# Onondaga County Adult SPOA Application

Onondaga County Civic Center, 10th Floor
421 Montgomery Street
Syracuse New York, 13210

## Services Requested

Desired Placement:
- ☐ OMH Residential; Congregate or Apartment Tx
- ☐ OMH Supportive Housing
- ☐ Forensic Case Management
- ☐ Non-Medicaid Case Management for SMI Eligible
- ☐ Assertive Community Tx (ACT team)
- ☐ TBD
- ☐ Single Room Occupancy (SRO)

## Client Information

| | | | |
|---|---|---|---|
| Name: | Gender: | DOB: | Last 4 SSN: |
| Preferred Name: | Primary Language: | Income source/ Amount: | / |
| Current Address where residing: | | | |
| Mailing Address if different from above: | | | |
| Phone: | May we leave a message on this phone? ☐ Yes ☐ No | | |
| Medicaid # (Ex:XY12345Z) | If inpatient, anticipated release date: | | |

## Eligibility Criteria Information

| Diagnoses: *Primary ICD.10 Diagnosis Listed First (Attach Supporting Documentation)* | ICD 10 Codes |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |

To be considered an adult with an Severe Mental Illness, **A** must be met. In addition, **B** or **C** or **D** must be met.

A. Designated Mental Illness Diagnosis ☐ Yes ☐ No

The individual is 18 years of age or older and currently meets the criteria for a psychiatric diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.

**AND**

B. SSI or SSDI due to Mental Illness ☐ Yes ☐ No

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

**OR**

C. 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 illness over the past 12 months on a continuous or intermittent basis.

- ☐ Yes ☐ No Marked difficulty in self-care (I.e. personal hygiene, diet, medical care ect)
- ☐ Yes ☐ No Marked restriction of activities of daily living
- ☐ Yes ☐ No Marked difficulties in maintaining social functioning
- ☐ Yes ☐ No Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.

2. The individual has met criteria for rating of 50 or less on the Global Assessment of Functioning Scale. *(If so, supporting documentation required.)* ☐ Yes ☐ No

**OR**

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports ☐ Yes ☐ No

A documented history shows that the individual, at some prior time, met the 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 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, which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of underlying mental disorder.

# Onondaga County Adult SPOA Application

## High Risk/ Priority Rating

Scale: Select one response for each. Provide narrative through a psychosocial or core history for responses of 3, 4 or 5.

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

| For internal use only | |
|---|---|
| Score: | |
| Priority: | |
| Initials: | |

| | 0 | 1 | 2 | 3 | 4 | 5 | U | Score |
|---|---|---|---|---|---|---|---|---|
| Homeless | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Imminent Risk of Homelessness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| ER visit (Medical) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| ER Visit (Psychiatric) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| ETOH/ Substance Use | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Suicidal ideation, plan or intent | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Attempted homicide | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Mental Illness that is impeding daily function | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Assaultive Behavior | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Arrested | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Incarcerated | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

*If yes to any of the following, please attach narrative psychosocial history*

Has the individual ever been suspected of sexual abuse to a child and/or adult? ☐ Yes ☐ No

Has the individual ever physically abused and/or assaulted a child and/or adult? ☐ Yes ☐ No

Has the individual ever engaged in arson? ☐ Yes ☐ No

Has the individual ever been a victim of physical or sexual abuse? ☐ Yes ☐ No

Sex Offender Status? ☐ Unknown ☐ Level I ☐ Level II ☐ Level III ☐ N/A

## Psychiatric Hospitalizations and/ or Inpatient Rehabilitation Stays

| Facility Name/ Location | Admission/ Discharge Dates | Reason for admission |
|---|---|---|
| | / | |
| | / | |
| | / | |
| | / | |
| | / | |

## Significant Other/ Emergency Contact

| Name? | Relationship? | Address: | Phone: |
|---|---|---|---|
| | | | |

## Referral Information

Substance Use: ☐ Current use ☐ In the last 6 months ☐ 6 months or more since last use

*List substance(s) used:*

Physical/ Medical Concerns:

# Onondaga County Adult SPOA Application

Reason for Referral: ( Why does this individual require the level of service? Identified barriers? Strengths? )

## Collateral Services/ Providers

Please list any service providers the individual is currently engaged with.

| | | |
|---|---|---|
| Name: | Name: | Name: |
| Role: | Role: | Role: |
| Agency: | Agency: | Agency: |
| Email: | Email: | Email: |
| Phone: | Phone: | Phone: |
| | | |
| Name: | Name: | Name: |
| Role: | Role: | Role: |
| Agency: | Agency: | Agency: |
| Email: | Email: | Email? |
| Phone: | Phone: | Phone: |

## Referral Source

| | |
|---|---|
| Name/ Title of referral Source: | Signature: |
| Agency: | Date: |
| Address: | |
| Phone: | |
| Email Address: | |

I understand that by signing this referral packet, I am voluntarily requesting access to mental health support services.

Signature of applicant:_____ Date:_____

*This referral will not be processed without the following items attached and <u>all</u> sections of referral completed:*

- ☐ Current psychosocial History
- ☐ Current Psychiatric Assessment
- ☐ Signed SPOA Release of Information

# Onondaga County Adult SPOA
# Consent for Release of Information

Client Name:_____ Gender:_____ DOB:_____

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it included many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under federal HIPPA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment of health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

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

- ☐ Mental Health treatment records
- ☐ Health Records
- ☐ Alcohol/ Substance Treatment Record
- ☐ Education Records

3. This information may be disclosed between Onondaga County Adult Single Point of Access (SPOA) and partners: AccessCNY, CirCare, Helio Health, Hutching's Psychiatric Center, Liberty Resources, Loretto Community Residence, Salvation Army of Syracuse and St. Joseph's Hospital Health Care and:

- ☐ Any person or organization that possess's the information to be disclosed.

***OR***

_____ _____

_____ _____

4. The purposes for which this information may be used and disclosed include:

- ☐ Evaluation of eligibility to participate in program's supported by the Onondaga County Adult SPOA
- ☐ Delivery of services, including care coordination and case management;
- ☐ Payment for services; and Health Care Operations such as quality assurance.

5. I understand that New York and federal law prohibits persons that receive mental health, alcohol or substance use, and education records from re-disclosing those records without permission. I also understand that not every organizationthat may receive a record is required to follow the federal HIPPA rules governing use and disclosure of protected health information.

6. This permission expires automatically 90 days from placement in services; and/or:

- ☐ On:_____ ☐ Upon the following event:_____

7. This permission is limited as follows:

- ☐ Permission only applies to records for the dates from_____ to _____.
- ☐ Other limitation: _____.

8. I understand ths permission may be revoked at anytime by notification in writing. I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of the possibility if I wish to revoke this permission. I also understand that records disclosed prior to this permission being revoked may not be retrieved. Any person or organization that relied on ths permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

**I am the individual whose records will be used or disclosed and my permission to use and disclose my records as described.**

_____ _____

Signature of Individual Date