Yates County Single Point of Entry (SPOE)

Client's Name: _____

SPOE Checklist

1. ___Release signed by client and witness and dated
2. ___Referral is fully filled out; all areas complete with information or noted as unknown
3. ___Client is informed that SPOE coordinator will be contacting them for an appointment
4. ___Attached to the Referral Form are the following:

    ___Psychiatric Assessment
    ___Psychological Assessment
    ___History/Psychosocial Summary
    ___Treatment Plan/Treatment Plan Reviews
    ___Compliance with treatment summary
    ___Additional Referral Packets (housing)

5. ___Diagnosis codes included on Axis I and Axis II
6. ___Please check source of referral and reason for referral

March 2013

Yates County SPOE

Mail to: SPOE, Kelly Behavioral Health, 465 N. Main St., Penn Yan, NY 14527

REFERRAL TO THE SPOE COMMITTEE

(Single Point of Entry for Adults)

RELEASE OF INFORMATION

I_____,consent to the release of clinical information to SPOA. I understand that SPOA will review and evaluate the information to determine eligibility for services, which could include a variety of formal and informal community resources. See Single Point of Access Information Summary for Specific list of Team Members.

I authorize SPOA to release clinical information and make recommendations for possible enrollment in the appropriate program, i.e, ACT, Case Management Services, Housing and Community Residence, addiction services, as well as formal and informal community resources.

I hereby permit the use or disclosure of the information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 CFR (164.524).
7. Substance abuse records are protected under Federal regulations governing Confidentiality of Alcohol & Substance Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent.

____ I have been given a copy the signed release ____ I have declined a copy of the signed release

Signed: _____ Date Signed**:** _____
Applicant

Witness: _____ Date Signed: _____

I hereby revoke my authorization given above to submit my name or to provide information to the SPOE Committee so that I might be considered for involvement in SPOE for services. . I am aware that my revocation is not effective to the extent that the persons I have authorized to use and / or disclose my protected health information have acted in reliance upon this authorization.

Signed: _____ Date Signed: _____
Applicant

Witness: _____ Date Signed: _____

Adult SPOE Referral

Yates County Single Point of Entry (SPOE)
Enrollment Referral Application
REFERRAL SOURCE

Client Information

First Name:	**Middle initial**:	**Last Name**
Current Address:		**Phone:**
Date of Birth:	**Gender:** **Male** ☐ **Female** ☐	**SSN:**
Medicaid ID 1:		**Primary Language:**
Ethnicity:		
Citizen of United States ☒ **YES** ☐ **NO**		
☐ **Legal Alien** ☐ **YES** ☐ **NO** **Date of Entry** _____ **ID#** _____ **Country** _____		
County of SPOA (Fiscal) Responsibility	**County of Residence** Yates	

Current Therapist

Name:	
Agency:	Phone Number:

Other Significant Contacts-

First Names, MI, Last Name	Primary contact? ☐ Yes ☐ No	Relationship to Client
Address, City, State, zip	Home phone	County
First Names, MI, Last Name	Primary contact? ☐ Yes ☐ No	Relationship to Client
Address, City, State, zip	Home phone	County

Current Providers – Use additional sheet of paper if necessary

Agency	Contact Person	County
Address	Phone	What Service is Agency Providing?
Agency	Contact Person	County
Address	Phone	What Service is Agency Providing?
Agency	Contact Person	County
Address	Phone	What Service is Agency Providing?

AOT

Has Consumer been assessed for Assisted Outpatient Treatment ☐ YES ☐ NO

Background Information

Living situation: (Check one box only)

01☐ Private Residence Alone
02☐ Private residence with spouse or domestic partner
03☐ Private Residence with parent, child, or other family
04☐ Voluntary operated MH Housing Supported Program
05☐ Voluntary Operated MH apartment Treatment Program
06☐ State operated residential Program
07☐ Inpatient, State psychiatric Center
08☐ Inpatient, general hospital or private psychiatric center
09☐ DOH Adult Home
10☐ Drug or Alcohol abuse residence
11☐ Correctional Facility
12☐ MH Care Facility
13☐ Residential
14☐ Homeless Shelter or emergency Housing
15☐ Homeless-street, park
16☐ Unknown
17☐ Other (please specify) _____

Highest level of education completed (check one box only)

01☐ No Formal Education
02☐ Grammar School (K-6)
03☐ Junior High (7-9)
04☐ High School (10-12 or GED)
05☐ Business, Vocational or Technical training
06☐ Some College but no degree
07☐ Associates Degree
08☐ Bachelor's Degree
09☐ Graduate School
10☐ Unknown
11☐ Other (please specify) _____

Current Employment Status:

01☐ No Employment of any Kind
02☐ Competitive employment with no formal supports
03☐ Competitive employment with ongoing supports
04☐ Community integrated employment run by a state or local agency
05☐ Employment in sheltered workshop run by state or local agency
06☐ Sporadic or casual employment for pay
07☐ Non-paid work experience
08☐ Unknown
09☐ Other (specify)_____

Average hours of employment or non-paid work experience

01☐ 1-10 hours
02☐ 11-20 hours
03☐ 21-30 hours
04☐ over 30 hours
05☐ None
06☐ unknown

01☐ Consumer is not a criminal Justice Consumer
02☐ Under arrest, in jail, lockup, or court detention
03☐ In NYS Dept. of Correctional Services (state prison)
04☐ Released from jail or prison within last 30 days
05☐ Under probation supervision
06☐ under parole supervision
07☐ CPL 330.20 Orders of conditions and order of release
08☐ ON bail, released, conditional discharged or other alternative to incarceration status
09☐ Own recognizance
10☐ Unknown
11☐ Other (please specify) _____

Marital Status:

☐ Single, never married
☐ Currently married
☐ Cohabiting with significant other/domestic
☐ Divorced/separated
☐ Widowed
☐ Unknown
☐ Other (please specify) _____

Child Custody Status

☐ No Children
☐ Have children all > 18 years old
☐ Minor children currently in consumer's custody
☐ Minor Children not in consumer's custody but have access (*who are children with)* _____
☐ Minor children not in consumer's custody no access (*who are the children with)* _____
☐ Unknown
☐ Other (please specify) _____

Other Benefits (Monthly Amounts)

Income or Benefits currently receiving? (Please include amounts)

- ☐ Wages/Salary or self-employed $ _____
- ☐ Spouse Wages/Salary or self-employed $ _____
- ☐ Social Security (All types and amounts applicable)
  - SSI $_____ SSD $_____
  - Retirement $_____ Survivors $_____
  - Other SS _____ $_____
- ☐ Veteran Benefits $ _____
- ☐ Workers comp. or disability insurance $ _____
- ☐ Unemployment or union benefits $ _____
- ☐ Retirement $ _____ Pension $ _____
- ☐ Public Assistance cash programs, TANF, Safety net, Temporary Disability. $ _____
- ☐ Other _____ $ _____

Insurance Information

- ☐ Medicare
- ☐ Medicaid
- ☐ Medicaid Pending
- ☐ Hospital-based Medicaid
- ☐ Medication Grant $ _____
- ☐ Private Insurance
- ☐ Employer Insurance
- ☐ Third Party
- ☐ No Fault
- ☐ None
- ☐ Other (please specify) _____

Diagnosis Information

Axis I Diagnosis: clinical disorders, other conditions that may be a focus of clinical attention – up to 4 diagnoses may be entered. Please list Axis 1 Primary Diagnosis first.

Axis II Diagnosis: personality disorders, mental retardation (if any) – Up to 4 diagnosis may be entered.

Axis III Diagnosis: general medical conditions (if any) – Up to 4 diagnosis may be entered.

Axis IV Diagnosis: psychosocial and environmental problems

- ☐ Problems with primary support group
- ☐ Problems related to the social environment
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Economic problems
- ☐ Problems with access to health care services
- ☐ Problems related to access with the legal system/crime
- ☐ Unknown
- ☐ Other psychosocial and environmental problems (please specify) _____

Axis V Diagnosis: Global Assessment of Functioning (GAF):

Who Made the Diagnosis:	*Date of Diagnosis:*

Physical Health Information

Is Client taking medications for psychiatric condition? ☒ **Yes** ☐ **No**

Medication Name	Dosage	Medication Name	Dosage

Client adherence to psychiatric medication regimen:

- ☐ Takes medication as prescribed
- ☐ Takes medication as prescribed most of the time
- ☐ Sometimes takes medication as prescribed
- ☐ Rarely or never takes medication as prescribed
- ☐ Medication not prescribed
- ☐ Client refuses medication
- ☐ Unknown
- ☐ Other (please specify) _____

Medications client takes for other medical conditions - type in name and dosage

Medication Name	Dosage	Medication Name	Dosage

Client adherence to medication regimen

- ☐ Takes medication as prescribed
- ☐ Takes medication as prescribed most of the time
- ☐ Sometimes takes medication as prescribed
- ☐ Rarely or never takes medication as prescribed
- ☐ Medication not prescribed
- ☐ Client refuses medication
- ☐ Unknown
- ☐ Other (please specify) _____

Current Medical Conditions:	*Any Medical Alerts:*

Treatment and Services History

	Enter amount of times	Reason for Visit(s)
Psychiatric hospitalization in last 6 months		
Emergency Room visits for psychiatric conditions in the last 6 month		
Emergency Room visits for psychiatric conditions in the last 24 month		
Arrest in the last 6 months		
Arrest in the last 12 months		

Consumer Services in the past 12 months: (Check all that apply)

- 01☐ ACT
- 02☐ AOT
- 03☐ ICM
- 04☐ SCM
- 05☐ Blended case management
- 06☐ Mental health housing & housing support
- 07☐ CSP residential mental health program
- 08☐ Emergency mental health
- 09☐ Self Help/peer support services
- 10☐ Alcohol/drug abuse inpatient
- 11☐ Alcohol/drug abuse outpatient
- 12☐ State psychiatric center inpatient
- 13☐ General hospital psychiatric unit
- 14☐ MH outpatient clinic, continuing day treatment, IPRT
- 15☐ Prison, Jail or other court mental health service
- 16☐ Local MH practitioner
- 17☐ Unknown
- 18☐ None
- 19☐ Other (please specify) _____

Risks

0. Never
1. Not at all in the past 6 months
2. One or more times in the past 6 months, but not in the past 3 months.
3. One or more times in the past 3months, but not in the past month
4. one or more times in the past month, but not in the past week
5. one or more times in the past week
U. Unknown

	0	1	2	3	4	5	U
How frequently did applicant do physical harm to self?	☐	☐	☐	☐	☐	☐	☐
How often did applicant attempt suicide?	☐	☐	☐	☐	☐	☐	☐
How frequently did applicant physically abuse another?	☐	☐	☐	☐	☐	☐	☐
How frequently did applicant assault another?	☐	☐	☐	☐	☐	☐	☐
How frequently was applicant a victim of sexual abuse?	☐	☐	☐	☐	☐	☐	☐
How frequently was applicant a victim of physical abuse?	☐	☐	☐	☐	☐	☐	☐
How frequently did the recipient engage in arson?	☐	☐	☐	☐	☐	☐	☐
How frequently did applicant engage in accidental fire setting?	☐	☐	☐	☐	☐	☐	☐

Other co-occurring disabilities, if any (please attach documentation)

- ☐ Drug or Alcohol abuse
- ☐ cognitive disorder
- ☐ Mental retardation or developmental disability
- ☐ Blindness
- ☐ Impaired ability to walk
- ☐ Hearing impairment
- ☐ Deaf
- ☐ Speech impairment
- ☐ Visual impairment
- ☐ Wheel chair required
- ☐ Amputee
- ☐ Incontinence
- ☐ Bedridden
- ☐ None
- ☐ Other (please specify) ____

Alcohol and Other Drugs

Using the scale below, indicate the degree of symptoms/behaviors.

	0	1	2	3	4	5	U
Alcohol	☐	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐	☐
Amphetamines	☐	☐	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐	☐	☐
PCP	☐	☐	☐	☐	☐	☐	☐
Inhalants	☐	☐	☐	☐	☐	☐	☐
Heroin/Opiates	☐	☐	☐	☐	☐	☐	☐
Marijuana/Cannabis	☐	☐	☐	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐	☐	☐	☐
Sedatives/hypnotics/anxiolytics	☐	☐	☐	☐	☐	☐	☐
Other prescription drugs	☐	☐	☐	☐	☐	☐	☐
Other (please specify) _____	☐	☐	☐	☐	☐	☐	☐

Services Client referred to SPOA for: (check all that apply)

- ☐ Assertive Community Treatment (ACT)
- ☐ Assisted Outpatient Treatment (AOT)
- ☐ Intensive Case Management
- ☐ Supportive Case Management
- ☐ Blended Case Management
- ☐ Mental Health housing and housing support
- ☐ CSP nonresidential mental health program (e.g. clubhouse, vocational services)
- ☐ Emergency mental health (nonresidential)
- ☐ Self help / Peer support services
- ☐ Alcohol / Drug abuse inpatient treatment
- ☐ Alcohol / Drug abuse outpatient treatment
- ☐ Other (please specify) _____

Other than Client who lives in the home?

Name	Relationship

Reason for Referral Please check appropriate box and explain

_____ A Marked Difficulties in Self-Care (Personal Hygiene, Diet, Clothing, Avoiding Injuries, Securing Health Care or complying with Medical Advice
How is client impacted:

_____ B. Marked Restriction of Activities of Daily Living (Maintaining A Residence, Using Transportation, Day to Day Money Management, Accessing Community Services)
How is client impacted:

_____ C. Marked Difficulties in Maintaining Social Functioning (Establishing & 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
How is client impacted:

_____ D. 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 or school settings, Individual may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period. Make frequent errors in tasks or require assistance in completion of tasks)
How is client impacted:

_____ E. Other
How is client impacted:

List Client's Strengths (Enter as many as desired)**:**

Interests and Hobbies

List of Family Supports

Referral Source to SPOA

01☐ Family/legal guardian
02☐ Self
06☐ School/education system
04☐ State-operated inpatient program
05☐ Local hospital acute inpatient unit
06☐ Juvenile justice system
07☐ Social Services
08☐ Mental Health
09☐ Physician
11☐ Emergency room *(psychiatric & general hospital)*
12☐ Private psychiatric inpatient hospital
13☐ Residential Treatment Facility
14☐ Community residence
15☐ Intensive Case Management
16☐ OMRDD
17☐ Other (please *specify)*

Name of person referring client to SPOA:	Title:

Criteria for Severe and Persistent Mental Illness - To be considered an Adult Diagnosed with Severe and Persistent 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 DSM-IV Psychiatric Diagnosis other than Alcohol or Drug Disorders, Organic Brain syndromes, Developmental disabilities, or Social Conditions.)

AND

_____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 1 or 2 below)

_____1. The Individual has experienced two of the following four functional limitations due to a designated Mental Illness over the Past 12 months on a continuous or intermittent Basis;

_____A. Marked Difficulties in Self-Care (Personal Hygiene, Diet, Clothing, Avoiding Injuries, Securing Health Care or complying with Medical Advice)

_____B. Marked Restriction of Activities of Daily Living (Maintaining A Residence, Using Transportation, Day to Day Money Management, Accessing Community Services)

_____C. Marked Difficulties in Maintaining Social Functioning (Establishing & 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

_____D. 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 or school settings, Individual may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period. Make frequent errors in tasks or require assistance in completion of tasks)

OR

_____2. The Individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-IV) 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
A 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) (Medication refers to psychotropic medications, which may control certain primary manifestations of mental disorders (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 the symptoms and signs of underling mental disorder)

ICM/SCM Eligibility Criteria (Please check all that Apply)

_____1. High Risk/Heavy User- Known to staff in emergency rooms, Acute Inpatient units, State Psychiatric Centers as well as know to providers of other acute and crisis centers. Often uses inpatient and emergency services when they access services at all (Two or more Utilizations within preceding twelve months). Cycles in and out of Psychiatric Inpatient Care (Two or more admissions within preceding twelve months).

_____2. Extended Care State Psychiatric Center Patients: Inpatient (90 days or longer) and cannot be discharged because of the absence of needed resources in the community.

_____3. Homeless Individuals- Homeless with psychiatric disabilities living on the streets in shelters or other non-permanent housing.

_____4. Person in Need of Support to Maintain and /or enhance Mental Health Treatment and current level of Functioning in the Community.