Lakeview Health Services, Inc.
Yates County SPOA
173 Main St.
Penn Yan, NY 14527
Phone: (315) 694-7444 Fax: (315) 694-7445

Thank you for your interest in referring to SPOA of Yates County. This referral form is for several programs. The following information should assist you in choosing an appropriate level of care and sending the required information.

To qualify for housing, the individual must have a primary mental illness diagnosis and meet the SPMI criteria outlined on page 3. In addition, he/she must be willing to participate in the services that are offered.

Descriptions of Programs and Services:

Supported Housing: Lakeview has a Supported Housing Program. This program assists individuals and families in finding and maintaining independent housing in the community. A rent stipend is provided to those who are eligible for the federal Section 8 Rental Assistance program. Staff has contact with individuals on a monthly basis and offers assistance with all housing related needs. This program is transitional, with a primary goal of linkage to Section 8.

Care Management: John D. Kelly Behavioral Health, Elmira Psychiatric Center, and several other agencies provide care management services to assist with linkage to surrounding resources in the community, supporting the individual's ability to handle periods of stress that might otherwise overwhelm them. **Medicaid recipients may access CM services via HHUNY, rather than through the SPOA process. Please contact the SPOA Coordinator for more info as needed.**

ACT (Assertive Community Treatment) Team: Elmira Psychiatric Center offers ACT services to individuals who have not been successful in working with clinics and other traditional forms of treatment. The program is designed specifically to serve those with high service needs, such as high use of psych emergency/crisis services and acute psych hospitals; severe symptomology; coexisting substance abuse disorder, and high risk of criminal involvement.

Instructions & Checklist:

- ☐ Complete and sign all designated areas. **Page 11, the client's consent to release information, is required in order to process the referral.**

- ☐ Attach the client's complete psychosocial history and psychiatric assessment, including DSM-V psychiatric diagnoses completed **within the past year**. Acceptable documents include initial psych evaluations and updates, clinic or hospital intake, admission, and/or discharge notes, and other history and diagnoses written by a Qualified Mental Health Professional (QMHP).

- ☐ Attach a current list of medications and dosages.

Mail completed referral packet to:

Lakeview Health Services, Inc.
Attention: Yates SPOA
173 Main St.
Penn Yan, NY 14527
Phone: (315) 694-7444
Fax: (315) 694-7445

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness, **"1" below must be met, in addition to either "2, "3, or "4."**

1. Designated Mental Illness Diagnosis.

The individual is 18 years of age or older and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx, 292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx, or social conditions. ICD-CM categories and codes that do not have an equivalent in DSM-IV are also included mental illness diagnoses.

AND

2. SSI or SSDI Enrollment due to Mental Illness.

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

OR

3. Extended Impairment in Functioning due to Mental Illness.

A. Documentation that 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:

i. **Marked difficulties in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).

ii. **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).

iii. **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).

iv. **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; individuals 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 the completion of tasks).

OR

4. Reliance on Psychiatric Treatment, Rehabilitation, and Supports.

A documented history shows that the individual at some prior time met the threshold for 3 (above), but the 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 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 (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

Adult SPOA Referral Packet
Yates County

*SPOA Received Date:*_____
Received By: _____

Programs Requested **(**check all applicable; see p. 1 for descriptions)

___ Supported Housing ___ Care Management ___ Finger Lakes/Mid Lakes ACT Program

Client Name: _____ **DOB:** _____
Home Address: _____ **Social Security #:** _____-_____-_____
_____ **Age:** _____ **Gender:** ____ **M** ____ **F**
Telephone Number: _____ **Medicaid # (If applicable):** _____
Client's County of Origin: _____

Referral Agency : _____ **Address:** _____
Telephone Number: _____ **Contact Person:** _____

Person to Notify in Case of Emergency:

Name: _____
Address: _____
Telephone: _____

Primary Care Physician:

Name: _____
Address: _____
Telephone: _____

Reasons for referral: Housing and Care Management needs: _____
_____
_____
_____

What is the client's level of acceptance of the need for this referral?

[ ] Accepts [ ] Interested in pursuing further [ ] Resistive [ ] Does not accept

Living Situation at time of referral:

[ ] Lives alone	[ ] Lives with parents	[ ] Lives with other relatives	[ ] Psychiatric Center
[ ] Homeless (street)	[ ] Lives with spouse	[ ] Assisted/supported living	[ ] Correctional Facility
[ ] Homeless (shelter)	[ ] Supervised living	[ ] Nursing home/medical setting	[ ] Other _____

Length of time in current living situation (move in date) _____
Any adult history of homelessness? [ ] Yes [ ] No

Does the client need 24-hour supervision? [ ] Yes [ ] No If yes, why? _____

Previous Residential History_____

Current Marital Status:
[ ] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
[ ] Living with significant other/domestic partner

Custody Status of Children: (check all that apply)
[ ] 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

Ethnicity:
[ ] White (non-Hispanic) [ ] Latino/Hispanic [ ] Black (non-Hispanic) [ ] Native American
[ ] Asian-Asian American [ ] Pacific Islander [ ] Other or dual (specify):

Current Educational Level:
[ ] Some grade school 1-8th grade [ ] Some HS 9-12th grade, but no diploma [ ] GED [ ] HS Grad
[ ] Some college, but no degree [ ] College Degree [ ] Masters Degree [ ] Not graded
[ ] Vocational, business training [ ] No formal education [ ] Other: _____

Current Employment Status:
[ ] Employed full-time [ ] Employed part-time [ ] Not employed [ ] Training program [ ] Other:_____

Current Criminal Justice Status:
[ ] None [ ] Currently incarcerated Release date: _____
[ ] CPL 330.20 [ ] Parole [ ] Probation
[ ] Released from jail/prison in the last 30 days [ ] Other: _____
Name of Probation or Parole Officer: Phone:
_____ _____

Current or Last Services (check all that apply)**:**
[ ] No prior service [ ] MH residential [ ] Case Management [ ] Prison, Jail, or Court
[ ] State Psychiatric Center (Inpt) [ ] MH outpatient [ ] General hospital
[ ] Emergency MH (nonresidential) [ ] Local MH practitioner [ ] CSP MH program

If no current services, specify date of last services: _____

Outpatient Services Current or Planned: (CHECK ALL THAT APPLY)

	Current	Planned		Current	Planned
Health			Psychiatrist/Clinic		
Education			Alcohol/Drug Treatment		
Day Treatment Program			AA/NA		
Psychiatric Day Program			Case Management		
Vocational Services			Intensive Case Management		
Community Residence			Family Support Services		
Halfway House			Children's ICM		
Adult Care Facility			Respite Services		
Child Preventative Services			Child Residential Treatment		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		

Currently receives Care Management: [ ] Yes [ ] No
Receives ACT: [ ] Yes [ ] No
Current AOT: [ ] Yes [ ] No If yes, please attach copy of AOT orders.

Mental health service utilization in past 12 months:

_____# Of Psych. ED Visits
_____# Of Inpatient Psych. Admissions _____# of days
_____ Admission to Outpatient clinical services (counseling/psychiatry)

Facilities & dates of previous psychiatric treatment and/or hospitalizations:
_____
_____
_____

Use/engagement with mental health services:

Does the client understand and accept the need for prescribed medications? [ ] Yes [ ] No

Rate client compliance with medication regime:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Rate client follow through with Mental Health Appointments:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Cognitive impairment? [ ] Yes [ ] No Explain: _____
_____

Behavior/circumstances precipitating most recent hospitalization:
_____
_____
_____

Signs/symptoms of decompensation (please be specific): _____

Does the client have a history of any of the following?

			If Yes, Dates
Fire setting	[ ] Yes	[ ] No	_____
Sexual offense	[ ] Yes	[ ] No	_____
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	_____
Aggressive /assaultive behavior	[ ] Yes	[ ] No	_____
Suicidal ideation	[ ] Yes	[ ] No	_____
Suicide attempts/gestures	[ ] Yes	[ ] No	_____
Destruction of property	[ ] Yes	[ ] No	_____
Victim of physical abuse	[ ] Yes	[ ] No	_____
Victim of sexual abuse	[ ] Yes	[ ] No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____

_____

_____

_____

Are there any guns or weapons in the client's home? [ ] Yes [ ] No

Medical Health: (Check all that apply)

[ ] None	[ ] Respiratory disease	[ ] Cardiovascular disease	[ ] Diabetes /metabolic
[ ] BMI over 25	[ ] HIV/AIDS	[ ] Incontinent	[ ] Impaired ability to walk
[ ] Hearing impairment	[ ] Impaired vision	[ ] Special medical equipment	[ ] Other Medical

Number of medical emergency room visits over the past 12 months: _____

Explanation of medical/emergency issues: _____

_____

Known Allergies:

Medications:_____

Food:_____

Other:_____

Are there any specific Emergency Procedures/Protocols to be used by residential staff? What are they?

_____

_____

Substance Use History:

Does the client have a history of drug/alcohol abuse/dependency? [ ] Yes [ ] No

If yes, at what age did use begin? _____ Date of last use:_____

Drugs of Choice: (check all that apply)

[ ] None	[ ] Cocaine	[ ] Methamphetamines	[ ] Prescription drugs	[ ] Any IV drug use
[ ] Crack	[ ] PCP	[ ] Inhalant: Sniffing glue	[ ] Alcohol	[ ] Heroin/Opiates
[ ] Sedative/hypnotic	[ ] Cannabis	[ ] Hallucinogens	[ ] Benzodiazepines	[ ] Other_____

Frequency of Drug Use:

[ ] none in past month [ ] 1-3 times in past month [ ] 1-2 times/week [ ] 3-6 times/week [ ] daily

Longest period of Sobriety: _____

Does the client smoke cigarettes? [ ] Yes [ ] No

Chemical Dependency Treatment: [ ] Yes [ ] No

If yes: Services within the past 12 months? [ ] Yes [ ] No

[ ] inpatient programs & dates:_____

[ ] outpatient programs & dates:_____

If client is currently in a chemical dependency treatment Program, anticipated discharge date? _____

Previous chemical dependency treatment:

[ ] inpatient programs & dates:_____

_____

_____

[ ] outpatient programs & dates:_____

_____

_____

FUNDING VERIFICATION FORM

	Case #	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security					
SSI					
SSD					
Public Assistance					
Veteran's Benefits					
Medicare					
Medicaid					
Food Stamps					
Pension					
Wages/Earned Income					
Unemployment					
Private Insurance					
Other 3rd Party Payer					
Trust Fund					
Medication Grant					

Court mandated expenses/debts (i.e., alimony, child support, student loans, utility bills). **Please list all known and amounts**:_____

_____

If Rep Payee, Name: _____ Address: _____

Agency: _____ Telephone #: _____

ADULT SINGLE POINT OF ACCESS (SPOA) SERVICES
CONSENT TO RELEASE INFORMATION

I hereby authorize the use or disclosure of my protected health information as follows:

1. Client Name: _____
   Last First Middle Initial

   Social Security Number: _____ Date of Birth: _____

2. The information that may be used or disclosed includes (check all that apply):

   - ☐ Mental health records
   - ☐ Alcohol/Drug records
   - ☐ School or Education records
   - ☐ Health records
   - ☐ All of the records listed above

3. This information may be disclosed by:

   - ☐ Any person or organization that possesses the information to be disclosed
   - ☐ Any persons from Lakeview Health Services, John D. Kelly Clinic, Yates County DSS, Elmira Psychiatric Center, Clifton Springs Hospital & Clinic, Soldiers & Sailors Hospital, Newark-Wayne Hospital, FLACRA, HHUNY & its affiliates.
   - ☐ The following persons or organizations:

   _____ _____

4. The information may be disclosed to Yates County SPOA Committee agencies or other community organizations that may contribute to planning for my care.

5. The purpose of disclosure is to assist in my care and to obtain payment for my care from insurance companies, government benefit programs and others participating in the Residential or Case Management services.

6. Permission will be valid during the SPOA application and waiting list process. This permission expires upon completion of SPOA.

7. It is understood that this permission may be revoked. To revoke this permission, a written request should be made to the provider(s) listed above. Information disclosed before permission is revoked may not be retrieved. If action was taken in reliance on this permission, the person who relied on this permission may continue to use or disclose protected health information as needed to complete the work that began because this permission was given.

8. Psychiatric and chemical dependency information is protected under Federal and State Regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further release of information is prohibited by law. If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, the information indicated above could be re-disclosed. Release of HIV-related information requires additional authorization.

I am the person whose records will be used or disclosed. I understand and agree to this authorization.

_____ _____ _____
Print Name Date Signature

Revised Sept. 2016

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I understand and agree to this authorization.

Representative_____ _____ _____
Print Name Date Signature

Witness_____ _____ _____
Print Name Date Signature