Tompkins County

Single Point of Entry

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The following documents need to be completed in order to present this application to the SPOE Committee:

- ❑ Signed, dated, and witnessed Release of Information
- ❑ Completed and signed SMI form
- ❑ Clinical information supporting the SMI criteria
- ❑ Identified source of income

ACT Referral

- ❑ Prior Authorization from Managed Medicaid

Incomplete applications will be returned for completion

For internal use only:

- ❑ This application has been reviewed and is complete
- ❑ This application has been reviewed and is missing the following required items:

Referral for:

- ☐ Housing
  - ☐ Community Residence
  - ☐ Horizon Apartment Program
- ☐ ACT (Assertive Community Treatment)
- ☐ Supported Housing
- ☐ SRO (Single Room Occupancy)

Referral Source			
Contact Person:		Date of Referral:	
Agency:		Phone:	

Client Identification					
Client Name:		DOB:		Age:	
Ethnicity:		Marital Status:		Gender:	
Address:					
Telephone:		SS#:			
Medicaid #:		NYS ID# (OMH):			
Emergency Contact:		Relationship to Client:			
		Telephone:			

Type of Current Residence			
☐ Room	☐ Family Home	☐ Community Residence:	
☐ Adult Home	☐ Own Apartment	☐ Shelter:	
☐ Family Care	☐ None	☐ Other (Specify):	

Insurance and Financial Information	
☐ Public Assistance (includes Medicaid)	☐ Medicare#:_____
☐ Medicaid (without Public Assistance)	☐ No Insurance
☐ If a Spend Down, enter amount:$ _____	☐ Earned Income
☐ Medicaid Managed Care (company name: _____)	☐ SSI
☐ Medicaid Denied (reason: _____)	☐ Social Security /SSD
☐ Medicaid Dependent on Hospitalization	☐ Veteran's Benefits
☐ Private Third Party; Name of Insurer: _____	☐ Other

Social Support Resources			
Household Composition:			
Last Name	First Name	Relationship	Age
Client is a dependent: ☐ yes ☐ no	Client has dependents: ☐ yes ☐ no	Client has rep. payee: ☐ yes ☐ no Name:_____	

Significant Relationships:			
Name	Relationship	Supportive / Problematic	Telephone

Community Supports:

(Probation Officer, Clergy, Attorney, Mental Health Providers, Care Management, etc.)

Organization / Person	Type of Service / Relationship	Contact Person (if organization)	Telephone

Medical Information

Primary Care Physician

Name		Address		Phone number	

Pharmacy

Name		Address		Phone number	
Medical dx/problems		Allergies			

Current Medications:

Medication:	Prescribed For:	Dose/Frequency:	Date Started:	Prescribed By:

What level of support does the applicant require to achieve medication compliance?	☐ Dispensing	☐ None (Independent)
	☐ Supervision	☐ Refuses / Non-Compliant
	☐ Reminders	☐ Not Applicable

Mental Health and Substance Use Treatment Information

Psychiatrist	Therapist:
DSM-5 Diagnoses	
Developmental Disability	
General Medical Condition	
Psychosocial and Environmental Problems	
GAF	

Mental Health and Substance Use Treatment History

Inpatient - Where:	When:	Outpatient - Where:	When:

Behavioral Characteristics					
	Current	History		Current	History
Cruelty to animals	☐	☐	Legal/Criminal Involvement	☐	☐
Delusions/Paranoia	☐	☐	Obsessive Compulsive Behavior	☐	☐
Depressed/Manic Moods	☐	☐	Panic/Agoraphobia	☐	☐
Hallucinations	☐	☐	Property Destruction	☐	☐
Disruptive/Bizarre Behavior	☐	☐	Substance Use	☐	☐
Eating Disorder	☐	☐	Suicidal Ideation/Attempts	☐	☐
Fire Setting/Arson	☐	☐	Thought Disorder	☐	☐
Homicidal Ideation/Attempts	☐	☐	Trauma/Abuse/Assault Victim	☐	☐
Interpersonal Difficulties	☐	☐	Traumatic Brain Injury	☐	☐
Development Disability/Cognitive Impairment	☐	☐	Threatening/Assaultive Behavior	☐	☐

Functional Strengths/Deficits Assessment					
Physical Functioning (Self Care)					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech Impairment	☐	☐	☐	☐	☐
Walking, use of legs	☐	☐	☐	☐	☐
Use of hands and arms	☐	☐	☐	☐	☐
Comments:					

Personal Care (Self Care)					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Toileting	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Personal hygiene	☐	☐	☐	☐	☐
Dressing self	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Care of own possessions	☐	☐	☐	☐	☐
Care of own living space	☐	☐	☐	☐	☐
Comments:					

Social Interaction					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Accepts contact with others	☐	☐	☐	☐	☐
Initiates contact with others	☐	☐	☐	☐	☐
Communicates effectively	☐	☐	☐	☐	☐
Engages in activities without prompting	☐	☐	☐	☐	☐
Participates in groups	☐	☐	☐	☐	☐
Forms and maintains friendships	☐	☐	☐	☐	☐
Asks for help when needed	☐	☐	☐	☐	☐
Comments:					

Social Functioning					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Verbally abuses others	☐	☐	☐	☐	☐
Physically abuses others	☐	☐	☐	☐	☐
Destroys property	☐	☐	☐	☐	☐
Physically abuses self	☐	☐	☐	☐	☐
Is tearful, crying, clinging	☐	☐	☐	☐	☐
Takes property from others without permission	☐	☐	☐	☐	☐
Performs repetitive behaviors	☐	☐	☐	☐	☐
Comments:					

Community Living Skills					
	No problem	Problem; no effect on functioning	Slight effect on functioning	Restricts functioning substantially	Unknown
Household responsibilities	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Handling personal finance	☐	☐	☐	☐	☐
Use of telephone	☐	☐	☐	☐	☐
Use of public transportation	☐	☐	☐	☐	☐
Use of leisure time	☐	☐	☐	☐	☐
Medication	☐	☐	☐	☐	☐
Use of medical and other community services	☐	☐	☐	☐	☐
Basic reading, writing and arithmetic	☐	☐	☐	☐	☐
Is able to sustain work effort	☐	☐	☐	☐	☐
Appears at appointments on time	☐	☐	☐	☐	☐
Follows verbal instructions accurately	☐	☐	☐	☐	☐
Completes assigned tasks	☐	☐	☐	☐	☐
Traveling from residence without getting lost	☐	☐	☐	☐	☐
Recognizing and avoiding common dangers	☐	☐	☐	☐	☐
Comments:					

Narrative

(Include/attach information that would be helpful to this application, reasons for referral, any legal issues, current living situation, A.O.T. status, family court, child support, etc.)

Criteria For Serious Mental Illness

To be considered an adult diagnosed with Serious Mental Illness, A must be met. In addition, B, C, or D must be met. **(please check all that apply):**

☐ A. Designated Mental Illness Diagnosis (the individual is 18 years of age or older and currently meets the criteria for a DSM psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions).

AND ONE OF THE FOLLOWING

☐ B. 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 I or II below):

I. ☐ The individual has experienced at least two of these functional limitations due to a designated mental illness over the past twelve months on a continuous or intermittent basis:

- ☐ Marked difficulties in self-care (personal hygiene; diet; clothing; avoiding injuries; securing health care; or complying with medical advice).
- ☐ Marked restriction of activities of daily living (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- ☐ 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).
- ☐ 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 to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance to complete tasks.

II. ☐ The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to designated mental illness over the past twelve months on a continuous or intermittent basis.

OR

☐ D. Reliance on Psychiatric Treatment, Rehabilitations, and Supports
Documented history shows that the individual at some prior time. Met with threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medications 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 which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of the underlying mental disorder.

Name of person completing this form | Title | Signature | Date

Multiple Party Release Form

Tompkins County SPOE Assessment Team

Client Name: _____ Date of Birth: _____

PURPOSE OF THE RELEASE:

To Complete and Process Referral for Adult Mental Health Housing & Case Management Services in Tompkins County

I, _____, do hereby consent and authorize information to be obtained from and/or released to the Tompkins County SPOE Assessment Team that includes:

Cayuga Medical Center
Elmira Psychiatric Center/Family Care
Lakeview Health Services, Inc.
Mental Health Association of Tompkins County
Mid Lakes Assertive Community Treatment - ACT
Southern Tier Care Coordination
Tompkins County Department of Social Services
Tompkins County Mental Health Services
Unity House

The following information pertaining to myself:

Drug/Alcohol History
Financial Status
Medical Records
Mental Health Housing Referral Package
Psychiatric Assessment
Psychosocial History

This release will expire: ☐ one year from date of signing
☐ _____

_____ _____
Signature of Client Date Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date Relationship to Client

☐ Copy of Release Given to Client
☐ Client Refused Copy of Release

This information has been disclosed to you from confidential records protected by Federal and State confidentiality laws (42 CFR Part 2,NYS MHL 33.13, NYPH Article 27-F). These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of Federal or State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.