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 # **required**: (ex: BW56248X)	SSD Eligible: ☐ Yes ☐No If Yes, list amount
Medicare # (if applicable):	SSI Eligible: ☐ Yes ☐No If Yes, list amount
DSS Temporary Assistance: ☐ Yes ☐No	Is the applicant his/her own payee ☐ Yes ☐No

Diagnoses

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults

To be considered an adult with severe and persistent 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 has a primary DSM-R psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes or developmental disabilities.

AND

B. SSI or SSDI Enrollment due to Mental Illness

☐Yes ☐No The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

OR

C. Extended 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 a. Marked difficulties in self–care
   - ☐Yes ☐No b. Marked restriction 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 or school settings.
2. ☐Yes ☐No The individual has met criteria for rating of 50 or less on the Global Assessment of Functioning scale.

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 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.

High Risk/Priority Population Rating

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	☐	☐	☐	☐	☐	☐	☐
Imminent risk of homelessness	☐	☐	☐	☐	☐	☐	☐
Emergency Room (medical)	☐	☐	☐	☐	☐	☐	☐
Emergency Room (psychiatric)	☐	☐	☐	☐	☐	☐	☐
ETOH / Substance use	☐	☐	☐	☐	☐	☐	☐
Expressed suicidal ideation, plan or intent	☐	☐	☐	☐	☐	☐	☐
Attempted suicide	☐	☐	☐	☐	☐	☐	☐
Expressed homicidal ideation, plan or intent	☐	☐	☐	☐	☐	☐	☐
Attempted homicide	☐	☐	☐	☐	☐	☐	☐
Mental illness that is impeding daily function	☐	☐	☐	☐	☐	☐	☐
Assaultive Behavior	☐	☐	☐	☐	☐	☐	☐
Arrested	☐	☐	☐	☐	☐	☐	☐
Incarcerated	☐	☐	☐	☐	☐	☐	☐

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)

☐ Independent living
☐ Family
☐ Community Residence
☐ Apartment Program
☐ Shelter/Emergency Housing
☐ Jail
☐ Private Psychiatric Inpatient
☐ General Hospital Psychiatric Inpatient
☐ State Psychiatric Inpatient
☐ 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
- ☐ ESSHI Supported Housing/SMI
- ☐ ESSHI Supported Housing/SUD
- ☐ 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 agencieslisted 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