Jefferson County
Single Point of Access (SPOA) Committee

UNIVERSAL REFERRAL FORM
FOR CARE MANAGEMENT AND RESIDENTIAL SERVICES

Name of Individual: _____ DOB: _____

Current Address: _____

I agree to be considered for one of the following adult case management and/or housing services: Care Management, Supported Housing Case Management, Transitional Living Services of Northern New York Community Residence and/or Apartment Program. I have been informed as to the nature of these services and understand that participation in any of these programs is voluntary.

I understand that with my agreement, acceptance into one of the above programs is decided by Jefferson County's Single Point of Access Committee. I understand that this committee is comprised of representatives from community agencies as well as consumer advocates. Community agencies represented include, but are not limited to: St. Lawrence Psychiatric Center, Jefferson County Community Services, Jefferson County Department of Social Services, Adult Protective, Office for the Aging, Jefferson County Probation, CHJC's Care Management, Transitional Living Services of Northern New York, Community Clinic of Jefferson County, Family Counseling Services, Samaritan Medical Center: Behavioral Health/Addiction Services/Inpatient Mental Health Unit, Credo Community Center: Behavioral Health/Addiction Services/Care Management, Watertown Vet Center, Jefferson County Veteran Administration, Mental Health Association of Jefferson County, Disabled Person's Action Organization, Jefferson Rehabilitation Center, Northern Regional Center for Independent Living, Fort Drum Behavioral Health and Exceptional Family Member Program, Carthage Behavioral Health, North Country Family Health Center, ACR Health, Planned Parenthood of the North Country, River Community Wellness.

I understand that the members of this committee are bound to maintain the highest standards of confidentiality defined by law and are not to disclose information that identifies me personally, outside of the SPOA Committee process. I understand that it is the role of the committee to oversee the use of adult case management/housing services in Jefferson County and to decide which level of service, depending upon availability and program eligibility requirements, is most appropriate for each individual based on their needs and desires. In making its decision, the committee will use and possibly discuss all information provided by the individual agency representatives regarding my circumstances. I understand that I may request that an agency which possesses my protected health information, exclude or hold private specific information from SPOA Committee consideration.

By signing this authorization, I give my permission for members of the Single Point of Access Committee to share information necessary to describe my situation, and to determine the most appropriate service or services based on my needs and desires. I understand that upon my written request, I may withdraw my permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future applications for these services. Unless my permission is withdrawn, I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Withdrawal of Request/Authorization

I voluntarily withdraw my request for case management and housing services and in doing so withdraw my authorization for the Single Point of Access Committee to continue to share information regarding my circumstances. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Referred to: (please check all that you prefer)	
Care Management	**Residential Services**
☐ **Care Management**	☐ **Transitional Living Services (Community Residence)**
☐ **Supportive Housing**	☐ **Transitional Living Services (Apartment Program)**
Eligible for Long Term Stay Funding: ☐Y ☐N	**Eligible for RCE Funding: ☐Y ☐N**
Eligible for MRT Funding: ☐Y ☐N	

Individual Being Referred			
Name:	**Sex:**	**DOB:**	**Age:**
Address:			**County:**
Phone:	**Social Security #:**		**Marital Status:**
Religion:	**Legal Status:**		**Veteran: ☐Y ☐N**
Current Living Arrangement:			

Health Insurance		
Medicare:	**Medicaid:**	**Private:**

Financial Information/sources of income **(If applied and not yet receiving a potential source of income, please describe & give date of application)**			
Monthly Income:		**Employer:**	
SSI:	**SSD:**	**PA:**	**VA:**
Alimony:	**Child Support:**	**Retirement:**	**Other:**
Existing Rep. Payee? ☐Y ☐N (Name, phone #)			

Emergency Contact		
Name:	**Relationship:**	**Phone:**
Address:		

Referred By		
Name:	**Title:**	**Agency:**
Address:		**Phone:**
		Fax:

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Psychiatric Data
Diagnosis:

Current Mental Health Services **(Include Name and Phone Number of Clinic, Primary Therapist, Psychiatrist And/or Relevant Providers)**

Other Agencies Involved With This Individual

Psychiatric Hospitalizations		
Currently Hospitalized: ☐ Y ☐ N	**Admission Date:**	**Anticipated/Actual Discharge Date:**
Where will the individual be referred upon discharge, if not already linked to outpatient mental health services?		

Psychiatric Hospitalizations within the LAST YEAR (Dates, Locations, Reasons)		
Date	**Location**	**Reason**

Current Medications (Dosage and Frequency) (Psychiatric and Medical)		
Medication Name	**Dosage**	**Frequency**

Risk Factors	**Yes**	**No**	**Comments**
Drug/Alcohol Abuse/Use	☐	☐	
Non-Compliance With Treatment	☐	☐	
AOT Referred	☐	☐	

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Risk Factors (cont)	Yes	No	Comments
Mild or Moderate Stress Creates Exacerbation of Symptoms			
Difficulty Coping with Major or Multiple Medical Problems			
Suicide Attempts			
Self-Injurious Behavior			
Trauma			
Sexual Misconduct			
Sexual Offender			Level:
Problems with Self Direction/Concentration			
Difficulty With Self Care			
Difficulty with ADL's			
Lack of Support System			
Frequent Crisis Contacts			
Parent/Child Problems			
Chronic Vocational/Economic Problems			
Property Damage			
History of Violence			
Temper Outbursts			
Incarceration			
Chronic Housing Problems			
Chronic Legal Problems			
Nighttime Agitation (Housing Only)			
Incontinence (Housing Only)			
Elopement (Housing Only)			
Smoke with Supervision (Housing Only)			

Criminal History		
Offense	**Outcome**	**Date**

Safety Concerns *Safety concerns are addressed to assure that case managers can safely go into the home*
Safety issues around this person or others in the household? Y N (Explain)
Firearms, swords, weapons in the home? Y N (Explain)
Animals in the home (dogs that are dangerous? Y N (Explain)

Medical Information (Housing Only)	Yes	No	Comments
Physical Exam (Within 1 year)			
Mantoux Test (Within 1 year)			

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Medical Information (Housing Only)	Yes	No	Comments
Cardiac/COPD Problems	☐	☐	
Diabetes	☐	☐	
Seizure Disorder (Indicate Date of Last Seizure)	☐	☐	
Allergies	☐	☐	
Special Diet	☐	☐	
Limited Ambulation	☐	☐	Able to do stairs?
Any Restriction of Activities	☐	☐	

Social Data	
Current Day/Social Programs:	
VESID:	Employment/Training Hx:
Any Previous Supervised Living (date/location):	
Family Care ☐ Y ☐ N Date:	
Gateway ☐ Y ☐ N Date:	
Northwood ☐ Y ☐ N Date:	
SRO ☐ Y ☐ N Date:	
NCTLS CR ☐ Y ☐ N Date:	
Independent Living ☐ Y ☐ N Date:	
Other	

Statement of Need **(Describe what the person sees as his/her concrete case management needs in terms of advocacy, linkage, monitoring or state the reason(s) individual needs requested level of housing.)**

Signature of Individual Making the Referral: _____ Date: _____

Signature of Individual Being Referred: _____ Date: _____

SEND OR FAX REFERRAL FORM TO:
Diane Zikowitz, SPOA Coordinator
PO Box 6550
Watertown, New York 13601
Phone: (315) 777-9716
FAX: (315) 779-1184

******TO PROCESS THIS REFERRAL WE NEED ALL INFORMATION ON FORMS TO BE COMPLETE AND ATTACHMENTS RECEIVED******

ATTACHMENTS NEEDED FOR CARE MANAGEMENT INCLUDE:

☐ Most Recent Psychiatric and Social Assessment (include an updated summary if PSA is more than 1 year old), **AND**
☐ Most Recent Discharge Summary (if hx of hospitalization)

ATTACHMENTS NEEDED FOR RESIDENTIAL SERVICES <u>INCLUDE THOSE LISTED ABOVE AND</u>:

☐ Statement of Ability to Self-Medicate (completed by Psychiatrist)
☐ Authorization for Restorative Services of Community Residences (completed by Psychiatrist)

Authorization for Restorative Services of Community Residences and Apartment Treatment

Authorization for the receipt of Restorative Services not to exceed:

☐ 6 months for Congregate Residences **(Check One Only)**

☐ 12 months for Apartment Residences **(Check One Only)**

Individual's Name:_____

Individual's Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, and having conducted a face-to-face assessment with said client as required pursuant to Part 593 of Title 14 NYCRR, have determined that _____ would benefit from the
(Individual's Name)
provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR.

_____ _____

Physician's Signature **Month/Day/Year of Signature**

_____ _____

Type or Print Physician's Name **License Number & State**

_____

NPI Number

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Statement of Ability to Self-Medicate

Resident's Name: _____ **C#: _____**

	Yes	No
Independently	☐	☐
With Supervision	☐	☐

Comments:_____

_____

_____

_____

_____

_____ _____

Physician's Signature **Date**