Thank you for your interest in referring to SPOA of Ontario and Seneca Counties for Housing, ACT services, and non-Health Home Care Management. 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:**

**Community Residence:** Lakeview offers a community residence program. This rehabilitative program is a homelike setting for individuals seeking daily guidance and support while learning to manage a mental illness. Staff is on site 24 hours. The community residence program is transitional with time-limited lengths of stay.

**Licensed Apartment Program:** Lakeview offers a treatment Apartment Program. These are smaller, individual apartment settings. Staff is available to assist residents during day and evening hours, and is also available by phone during nighttime hours for emergency purposes. Residents work on rehabilitation plans to develop skills to live more independently. These programs are transitional with time-limited lengths of stay.

**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.

**Supported SRO Housing:** DePaul Community Services offers housing through Trolley Station Apartments in the Town of Canandaigua. Supported Housing staff are on site to provide services to up to 26 tenants, with office hours Monday through Friday from 8 am to 5 pm. Services include collaboration with community providers to learn independent living skills, and providing necessary linkage toward community integration.

**Care Management:** Lakeview and Elmira Psychiatric Center 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: SPOA, Betsy Fuller
611 W. Washington St.
Geneva, NY 14456
Phone: (315) 789-0550
Fax: (315) 789-0555

Revised May 2016
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

   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

Services requested for (check one):

______ Ontario County

______ Seneca County

SPOA Received Date: __________________________
Received By: ________________________________

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

___ Community Residence  ___ Licensed Apartment Program  ___ Supported Housing
___ Trolley Station SP SRO  ___ 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:  Primary Care Physician:
Name: ________________________________  Name: ________________________________
Address: ________________________________  Address: ________________________________
Telephone: ________________________________  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
[ ] State Psychiatric Center (Inpt)    [ ] MH outpatient    [ ] General hospital    Court
[ ] 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)

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

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

Revised May 2016
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

<table>
<thead>
<tr>
<th>Case #</th>
<th>Currently Receives Y/N</th>
<th>Amount Receives (#)</th>
<th>Pending Application Submitted Y/N</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
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<td>SSI</td>
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<td>SSD</td>
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<td>Public Assistance</td>
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<td>Veteran’s Benefits</td>
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<td>Wages/Earned Income</td>
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<tr>
<td>Private Insurance</td>
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<tr>
<td>Other 3rd Party Payer</td>
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<tr>
<td>Trust Fund</td>
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<tr>
<td>Medication Grant</td>
<td></td>
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</tr>
</tbody>
</table>

**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 Name: ____________________________________________________________________
   First Name: ____________________________________________________________________
   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, Elmira Psychiatric Center, Clifton Springs Hospital & Clinic,
   Soldiers & Sailors Hospital, Newark-Wayne Hospital, Ontario County Mental Health, Seneca County
   Community Counseling Center, FLACRA, HHUNY & affiliates, DePaul Community Services.

   The following persons or organizations:
   ______________________________________  ______________________________________

4. The information may be disclosed to Ontario or Seneca County Mental Health and their contract agencies (Lakeview Health,
   Elmira Psychiatric Center) providing Housing or Case Management services, or other community agencies 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 ____________________________

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 ____________________________ Date ____________ Signature ____________________________

Witness ____________________________ Date ____________ Signature ____________________________

Revised May 2016