

Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Attn: Hope Silverman
Sullivan County Department of Community Services
20 Community Lane
Liberty, New York 12754
Phone number (845) 513-2058
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 DCMH for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 995-5245.

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	

Eligibility Determination

In order to be eligible for services through DCMH, applicants for Housing, Case Management or ACT 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 DSM-IV 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 (V-codes).

Please complete: DSM-IV code: _____

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 or school setting.**

2. The individual has met criteria for ratings of **50 or less** on the Global Assessment of Functioning Scale (Axis V of DSM-IV) due to a designated mental illness over the past 12 months on a continuous or intermittent basis.

Yes Date: From _____ To: _____ Score: _____

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

Referral Source (including RPC Long Stay)

Name: _____ Phone: _____
Agency: _____ Fax: _____
Address: _____
Program: _____ Relationship: _____

Psychiatric Information:

Diagnosis

DSM IV Codes

Axis I: _____

Axis II: _____

Axis III: Current Medical Problems

Axis IV Diagnosis: psychosocial and environmental problems: Please list below

Axis V: Global Assessment of Functioning (GAF Score) _____

Current Medications: Please List

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

___ Supportive (SCM) ___ Intensive (ICM) ___ Adult Home (AHCM)

Is there a specific case management program requested? _____

Residential Services Requested

___ Supervised Community Residence
___ Supervised MICA Community Residence ___ Treatment Apartment Programs
___ Supported Housing ___ Individual ___ Family
___ Family Care

Geographical Preference/Community: _____

Recipient Requests:

Recipient Signature: _____ Date: _____

Referring Party Signature: _____ Date: _____

**AUTHORIZATION FOR RESTORATIVE SERVICES
OF COMMUNITY RESIDENCES**

- Initial Authorization
- Semi-Annual Authorization
- Annual Authorization

CLIENT'S NAME: _____

CLIENT'S MEDICAID NUMBER: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____
(client'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.

Mo/Day/Yr

Signature & Licensure #

Print Name