



# Saratoga County Single Point of Access

## Adult SPOA Universal Referral Form

135 South Broadway  
 Saratoga Springs, New York 12866  
 Telephone: (518) 584-9030  
 Fax: (518) 581-1709

Client Information				
Name:	Gender:	D O B:	SSN:	
Home Address:	City:	State:	Zip:	Phone:
Medicaid # <b>required:</b> (ex: BW56248X)		SSD Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list amount		
Medicare # (if applicable):		SSI Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list amount		
DSS Temporary Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the applicant his/her own payee <input type="checkbox"/> Yes <input type="checkbox"/> No		

Diagnoses	
Primary ICD.10 Diagnosis listed first (attach supporting documentation)	ICD.10 Code
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults
<p style="text-align: center;">To be considered an adult with severe and persistent mental illness, <b>A</b> must be met.          In addition, <b>B</b> or <b>C</b> or <b>D</b> must be met</p> <p><b>A. Designated Mental Illness Diagnosis</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No The individual is 18 years of age or older and has a primary DSM-R psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes or developmental disabilities.</p> <p style="text-align: center;">AND</p> <p><b>B. SSI or SSDI Enrollment due to Mental Illness</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No The individual is currently enrolled in SSI or SSDI due to a designated mental illness.</p> <p style="text-align: center;">OR</p> <p><b>C. Extended Impairment in functioning due to Mental Illness</b>          The individual must meet 1 or 2 below:</p> <p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Marked difficulties in self-care  <input type="checkbox"/> Yes <input type="checkbox"/> No b. Marked restriction of activities of daily living  <input type="checkbox"/> Yes <input type="checkbox"/> No c. Marked difficulties in maintaining social functioning  <input type="checkbox"/> Yes <input type="checkbox"/> No d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.</p> <p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No The individual has met criteria for rating of 50 or less on the Global Assessment of Functioning scale.</p> <p style="text-align: center;">OR</p> <p><b>D. Reliance on Psychiatric Treatment, Rehabilitation and Supports</b>  <input type="checkbox"/> Yes <input type="checkbox"/> 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 certain primary manifestations of mental disorder, eg. 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.</p>

Scale: Select one response for each. Describe responses 1 – 5 in attached psychosocial history.

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

	0	1	2	3	4	5	U
Homeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imminent risk of homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room (medical)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room (psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ETOH / Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressed suicidal ideation, plan or intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressed homicidal ideation, plan or intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attempted homicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness that is impeding daily function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assaultive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the following questions, please describe events in attached psychosocial history.

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

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

Has the recipient ever engaged in arson? Yes No

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

Sex offender status? Yes No If Yes, Level I Level II Level III

**Psychiatric hospitalizations and/or rehab stays**

Hospital/Rehab Name:	Dates:	Reason for Admission:

**Living situations tried in the past 5 years (check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Independent living        | <input type="checkbox"/> Jail                                   |
| <input type="checkbox"/> Family                    | <input type="checkbox"/> Private Psychiatric Inpatient          |
| <input type="checkbox"/> Community Residence       | <input type="checkbox"/> General Hospital Psychiatric Inpatient |
| <input type="checkbox"/> Apartment Program         | <input type="checkbox"/> State Psychiatric Inpatient            |
| <input type="checkbox"/> Shelter/Emergency Housing | <input type="checkbox"/> Other (specify): _____                 |

**Significant Other / Emergency Contact**

Name:	Relationship:	Address:	Phone:

**Medical Information**

Current Medical Conditions/Medical Alerts:

**Attach list of all prescribed medications**

Is the applicant responsible for taking his/her own medications? Yes  No  If not, explain in attached psychosocial history

**Services Requested**

- Care Management (do not check if separate referral sent to AHI)
- Community Residence
- Supportive Treatment Apartment
- Supported Housing
- Enhanced Supported Housing
- ACT Team

**Please describe why the applicant requires this level of support service. Include service needs, any barriers to meeting those needs, the applicant's strengths and any informal support systems.**

Name of Person Referring Applicant to SPOA:

Agency:

Signature of Person Referring Applicant to SPOA:

Title:

Date:

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

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

The following is a brief description of what I would find most helpful for myself:

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

- Current Psychosocial history
- Current Psychiatric assessment
- Signed SPOA Release of Information

**Additional information required at intake if found eligible for residential:**

- Copy of Medicaid/Medicare Card and Social Security Card
- Current physical/PPD or date of scheduled physical \_\_\_\_\_
- Physicians Authorization for Restorative Services

**Mail completed referral to: SPOA Coordinator, 135 S. Broadway, Saratoga Springs, NY 12866**

Client Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

The Single Point of Access Committee (SPOA) is composed of representatives of community agencies including, but not limited to, the Saratoga County Department of Mental Health and Addiction Services, Saratoga Hospital Mental Health Unit, RISE Healthy Housing and Support Services, Parsons Home and Community Based Services Waiver, Saratoga County Department of Social Services, Probation, Saratoga County Alcoholism Services, Community Human Services, Saratoga County PROS, Parsons Home Based Crisis Intervention, Four Winds Hospital, Shelters of Saratoga, Captain Youth and Family Services, Unlimited Potential, Capital District Psychiatric Center, Northeast Parent and Child Society, Alliance for Positive Health, Conifer Park, Wellspring, Legal Aid Society of Northeastern NY, Saratoga County Options for Independent Living, Saratoga Springs Office of Community Development, Veterans and Community Housing Coalition, Inc., Saratoga County Treatment Court, Saratoga Springs Housing Authority, Saratoga Supreme & County Courts, Catholic Charities Care Coordination, St. Peter’s Addiction and Recovery, Regional Adult Mobile Program, Youth Mobile Crisis, Capital District Office for People with Developmental Disabilities, Children’s Health Home of Upstate NY, Fort Hudson Care Management, Rehabilitation Support Services Supported Housing and Transition Support Team, Warren and Washington County SPOA and Assertive Community Treatment. In order to determine the most appropriate level of service based on strengths, needs and availability of program openings, I give my permission for members of the SPOA Committee to exchange information between the agencies listed above and to obtain information from and/or release information to the following Person, Organization, Facility or Program:

\_\_\_\_\_  
Outpatient Mental Health Treatment Provider (required)

\_\_\_\_\_  
Referring Agent (if different from Mental Health Treatment Provider)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

The extent or nature of information to be disclosed includes:

- Clinical summaries (i.e. psychiatric evaluations)
- Admission and/or discharge summaries
- Medication records and laboratory results
- Treatment plans and treatment plan reviews
- Notes of psychiatric or other clinic visits
- Other: \_\_\_\_\_

**Affirmation of Release:** I understand that treatment will not be refused, but clinical decisions may be affected, if I do not sign any authorizations to release information. I have the right to revoke (take back) in writing this authorization at any time except to the extent that action has been taken in reliance on it and unless receiving services from Alcoholism and Substance Abuse Service as a result of criminal justice involvement, in which case consent for disclosure to the criminal justice system cannot be revoked. The revocation will take effect on the day it is received. Alcohol and drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records as well as the Health Insurance Portability and Accountability Act of 1996. Confidential information cannot be disclosed without my written consent unless otherwise provided for (i.e. suspected child abuse, health or mental health emergency under the above noted regulations). If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may no longer be protected. Alcohol and drug program treatment records are protected.

**Expiration:** This authorization will expire,  when acted upon (one time disclosure),  
 90 days from this date,  when I am no longer receiving services from \_\_\_\_\_, or  
 other \_\_\_\_\_.

\_\_\_\_\_  
Applicant (Print Name)

\_\_\_\_\_  
Applicant (Signature)

\_\_\_\_\_  
Referring Agent (Signature and Title)

\_\_\_\_\_  
Date