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MENTAL HEALTH & ADAS
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SULLIVAN COUNTY

DEPARTMENT OF COMMUNITY SERVICES

DIVISION OF HEALTH & FAMILY SERVICES

MENTAL HEALTH, MENTAL RETARDATION, ALCOHOL AND DRUG ABUSE SERVICES

P. O. BOX 716
20 COMMUNITY LANE
LIBERTY, NEW YORK 12754

CONTINUING DAY TREATMENT
AND IPRT FAX: 845-513-2110

Dear Colleague/Consumer,

Enclosed please find an application for Sullivan County Single Point of Access (SPOA) which is the access point to obtain Case Management and Residential Services for Adults, aged 18 and over, with Severe and Persistent Mental Illness (SPMI). Also, enclosed are the definition for SPMI and the criteria for Intensive Case Management (ICM).

The application needs to be completed fully and the necessary up to date medical and clinical documentation needs to be submitted along with the application. A list of this documentation can be found at the top of page one. Also enclosed is a Consent for Release of Information; please feel free to copy this if you require additional copies and complete fully.

Any omissions will result in the application being returned to the referral source for completion.

Once a completed application is received, it will be placed on the agenda for the SPOA Committee Meeting which is held every second Thursday. At that time, a priority rating will be assigned based on the client's current situation and need and, if no immediate slot is available, the client will be placed on a rolling wait list. When there is an opening available to service the client, the application will be given to the provider agency and their staff will contact the client directly.

If you have any questions, please feel free to call me at 845-292-8770, Ext 2077. Information or applications can also be faxed directly to me at 845-513-2110.

Very Truly Yours,

Melissa Stickle, LCSW, CASAC

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

Designated Mental Illness Diagnosis

The individual is 18 years of age or older and has a primary DSM-IV psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes or developmental disabilities.

AND

SSI or SSDI Enrollment due to Mental Illness

The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

OR

Extended impairment in Functioning due to Mental Illness

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.

- Marked difficulties in self-care
- Marked restriction of activities of daily living
- Marked difficulties in maintaining social functioning
- Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.

The individual has met criteria for rating of *50 or less* on the Global Assessment of Functioning Scale

OR

Reliance on Psychiatric Treatment, Rehabilitation and Supports in order for the individual to remain stable in the Community.

Criteria for Case management Services

Intensive Case Management (ICM) and Supportive Case Management (SCM) client needs to have a GAF of 50 or less and three or more documented hospitalizations in the last three years.

Sullivan County Single Point of Access
Application for Services

The referral source must submit the following documents (current within 12 months of application):

- Comprehensive Psychosocial Assessment, ***COMPLETED WITHIN THE LAST 12 MONTHS***
- Psychiatric Assessment, including DSM IV diagnosis, ***COMPLETED WITHIN THE LAST 12 MONTHS***
- Hospital Admission and Discharge Plan as appropriate
- Copy of Client's Medicaid Card

Applications for a Community Residence, Family Care or Supportive Apartment must also include:

- Copy of physical exam and TB test results

All applications must be submitted to: Melissa Stickle, LCSW, CASAC
Sullivan County Department of Community Services
PO Box 716, 20 Community Lane
Liberty, NY 12754
Phone: (845) 292-8770 Fax: (845) 513-2110

DO NOT SUBMIT INCOMPLETE APPLICATION, IT WILL BE RETURNED AND DELAY THE PROCESS.

Applicant Information:

Name:_____ Date of Birth:_____

Social Security #:_____ Medicaid #:_____

Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Telephone #:_(____)_____ Gender: _____ Male _____ Female

Citizenship: Yes No (If no, immigration status):_____

Marital Status

____Single – never married ____Married
____Divorced/Separated ____Widowed
____Lives with significant other

Primary Language

____English ____Spanish
____French ____Italian
____German ____Other

English Proficiency

____Does not speak English ____Poor
____Fair ____Good

Educational Level

____Grade School ____Some HS ____HS Diploma/GED
____Voc Training ____Some College ____College Degree
____Master's Degree ____Ungraded
____No Formal Education ____Other_____

Employment Status

____Full Time ____Part Time ____Not Employed
____Other_____

Others in home/household:

Name	Age	Gender	Relationship

Rev. 1/3/07

Others in home/household (continued):

Name Age Gender Relationship

Custody Status of Children

____No children
____Children are all above the age of 18
____Minor children currently in applicant's custody
____Minor children not in applicant's custody, but have access
____Minor children not in applicant's custody – no access

Current Living Situation

____Room
____Own apartment
____Supervised Living
____Supported Housing
____Lives with spouse/ significant other
____Correctional Facility
____Homeless (shelter)
____Homeless (streets)
____Nursing Home
____Psychiatric Hospital
____Lives with parents/ family member
____Other_____

Insurance and Financial Information:

Benefits or Insurance	Currently Receives (fill in amount)	Pending Application Submitted	Eligible – No Application Submitted	Ineligible	Unknown
Social Security					
SSI and/or SSD					
Public Assistance					
VA Benefits					
Medicaid					
Medicare					
Food Stamps					
Pension					
Wages					
Worker's Comp					
Unemployment					
Private Insurance					
Trust Fund					
Section 8/Hud /Low Income Housing					
Other					

Is applicant his/her own payee for benefit checks? _____Yes _____No

If not, who is the representative payee? Name:_____

Relationship to applicant:_____

Referral Source

Name:_____ Telephone #:__(_____)_____

Agency:_____ Fax #:__(_____)_____

Address:_____ City:_____

State:_____ Zip:_____ Email::_____

Relationship to applicant:_____

Person to Notify in Emergency

Name:_____ Telephone #:__(_____)_____

Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Relationship to applicant:_____

Skills/Supports Assessment

Can the applicant function independently in the following areas?

Skill	Yes	No	Unknown	Skill	Yes	No	Unknown
Paying Rent				**Housekeeping**			
Money Management				**Program Participation**			
Nutrition				**Use of Leisure Time**			
Socialization				**Traveling in Community**			
Own Car				**Shopping**			
Cooking				**Grooming**			
Securing/Maintaining Benefits				**Making/keeping necessary appointments**			
Personal Hygiene				**Use of Health Services**			

Indicate all services current or planned:

Service	Current	Planned	Service	Current	Planned
Health			**Club House**		
Education			**Psychiatrist/ Clinic**		
MICA Day Program			**Substance Abuse Treatment**		
Psychiatric Day Program			**Case Management**		
Vocational Services			**NA/AA/DTR**		
MH Housing Program			**Other**		

Psychiatric Information

DIAGNOSIS	DSM IV CODE(S)
AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V	

Current Psychotropic Medications

Medication Name	Dosage	Schedule

What level of support does the applicant require to achieve medication compliance?

____Dispensing ____Reminders ____Refuses/Non-compliant
____Supervision ____None – Independent ____Not Applicable

Is the person currently hospitalized? _____Yes _____No Date of Admission:_____

Hospital:_____

Outpatient Treatment Provider Information (Please have client sign consent for aftercare provider and forward with package).

Agency:_____ Program:_____

Contact:_____ Telephone #:__(_____)_____

To the degree known, list all psychiatric hospitalizations during the past three years:

Hospital/ER	Admission Date	Discharge Date	Source of Information

Number of psych hospitalizations in the past year:_____ Number of ER visits in the past year:_____

Behavioral Characteristics

Characteristic	Current	History	None	Unknown	Date of Most Recent Event
Childhood Violence					
Cognitive Impairment					
Criminal History					
Cruelty to Animals					
Delusions					
Destruction of Property					
Disruptive Behaviors					
Fire Setting					
Hallucinations					
Homicidal Ideas/Attempts					
Severe Depression					
Severe Thought Disorder					
Severe Violence Against Others					
Significant Difficulty in Treatment Compliance					
Suicidal Behavior					

Substance Abuse History

Drugs of Choice:

____None ____Any IV Drug Use ____Alcohol ____Marijuana
____Cocaine ____Crack ____Heroin/Opiates ____Hallucinogens
____Amphetamines ____PCP ____Sedatives/Hypnotics ____Benzodiazapines
____Prescription Drugs ____Inhalants ____Other _____

Frequency of Use:

____Not in the last month ____1-2 times per week ____Daily
____1-3 times in the last month ____3-6 times per week ____Unknown

Length of time applicant has been substance free: _____

Alcohol/Substance Abuse Treatment Program(s) applicant has attended within the past three years:

Program Name	Dates Attended	Program Completed Yes/No

Medical Information

List any significant medical hospitalizations:

Hospital	Admission Date	Discharge Date	Chief Complaint

Current Non-Psychotropic Medications:

Medication Name	Dosage	Schedule

Does the person have a medical condition that requires special services? _____ Yes _____ No

If yes, please describe service(s) needed:_____

Tuberculosis Clearance: *(For Residential Placement Only)*

PPD Date: _____ **Results:**_____

If positive PPD, Chest X-Ray Date: _____

Recommendations: _____

Criminal Justice History

Current Status:

____None ____Incarcerated-Jail ____Incarcerated-Prison ____CPL 330.20/730
____Probation ____Parole ____Diversion/Alternative to Incarceration Program
____Other:_____

Contact:_____ **Telephone #:_(_____)_____**

Reason for arrest:

_____

_____

Number of arrests in the past year:_____ **Number of incarcerations in the past year:** _____

Assisted Outpatient Treatment (AOT)

Does the applicant have court ordered AOT under Kendra's Law? _____Yes _____No

Date of Court Order: _____

Petitioner: _____

Please list any other significant community supports not otherwise noted in this application (i.e. supportive family, friends, etc.)

TO BE COMPLETED BY THE APPLICANT:

Please describe, in your own words, your request for services:

Applicant Signature **Date**

CASE MANAGEMENT SERVICES

(Check off level of Case Management requested)

_____ **Case Management:**
To be eligible for Case Management Services a client must have a diagnosis of Mental Illness and must be functionally disabled due to Mental Illness. Individuals receiving General Case Management Services are typically clients who can function relatively independently in the community with occasional support from their Case Manager. Staff to client ratio is 1:25. The minimum face to face contacts per month is one.

_____ **Supportive Case Management:**
Recipients are assisted with linkage to a community-based system of care. Coordinates service with the recipient, family, treatment provider and assists with negotiating various service systems. Develops an individualized community service plan and facilitates implementation, monitors services received, documents activities, and initiates periodic reviews. Staff to client ratio is 1:20. The minimum face to face contacts per month is two.

_____ **Intensive Case Management:**
Recipients are engaged through outreach. Monitors and coordinates evaluations and assessments to identify a recipient's needs, coordinates with family and treatment providers the development of an individualized community service plan. Provides "on the street" support, training, and assistance in the use of personal and community resources. Provides coordination and assists with crisis intervention and stabilization. Staff to client ratio is 1:12. The minimum face to face contacts per month is four. Individual must also meet OMH eligibility criteria for this level of service (see attachment 1-B).

Is there a specific case management program being requested?_____

Primary Preference:_____ ***Secondary Preference:***_____

RESIDENTIAL SERVICES

(Check off level of Residential Service requested)

APPLICANTS NEED TO BE MEDICALLY STABLE

_____ **Family Care:** Licensed private homes, located throughout Sullivan County, with a maximum capacity to care for six residents who have a psychiatric diagnosis. Services provided in this clean and home-like environment are medication monitoring, financial monitoring, provision of three meals and daily snacks, and ensuring that all medical appointments are made and kept. The care providers also make sure that there is access to social, family, and community resources. **CLIENT MUST BE RECEIVING SSDI OR SSI PRIOR TO PLACEMENT OR PRIVATE PAY.**

_____ **Supervised Community Residence:** These residences provide 24-hour supervision. Residents develop goal plans based on principles of Psychiatric Rehabilitation. Skill training is provided in areas including medication management, daily living skills, assertiveness, skill development, and community integration. Other areas are addressed depending on the need of each individual. The program is highly structured, with an emphasis on movement towards an increased level of independent living.

_____ **Supportive Apartment Programs:** These apartments are located throughout Sullivan County. Both individual and shared (roommate) placements are available. Staff visits recipients to provide supervision with apartment maintenance, socialization, interpersonal relations, and general daily living skills. Staff is also available 24 hours daily to provide crisis intervention and support. Emphasis at this level of housing is on maintaining a high level of functioning in daily living, medication compliance, emotional stability, and possible movement towards more independence.

_____ **Supported Housing:**
Support services are provided to recipients capable of living independently. A recipient must be willing and able to take their medications as prescribed, maintain clinical involvement, pay the bills necessary to maintain an apartment, and possess the daily living skills essential to living independently in the community. Recipients are assisted in securing permanent housing and, through donations and/or limited funding, in obtaining initial furnishings and basic start-up supplies for an apartment. Each recipient will apply for a Section 8 Certificate, and interim rent stipends will be provided until the Section 8 application is approved. The program works to ensure that residents pay no more that 30% of their total household income for rent.

Is there a specific Community Residence being requested?

First Choice:_____ ***Second Choice:***_____

For Apartment Programs, Family Care, and Supported Housing, what is the town or location preference?

_____

SULLIVAN COUNTY RESIDENTIAL REFERRAL APPLICATION
PHYSICIAN'S AUTHORIZATION FOR COMMUNITY SERVICES

_____ Initial Authorization

_____ Semi-Annual Authorization

_____ Annual Authorization

CLIENT'S NAME:_____

CLIENT'S MEDICAID NUMBER:_____

ICD.9 DIAGNOSIS:_____

I, the undersigned licensed physician, based on my review of the assessment made available to me, have determined that _____ would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period from _____ to _____, at which time there will be an evaluation for continued stay.

(client's name)

(start date)

(end date)

____/____/____ _____ _____

Mth/Day /Year **Name (Please Print)** **Licensure Number**

_____

Signature

_____ Check here is client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter Primary Care Physician's name and Managed Care Provider Identification Number.

_____ _____

Physician **Managed Care Provider Number**

SULLIVAN COUNTY SINGLE POINT OF ACCESS – CASE MANAGEMENT AND RESIDENTIAL SERVICES

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.

Client Name:_____ **DOB:**_____

Extent or Nature of Information to be Disclosed:

Psychiatric Assessment/Core Evaluation
(must include current clinical updates)
Psychosocial Assessment/Core History
Hospital Admission and Discharge Plan (if appropriate)
Physical Examination and TB Test Results (For Residential Placement only)

Other:_____

Purpose or Need for Information

To facilitate a referral for residential and/or case management 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)

Information Being Disclosed to: ***(NOTE: All referrals go directly to SPOA Coordinator, who then disseminates them to the appropriate program(s) listed below when there is a vacancy)***

Catskill Regional Medical Center
Mobile Mental Health Team
Sullivan County Department of Community Services
Rehabilitation Support Services
Rockland Psychiatric Center
Friends and Advocates for Mental Health

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 a final SPOA placement takes place.

_____
Signature of Applicant Date Signed

_____
Signature of Witness Relationship to Applicant Date Signed

ATTACHMENT 1

New York State Office of Mental Health Case Management Eligibility Criteria

In order to be considered for adult ICM services, an individual must fulfill the following general eligibility criteria:

- At least 18 years of age
- Meet the OMH criteria for individuals with a serious and persistent mental illness

And ONE of the following specific conditions:

1. Have experienced 3 separate psychiatric admissions within the preceding 18 months (please attach consecutive history of psychiatric admissions).

2. Have utilized psychiatric emergency services (crisis team and/or emergency room) on at least 3 separate occasions within the preceding 12 months (please give facility and admission date{s}).

3. Currently inpatient in a state psychiatric facility for at least 90 days and in need of extensive assistance to return to the community (please give facility and admission date).

4. Currently living in a homeless shelter, other non-permanent housing, or on the street.