Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Attn: Victoria Winchester, Adult SPOA Coordinator
Sullivan County Department of Community Services
20 Community Lane
Liberty, New York 12754
Phone number (845) 513-2008
Fax number (845) 513-2110

2. Please review REQUIRED DOCUMENTATION FORM below.
   Referrals will NOT be considered complete without:
   Complete SPOA Application
   Clinical Information as specified below.

3. Upon receipt, application will be reviewed by SCDCS for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 845 513-2008.

REQUIRED DOCUMENTATION

Required Documents	**Care Management**	**CR**	**TX APT**	**SH**
Eligibility Determination	X	X	X	X
Referral Form	X	X	X	X
Psychiatric Evaluation (Including DSM VI and Current within 90 days)	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X
Physical Exam & Immunization Record		X	X	
Authorization for Restorative Services **(MUST BE ORIGINAL)**		X	X	

NOTE: All SPOA applications have to be single-sided and all clinical backup must be less than a year old

Eligibility Determination

In order to be eligible for services through SCDS, applicants for Housing or Case Management Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, B, C, **or** D must be met:

Yes ____ No _____ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions.

Yes ____ No _____ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI ***DUE TO A DESIGNATED MENTAL ILLNESS***.

Yes ____ No _____ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant must meet 1 or 2 below:

1. 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.* (Documentation in psychosocial assessment required.)

Yes ___ No ___ **a. Marked difficulties in self-care.**
Yes ___ No ___ **b. Marked restrictions 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 of school setting.**

Yes ____ No _____ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)
Yes ____ No _____ One six month stay in an inpatient psychiatric unit
Yes ____ No _____ Two stays of any length in an inpatient psychiatric unit in the preceding two years.
Yes ____ No _____ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.
Yes ____ No _____ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.
Yes ____ No _____ Six months consecutive residency in a designated Adult Home.
Yes ____ No _____ Six months consecutive residency in a Residential Care Center for Adults (RCCA)
Yes ____ No _____ Six months consecutive residency in a Residential Treatment Facility (RTF)

Applicant Information

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

County of residence: _____

Telephone _____ Male __ Female __ Citizenship: Yes ____ No (if no, immigration status): _____

Ethnicity

____ White (Non-Hispanic)
____ Black (Non-Hispanic)
____ Latino/Hispanic
____ Asian/Asian American
____ Native American
____ Pacific Islander
____ Other _____

Primary Language

___English ___Spanish ___Chinese ___French
___Italian ___Russian ___German ___Japanese
___Other

Custody Status of Children

____ No children
____ Children are all above 18 years of age
____ Minor children currently in client's custody
____ Number of children: ____ Gender: _____
____ Minor children not in client's custody but have access
____ Minor children not in client's custody – no access

Current Living Situation

____ Room ____ Homeless (shelter)
____ Own apt ____ Homeless (streets)
____ Supervised Living ____ Nursing Home
____ Supported Housing ____ Psychiatric Hospital
____ Lives with spouse ____ Lives with Parents
____ Correctional facility Other _____

Insurance and financial information: ***Currently receives***

Social Security ☐
SSI/SSD ☐
Public Assistance ☐
Medicaid ☐
Medicare ☐
Earned Income/Wages ☐
Food Stamps ☐
VA Benefits ☐
Representative Payee ☐
Other _____

Referral source (including RPC Long Stay)

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program: _____ Relationship: _____

Email address: _____

Current diagnosis:

_____

_____

_____

Current medical conditions:

_____

_____

_____

Psychosocial and environmental problems:

_____

_____

_____

Current medications:

_____

Outpatient Treatment Provider:

Agency: _____ **Program:** _____

Contact: _____ **Telephone:** _____

Substance Abuse History : **Please List Drugs of Choice**

_____

Length of Time Recipient Has Been Substance Free: _____

Criminal Justice – Current Status

___ None ___ Incarcerated-Jail ___ Incarcerated-Prison ___ CPL 330.20/730
___ Probation ___ Parole ___ ___ Other:_____

P.O. Name: _____ Telephone: _____

Number of arrests/incarcerations in past year _____ **Number of lifetime arrests** _____

Reason for Arrest: _____ _____ **Date:** _____

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law? _____ **Yes** ____ **No**

Is an AOT under Kendra's Law currently being pursued? _____ **Yes** ____ **No**

Case Management Service Requested

____ Health Home Care Management ____ CSS Care Management

Is there a specific case management program requested? _____

Residential Services Requested

_____Supervised Community Residence
_____Supportive Apartments
____Treatment Apartment Programs
_____ RSS Supported Housing
_____ Chestnut Street Apartments
_____Invisible Children's Program (for families with children under the age of 18).
____ Family Care
____Golden Ridge Supported Housing
____COC Housing
_____ACCESS SFL TLS (AKA Treatment Apartment)
_____ Scattered Sites Housing Program

Geographical Preference/Community: _____

~~**Recipient Requests:**~~

Recipient Signature: _____ **Date:** _____

Referring Party Signature: _____ **Date:** _____

Rehabilitation Support Services, Inc.

RSS

Service Authorization for Adult Community Residences and Treatment Apartment Programs

A. Type of Authorization: ☐ Initial Authorization
☐ Re-Authorization

B. Client's Name: _____

C. Client's Medicaid Number: _____

I, the undersigned licensed physician/practitioner, based on either:
a) **INITIAL AUTHORIZATION:** Must be signed by a physician ONLY and based upon clinical information **and** a face to face assessment of the individual

OR

b) **RE-AUTHORIZATION:** Must be signed by a Physician, Physician Assistant or Nurse Practitioner in Psychiatry.

D. have determined that _____ would benefit from the provision
(client's name)
of community rehabilitation services as known to me and defined pursuant to 14 NYCRR Part 593.

E. This determination is in effect for the period _____ to _____, at which time there will be an evaluation of continued stay.

F.	ICD.10 Primary Mental Health Diagnosis Code F ___ ___ . ___ ___ ICD.10 Diagnosis_____	
	Name of Practitioner (Please Print): ☐ Physician ☐Physician Asst. ☐ Nurse Practitioner in Psychiatry	Practitioner's License#
G.	Signature of Practitioner / Date	Practitioner's NPI #

INSTRUCTIONS:
Initial Authorization: Must be a Face to Face visit with a PHYSICIAN: Residents, PA's or NPP's cannot sign for the physician. Complete sections F and G.
Re-Authorization: PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTIONER IN PSYCHIATRY Complete Section F and G
RSS Staff: Complete Sections A, B, C, D and E and NPI # if blank

RSS MBP 3 Revised 8.15

ACCESS: Supports for Living Inc.
MH Residential
Service Authorization

☐ Initial (admission) Authorization (*requires face to face contact in writing signed by NYS licensed physician for Residential Services)*
☐ Semi-Annual re-authorization *(CR resident only / every 6 month. Does not require face to face contacts)*
☐ Annual re-authorization *(Supportive Apt Treatment residents / every 12 months) Does not require face to face contacts) check regs.MD or NP can sign*

Client's Name: _____
Client's Medicaid Number: _____

Based on my examination of _____ and/or a review of the documentation
(Resident's name)
made available to me, I have determined that this individual would benefit from the provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR.

This determination is in effect for the period _____ to _____,

at which time there will be an evaluation for continued stay.

Physician completes this section ↓

Diagnosis
(ICD 10): _____

Month/Day/Year	MD/NP Name (Please Print)	NYS Licensure #
	Signature	

☐	Check here if client is enrolled in Managed Care (e.g. an HMO or Managed Care Coordinator Program) and enter primary care physician name and Managed Care provider.
Primary Care Physician Name:	
Managed Care Provider:	

SULLIVAN COUNTY SINGLE POINT OF ACCESS
CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: This release cannot be used for the release of HIV- related information nor for the re-disclosure of confidential information provided to the agencies listed below except as allowable by law.

Applicant's Name:_____ **DOB:**_____

Extent or Nature of Information to be Disclosed:
Contents of the SPOA Referral Packet including but not limited to:
Psychiatric Assessment/Core Evaluation
Psychosocial Assessment/Core History
Hospital Admission and Discharge Plan (if appropriate)
Physical Examination and TB Test Results
List of Medications
Physician's Authorization
Other:_____

Purpose or Need for Information
To facilitate a referral for residential and/or care coordination services, determine eligibility for such services, and assess appropriateness of applicant for the various programs available.

Information Being Disclosed From: (Name, Address, and Title of Person/Organization/Facility/Program)

All referrals go directly to SPOA Coordinator, who then distributes relevant information to the SPOA Committee including:

Access: Supports for Living, Inc. (Devon Mgmt./Golden Ridge)
Action Toward Independence
A-SPOA Referral Source
Garnet Health Medical Center (formerly Catskill Regional Medical Center)
EESHI Scattered Sites Program
Hudson Valley Community Services
Independent Living, Inc.
NYS Office of Mental Health
Rehabilitation Support Services, Inc.
Rockland Psychiatric Center/Rockland Psychiatric Center MTR
Sullivan County Center for Workforce Development
Sullivan County Department of Community Services
Sullivan County Department of Social Services
Kearney Realty and Development Group (Chestnut Street Apartments)
Sara Watson, ODTA (Office of Temporary and Disability) Program Manager
Unite Us
SunRiver Health Care
SYNERGY
Sullivan County Probation
NYS Dept. of Corrections and Community Supervision
OPWDD
Sullivan County Office for the Aging

I hereby authorize the release of the above information to the persons/organizations/facilities/programs identified above. I understand that the information is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time in writing. This authorization will expire when I am no longer receiving SPOA services.

_____
Signature of Applicant **Date Signed**

_____
Signature of Witness **Relationship to Applicant** **Date Signed**