment Agency: _____*Therapist:* _____*Phone #:* _____*Psychiatrist:* _____*Phone #:* _____*Last Treatment Program:* _____*Date of Last Service:* _____*Age of Onset of Illness:* _____*List Medications:**Check off any of the following that apply:*

- Symptoms of mental illness interferes with taking medications as prescribed/recommended.
- Prescribed oral medications.
- Prescribed injectable medications.

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4 - CLINICAL INFORMATION CONTINUED:Number of ER Visits For Psychiatric Reasons in the Last **6 Months**: _____ in Last **12 Months**: _____Number of Psychiatric Hospitalizations in the Last **6 Months**: _____ in Last **12 Months**: _____

<i>Date</i>	<i>Hospital</i>	<i>Length of Stay</i>

Substance Use**Drugs of Choice:**

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

Physical Health/Wellness**Check off any of the following that apply:**

- | | | |
|---|---|---|
| <input type="checkbox"/> Incontinent | <input type="checkbox"/> Impaired walking | <input type="checkbox"/> Requires special medical equipment |
| <input type="checkbox"/> Hard of Hearing/Deaf | <input type="checkbox"/> Impaired Vision/Blind | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Weight Concern | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Developmental Disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Other: _____ | |

5 - ALERTS RELATED TO RISK TO SELF OR OTHERS:

	Yes	No	Date of most recent episode
History of Homelessness			
Victim of Physical/ Sexual Abuse			
Current Domestic Violence in home			
Chronic self-harm/ self-mutilation			
History of Suicidal Ideation			
History of Suicide Attempts / Self Harm			
Elaborate on other serious attempts:			
Arson			
Physically abusive and/or assaultive of another			
Sexually assaultive behavior			
Destruction of Property			
Current Access to Firearms			n/a
Criminal Justice Involvement			
AOT Order			
AOT Enhanced			

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6 – Legal:

Involved with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Treatment Court | <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Adult Protective Services |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Assisted Outpatient Treatment (AOT) | <input type="checkbox"/> Parole |
| <input type="checkbox"/> CPL | <input type="checkbox"/> Court Order or Diversion | <input type="checkbox"/> Other: _____ |

7- Reason for Referral:

Strengths:

Reason for Referral:

Current Symptoms Prompting Referral:

Desired Outcome of Care Coordination or Residential services:

For Individuals Currently on Inpatient Unit, Please Specify Discharge Plans and Discharge Date:

I am the individual requesting services and agree to the submission of this information and the review of it by the SPOA Committee for Care Coordination and / or residential services.

YES NO

OR

I completed this application for the individual requesting services and they agreed to this submission and review by the SPOA Committee.

YES NO

If you do not have SSI / SSD or DHS Temporary Case Assistance, please apply for TA immediately.

Date: _____

Applications for the Care Coordination are reviewed and prioritized by the SPOA Community Meeting which has representatives from the following agencies: Onondaga Case Management, Hutchings Psychiatric Center, St. Joseph’s Hospital Health Care, Central New York Services, Onondaga Department of Mental Health, Adult Protective, Transitional Living Services, The Salvation Army, Rescue Mission, Community General Hospital, Upstate Medical University, Brownell Center, ARISE, Loretto, Chadwick Residence, YWCA, Syracuse Behavior Health, and Crouse Hospital.

