St. Lawrence County
Single Point of Access (SPOA) Committee

UNIVERSAL REFERRAL FORM
FOR CARE MANAGEMENT AND RESIDENTIAL SERVICES

Name of Individual: _____ DOB: _____

Current Address: _____

I agree to be considered for one of the following adult case management and/or housing services: Assertive Community Treatment, Intensive Case Management, Care Management, Supported Housing Case Management, Peer Supported Case Management, Family Care, Northwood Manor, Gateway, North Country Transitional Living Services Community Residence and SRO. I have been informed as to the nature of these services and understand that participation in any of these programs is voluntary.

I understand that with my agreement, acceptance into one of the above programs is decided by St. Lawrence County's Single Point of Access Committee. I understand that this committee is comprised of representatives from community agencies as well as consumer advocates. Community agencies represented include, but are not limited to: St. Lawrence Psychiatric Center, United Helpers Mosaic, Office for Persons with Developmental Disabilities, Cerebral Palsy Association of the North Country, STEP by STEP, Transitional Living Services, Claxton Hepburn Medical Center, ACR Health, CNYHHN, Inc., Northern Regional Center for Independent Living, Citizen Advocates, HCR, CHJC, Seaway Valley Prevention Council, Community Health Center of the North Country and St. Lawrence County Community Services.

I understand that the members of this committee are bound to maintain the highest standards of confidentiality defined by law (HIPAA 45CFR Parts 160 and 164; and 42 CFR, Section 2) and are not to disclose information that identifies me personally, outside of the SPOA Committee process. I understand that it is the role of the committee to oversee the use of adult case management/housing services in St. Lawrence County and to decide which level of service, depending upon availability and program eligibility requirements, is most appropriate for each individual based on their needs and desires. In making its decision, the committee will use and possibly discuss all information provided by the individual agency representatives regarding my circumstances. I understand that I may request that an agency which possesses my protected health information, exclude or hold private specific information from SPOA Committee consideration.

By signing this authorization I give my permission for members of the SPOA Committee to share information necessary to describe my situation, and to determine the most appropriate service or services based on my needs and desires. I understand that upon my written request, I may withdraw my permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future applications for these services. Unless my permission is withdrawn I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Withdrawal of Request/Authorization

I voluntarily withdraw my request for case management and housing services and in doing so withdraw my authorization for the Single Point of Access Committee to continue to share information regarding my circumstances. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

St. Lawrence County
Single Point of Access (SPOA) Committee

Referred to: (please check all that you prefer)	
Care Management	**Residential Services**
_____ Assertive Community Treatment (ACT)	**_____ Family Care**
_____ Specialty Mental Health Care Management	**_____ Northwood Manor**
_____ Care Management	**_____ Gateway**
_____ Supportive Housing Case Management (SHCM) ____Long Term Stay/ ____ RCE	**_____ Transitional Living Services CR**
_____ Peer Supported Case Management (PSCM)	**_____ SRO**
	_____ Step by Step Supportive Housing
	_____ Step by Step Apartments (Mansion and Ford)

Individual Being Referred			
Name:	**Sex:**	**DOB:**	**Age:**
Address:			**County:**
Phone:	**Social Security #:**	**Marital Status:**	
Religion:	**Legal Status:**	**Veteran: ___Y ___N**	
Current Living Arrangement:			

Health Insurance		
Medicare:	**Medicaid:**	**Private:**

Financial Information/sources of income **(If applied and not yet receiving a potential source of income, please describe & give date of application)**			
Monthly Income:		**Employer:**	
SSI:	**SSD:**	**PA:**	**VA:**
Alimony:	**Child Support:**	**Retirement:**	**Other:**
Existing Rep. Payee? ___Y ___N (Name, phone #)			

Emergency Contact		
Name:	**Relationship:**	**Phone:**
Address:		

Referred By	
Name:	**Agency/Title:**
Email:	**Phone:**

Address:	**Fax:**

Psychiatric Data
Diagnosis:

Current Mental Health Services **(Include Name and Phone Number of Clinic, Primary Therapist, Psychiatrist And/or Relevant Providers)**

Other Agencies Involved With This Individual

Psychiatric Hospitalizations		
Currently Hospitalized: ___Y___ N	**Admission Date:**	**Anticipated/Actual Discharge Date:**
Where will the individual be referred upon discharge, if not already linked to outpatient mental health services?		

Psychiatric Hospitalizations within the LAST YEAR (Dates, Locations, Reasons)		
Date	**Location**	**Reason**

Current Medications (Dosage and Frequency) (Psychiatric and Medical)		
Medication Name	**Dosage**	**Frequency**

Risk Factors	**Yes**	**No**	**Comments**
Drug/Alcohol Abuse/Use			
Non-Compliance With Treatment			

AOT Referred			
Risk Factors (cont)	**Yes**	**No**	**Comments**
Mild or Moderate Stress Creates Exacerbation of Symptoms			
Difficulty Coping with Major or Multiple Medical Problems			
Suicide Attempts			
Self-Injurious Behavior			
Trauma			
Sexual Misconduct			
Sexual Offender			Level:
Problems with Self Direction/Concentration			
Difficulty With Self Care			
Difficulty with ADL's			
Lack of Support System			
Frequent Crisis Contacts			
Parent/Child Problems			
Chronic Vocational/Economic Problems			
Property Damage			
History of Violence			
Temper Outbursts			
Incarceration			
Chronic Housing Problems			
Chronic Legal Problems			
Nighttime Agitation (Housing Only)			
Incontinence (Housing Only)			
Elopement (Housing Only)			
Smoke with Supervision (Housing Only)			

Criminal History		
Offense	**Outcome**	**Date**

Safety Concerns ***Safety concerns are addressed to assure that case managers can safely go into the home***
Safety issues around this person or others in the household? ___Y ___N (Explain)
Firearms, swords, weapons in the home? ____Y ___N (Explain)
Animals in the home (dogs that are dangerous? ___Y ___N (Explain)

Medical Information (Housing Only)	**Yes**	**No**	**Comments**
Physical Exam (Within 1 year)			**Date:**

Mantoux Test (Within 1 year)			
Medical Information (Housing Only)	**Yes**	**No**	**Comments**
Cardiac/COPD Problems			
Diabetes			
Seizure Disorder (Indicate Date of Last Seizure)			
Allergies			
Special Diet			
Limited Ambulation			Able to do stairs?
Any Restriction of Activities			

Social Data	
Current Day/Social Programs:	
VESID:	Employment/Training Hx:
Any Previous Supervised Living (date/location):	
Family Care _____ Y _____N Date:	
Gateway _____ Y _____N Date:	
Northwood _____ Y _____N Date:	
SRO _____ Y _____N Date:	
NCTLS CR _____ Y _____N Date:	
Independent Living _____ Y _____N Date:	
Other	

Statement of Need
(Describe what the person sees as his/her concrete case management needs in terms of advocacy, linkage, monitoring or state the reason(s) individual needs requested level of housing.)

Signature of Individual Making the Referral: _____ Date: _____

Signature of Individual Being Referred: _____ Date: _____

SEND REFERRAL FORM TO: Lindsay Best, Deputy Director of SLC CS, FAX# (315) 386-2435 (OR) 80 SH 310, Suite 1, Canton, NY 13617, Phone: (315) 229-3871, email: lbest@stlawco.gov

******TO PROCESS THIS REFERRAL WE NEED ALL INFOMRATION ON FORMS TO BE COMPLETE AND ATTACHMENTS RECEIVED******

ATTACHEMENTS NEEDED FOR CARE MANAGEMENT INCLUDE:

___ Most Recent Psychiatric and Social Assessment (include an updated summary if PSA is more than 1 year old), AND

___ Most Recent Discharge Summary (if hx of hospitalization)

ATTACHMENTS NEEDED FOR RESIDENTIAL SERVICES INCLUDE THOSE LISTED ABOVE AND:

___ Statement of Ability to Self-Medicate (completed by Psychiatrist)

___ Authorization for Restorative Services of Community Residences (completed by Psychiatrist)

Authorization for Restorative Services of Community Residences

**** Not Required for Family Care, Northwood Manor, SRO ****

Initial Authorization for the receipt of Restorative Services not to exceed:

☐ 6 months for Congregate Residences (**Check One Only)**

☐ 12 months for Apartment Residences **(Check One Only)**

Individual's Name: _____

Individual's Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, and having conducted a face-to-face assessment with said client as required pursuant to Part 593 of Title 14 NYCRR, have determined that _____

(Individual's Name)

would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR.

_____ _____

Physician's Signature **Date of Signature**

_____ _____

Type or Print Physician's Name **License # and State**

_____

NPI Number

(Agency use only)

_____ **Provider enrollment in Medicaid verified by OPRA search [ ] YES [ ] NO**
reviewed by (init/date)

Statement of Ability to Self-Medicate

Resident's Name: _____ **C#: _____**

	Yes	No
Independently	☐	☐
With Supervision	☐	☐

Comments:_____

_____

_____

_____

_____

_____ _____

Physician's Signature **Date**