Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Attn: Victoria Winchester, Adult SPOA Coordinator
Sullivan County Department of Community Services
20 Community Lane
Liberty, New York 12754
Phone number (845) 513-2008
Fax number (845) 513-2110

2. Please review REQUIRED DOCUMENTATION FORM below.
   Referrals will NOT be considered complete without:
   Complete SPOA Application
   Clinical Information as specified below.

3. Upon receipt, application will be reviewed by SCDCS for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 845 513-2008.

REQUIRED DOCUMENTATION

Required Documents	**Care Management**	**CR**	**TX APT**	**SH**
Eligibility Determination	X	X	X	X
Referral Form	X	X	X	X
Psychiatric Evaluation (Including DSM VI and Current within 90 days)	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X
Physical Exam & Immunization Record		X	X	
Authorization for Restorative Services **(MUST BE ORIGINAL)**		X	X	

Eligibility Determination

In order to be eligible for services through SCDS, applicants for Housing or Case Management Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, B, C, **or** D must be met:

Yes ____ No _____ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions.

Yes ____ No _____ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI ***DUE TO A DESIGNATED MENTAL ILLNESS***.

Yes ____ No _____ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant 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. (*Documentation in psychosocial assessment required.)

   Yes ___ No ___ **a. Marked difficulties in self-care.**
   Yes ___ No ___ **b. Marked restrictions of activities of daily living.**
   Yes ___ No ___ **c. Marked difficulties in maintaining social functioning.**
   Yes ___ No ___ **d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home of school setting.**

Yes ____ No _____ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)

Yes ____ No _____ One six month stay in an inpatient psychiatric unit
Yes ____ No _____ Two stays of any length in an inpatient psychiatric unit in the preceding two years.
Yes ____ No _____ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.
Yes ____ No _____ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.
Yes ____ No _____ Six months consecutive residency in a designated Adult Home.
Yes ____ No _____ Six months consecutive residency in a Residential Care Center for Adults (RCCA)
Yes ____ No _____ Six months consecutive residency in a Residential Treatment Facility (RTF)

Applicant Information

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #:_____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

County of residence:_____

Telephone _____ Male __ Female __ Citizenship: Yes ____ No (if no, immigration status): _____

Ethnicity

____ White (Non-Hispanic)
____ Black (Non-Hispanic)
____ Latino/Hispanic
____ Asian/Asian American
____ Native American
____ Pacific Islander
____ Other _____

Primary Language

___English ___Spanish ___Chinese ___French
___Italian ___Russian ___German ___Japanese
___Other

Custody Status of Children

____ No children
____ Children are all above 18 years of age
____ Minor children currently in client's custody
____ Number of children:_____ Gender: _____
____ Minor children not in client's custody but have access
____ Minor children not in client's custody – no access

Current Living Situation

____ Room ____ Homeless (shelter)
____ Own apt ____ Homeless (streets)
____ Supervised Living ____ Nursing Home
____ Supported Housing ____ Psychiatric Hospital
____ Lives with spouse ____ Lives with Parents
____ Correctional facility Other _____

Insurance and financial information: Currently receives

Social Security ☐
SSI/SSD ☐
Public Assistance ☐
Medicaid ☐
Medicare ☐
Earned Income/Wages ☐
Food Stamps ☐
VA Benefits ☐
Representative Payee ☐
Other _____

Referral source (including RPC Long Stay)

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program: _____ Relationship: _____

Email address: _____

Current diagnosis:

_____
_____
_____

Current medical conditions:

_____
_____
_____

Psychosocial and environmental problems:

_____
_____
_____

Current medications:

_____

***Outpatient Treatment Provider*:**

Agency: _____ **Program:** _____

Contact: _____ **Telephone:** _____

***Substance Abuse History* : Please List Drugs of Choice**

_____

Length of Time Recipient Has Been Substance Free: _____

Criminal Justice – Current Status

___ None ___ Incarcerated-Jail ___ Incarcerated-Prison ___ CPL 330.20/730
___ Probation ___ Parole ___ ___ Other:_____

P.O. Name: _____ Telephone: _____

Number of arrests/incarcerations in past year _____ **Number of lifetime arrests** _____

Reason for Arrest:_____ _____ **Date:** _____

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law? _____ **Yes** ____ **No**

Is an AOT under Kendra's Law currently being pursued? _____ **Yes** ____ **No**

Case Management Service Requested

_____ Health Home Care Management _____ CSS Care Management

Is there a specific case management program requested? _____

Residential Services Requested

_____Supervised Community Residence
_____Supervised MICA Community Residence
____ Treatment Apartment Programs
_____ RSS Supported Housing
_____Invisible Children's Program (for families with children under the age of 18).
____ Family Care
____Golden Ridge Supported Housing

Geographical Preference/Community: _____

Recipient Requests:

_____

_____

Recipient Signature: _____ **Date:** _____

Referring Party Signature: _____ **Date:** _____

Rehabilitation Support Services, Inc.

Service Authorization for Adult Community Residences and Treatment Apartment Programs

A. Type of Authorization: ☐ Initial Authorization
☐ Re-Authorization

B. Client's Name: _____

C. Client's Medicaid Number: _____

I, the undersigned licensed physician/practitioner, based on either:
a) **INITIAL AUTHORIZATION:** Must be signed by a physician ONLY and based upon clinical information **and** a face to face assessment of the individual

OR

b) **RE-AUTHORIZATION:** Must be signed by a Physician, Physician Assistant or Nurse Practitioner in Psychiatry.

D. have determined that _____ would benefit from the provision
(client's name)
of community rehabilitation services as known to me and defined pursuant to 14 NYCRR Part 593.

E. This determination is in effect for the period _____ to _____, at which time there will be an evaluation of continued stay.

F.

ICD.10 Primary Mental Health Diagnosis Code	F			.		
ICD.10 Diagnosis_____						
_____						

Name of Practitioner (Please Print): ☐ Physician ☐Physician Asst. ☐ Nurse Practitioner in Psychiatry		Practitioner's License#
G. Signature of Practitioner	Date	Practitioner's NPI #

INSTRUCTIONS:

Initial Authorization: Must be a Face to Face visit with a PHYSICIAN: Residents, PA's or NPP's cannot sign for the physician. Complete sections F and G.

Re-Authorization: PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTIONER IN PSYCHIATRY Complete Section F and G

RSS Staff: Complete Sections A, B, C, D and E and NPI # if blank

RSS MBP 3 Revised 8.15

SULLIVAN COUNTY SINGLE POINT OF ACCESS – CASE MANAGEMENT AND RESIDENTIAL SERVICES

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: This release cannot be used for the release of HIV-related information nor for the re-disclosure of confidential information provided to the agencies listed below except as allowable by law.

Client Name: _____ **DOB:** _____

Extent or Nature of Information to be Disclosed:

Psychiatric Assessment/Core Evaluation
(must include current clinical updates)
Psychosocial Assessment/Core History
Hospital Admission and Discharge Plan (if appropriate)
Physical Examination and TB Test Results (For Residential Placement only)

Other: _____

Purpose or Need for Information

To facilitate a referral for residential and/or case management services, determine eligibility for such services, and assess appropriateness of applicant for the various programs available.

Information Being Disclosed From: (Name, Address, and Title of Person/Organization/Facility/Program)

Information Being Disclosed to: ***(NOTE: All referrals go directly to SPOA Coordinator, who then disseminates them to the appropriate program(s) listed below when there is a vacancy)***

Catskill Regional Medical Center
Mobile Mental Health Team
Sullivan County Department of Community Services
Rehabilitation Support Services
Rockland Psychiatric Center

I hereby authorize the release of the above information to the persons/organizations/facilities/programs identified above. I understand that the information is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time in writing. This authorization will expire when a final SPOA placement takes place.

_____
Signature of Applicant Date Signed

_____
Signature of Witness Relationship to Applicant Date Signed