Westchester County Department of Community Mental Health
Single Point of Access Application
Case Management, ACT and Residential Services

Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

2. **Two copies** of the completed Single Point of Access Application and supporting documents should be mailed to:

SPOA UNIT
Adult Mental Health Services
Westchester County Department of Community Mental Health
112 East Post Road, 2nd Floor
White Plains, NY 10601

THIS MATERIAL CANNOT BE FAXED

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

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

5. Referring parties will be notified by fax of agency assignments or committee recommendations.

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

REQUIRED DOCUMENTATION

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

DO NOT SEND:

- **Progress Notes**
- **Outdated Psychiatric/Psychosocial Assessments (older than 90 days)**
- **Illegible (Handwritten) Assessments**

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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 of 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.

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)

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Applicant Information

Name: ______________________ Date of Birth: ____________
Social Security #: ______________________ Medicaid #: ____________
Address: ______________________ Apt#: ____________
City: ______________ State: ____________ Zip: ____________
Tel. No.: ( ) ______________ Gender: ____ Male ____ Female
Citizenship: ___ Yes ___ No (If no, immigration status):__________ Email : ____________

Ethnicity

___ White (Non-Hispanic) ___ Black (Non Hispanic)
___ Latino/Hispanic ___ Asian/Asian American
___ Native American ___ Pacific Islander
___ Other ______________

Marital Status

___ Single never married ___ Married
___ Divorced/Separated ___ Widowed
___ Lives with significant other

Primary Language

___ English ___ Spanish ___ Chinese ___ French
___ Italian ___ Russian ___ German ___ Japanese
___ Hindi ___ Urdu ___ Vietnamese ___ Creole
___ Greek ___ Other ___ American Sign Lang.

English Proficiency

___ Does not speak English ___ Poor
___ Fair ___ Good

Educational Level

___ Some Grade Schl ___ Grade School ___ Some HS
___ HS Diploma/GED ___ Voc Training ___ Some College
___ College Degree ___ Master's Degree ___ Ungraded
___ No Formal Ed. ___ Other ______________

Employment Status

___ Full Time ___ Part Time
___ Not Employed ___ 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 ____________

Referral Source

Name: ______________________ Phone: ____________
Agency: ______________________ Fax: ____________
Address: ______________________
Program: ______________________ Email Address: ____________
Relationship: ______________________

Person to Notify in Emergency

Name: ______________________ Phone: ____________
Address: ______________________ Apt #: ____________
City: ______________________ State: ____________ Zip ____________
Relationship: ______________________

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Criminal Justice

Current Status

___ None	____ Incarcerated-Jail	____ Incarcerated-Prison	____ CPL 330.20/730
___ Probation	____ Parole	____ TASC/MHATI	____ Other:________________

P.O. Name: ______________________________ Telephone: __________________________

Reason for Arrest: ______________________________________ **Date:** ________________

Number of arrests in the past year: ________ **Number of incarcerations in the past year:** __________

Number of lifetime arrests: ________

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**

Insurance and Financial Information:

Benefits or Insurance	Currently Receives	Benefits or Insurance	Currently Receives
Social Security	☐	Earned Income/Wages	☐
SSI/SSD	☐	Worker's Comp	☐
Public Assistance	☐	Unemployment	☐
VA Benefits	☐	Private Insurance	☐
Medicaid	☐	Trust Fund	☐
Medicare	☐	Medication Grant	☐
Food Stamps	☐	Other	☐
Pension	☐	Representative Payee	☐

***Psychiatric Information*:**

	Diagnosis	DSM IV Codes
Axis I:	______________________________	____________
	______________________________	____________
Axis II:	______________________________	____________
	______________________________	____________

Axis III: Current Medical Problems (select all that apply)
(Agencies may require Physical Exam as related to all that apply.)

- ☐ None
- ☐ Arthritis/joint disorder
- ☐ Asthma
- ☐ Cancer
- ☐ Coronary artery disease
- ☐ Dementia/Organic Brain Disorder
- ☐ Diabetes
- ☐ Female Reproductive problem
- ☐ Genital/Urinary Disorder
- ☐ Head Injury
- ☐ Hepatitis/Cirrhosis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Neurological
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Renal/Renal Dialysis
- ☐ Sexually Transmitted Disease
- ☐ Sleep Disorder
- ☐ TB
- ☐ Ulcer/Gastrointestinal Disorder
- ☐ Other (specify)
- ☐ Unknown

Current Health Care Provider(s): ______________________________ Phone: ______________

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Axis IV Diagnosis: psychosocial and environmental problems (select all that apply)

- ☐ Problems with primary support group
- ☐ Problems related to the social environment
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Economic problems
- ☐ Problems with access to health care services
- ☐ Problems related to access to the legal system
- ☐ Other (specify)________________
- ☐ Other psychosocial and environmental problems

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

Current Medications:

Name	Dosage	Schedule	Reason

Outpatient Treatment Provider:

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: ________

Is the person currently hospitalized? ____ Yes ____ No **Date of Admission:** ________________

Hospital: ________________________________

Behavioral Characteristic	Current	History
Childhood violence		
Cognitive Impairment		
Criminal History		
Cruelty to Animals		
Delusions		
Destruction of Property		
Disruptive Behaviors		
Fire Setting		

Behavioral Characteristic	Current	History
Hallucinations		
Homicidal Ideas/Attempts		
Severe Depression		
Severe Thought Disorder		
Severe Violence Against Others		
Significant difficulty in Treatment Compliance		
Suicidal Behavior		

Any Characteristic checked must be documented in Psychosocial and/or Psychiatric Summary.

Substance Abuse History

Drugs of Choice

____ None ____ Any IV Drug Use ____ Alcohol ____ Marijuana
____ Cocaine ____ Crack ____ Heroin/Opiates ____ Hallucinogens
____ Amphetamines ____ PCP ____ Sedative/hypnotics ____ Benzodiazapines
____ Prescription Drugs ____ Inhalants ____ Other ________________

Alcohol/Substance Abuse Treatment Program within the Past 3 Years: **Dates:**

________________________________ ________________

________________________________ ________________

Length of Time Recipient Has Been Substance Free: ________________

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Case Management Service Requested

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

Is there a specific case management program requested? ____________________

Please check all areas needing the assistance of a Case Manager:

Money Management	____	Program Participation	____	Community Linkage	____
Nutrition	____	Use of Leisure Time	____	Travel Training	____
Socialization/Relationship	____	Use of Health Services	____	Educational	____
Securing/Maintaining Benefits	____	Personal Hygiene	____	Vocational	____
Other: ____________		Housing	____		

Act Services Requested ____

Is there a specific ACT Team requested?____________________

Residential Services Requested

____ Supervised Community Residence
____ Supervised MICA Community Residence
____ Supervised Community Residence MI/MR
____ Supported Single Room Occupancy (SRO)
____ Treatment Apartment Programs
____ Supported Housing ____ Individual ____ Family
____ Shelter Plus Care ____ Individual ____ Family

Is there a specific agency requested? ____________________
Geographical Preference/Community: ____________________

If on inpatient status at the time of referral, state discharge plan while awaiting housing?

- ☐ Shelter
- ☐ Return to own apartment
- ☐ Return to live with family, significant other
- ☐ Other ____________________

Contact Upon Discharge: ____________ Phone: ____________ Email: ____________

Recipient Requests:

____
____
____
____

If application is completed Online, please give date plan was reviewed with recipient. ____________
Recipient Signature: ____________________ **Date:** ____________
Referring Party Signature: ____________________ **Date:** ____________

DCMH Use Only	
Medicaid Check	____
Clinical Documents	____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV (Human Immunodeficiency Virus) related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV-related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV-related information without a release form by calling the HIV Confidentiality Law Hotline at 1-800-962-5065.

If you sign this form, HIV-related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form to obtain housing and you can change your mind at any time. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 961-8624. This agency is responsible for protecting your rights

Name and address of facility/agency/provider obtaining release:
Name of person whose HIV-related information will be released:
Names and address of person(s) who will be given HIV-related information: Westchester County Department of Community Mental Health's System of Services
Reason for release of HIV-related information: Coordination of Services
Time during which release is authorized: Six months from date that release is signed.

I authorize the disclosure of HIV-related information to the people/agencies listed on this form, and for the reason(s) listed on the form. My questions about this form have been answered. I know that I do not have to allow release of HIV-related information and that I can change my mind at any time.

Date: __________ Signature: ______________________________________

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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**