

# Cayuga County Community Mental Health Center

## ADULT SINGLE POINT OF ACCESS (SPOA) APPLICATION

Send completed checklist and application by **encrypted** email to: [AdultSPOA@cayugacounty.us](mailto:AdultSPOA@cayugacounty.us)

or by fax to: 315-253-1687

or by mail to: c/o Adult SPOA Coordinator,  
146 North Street, Auburn, New York 13021

Applicant Name \_\_\_\_\_ D.O.B \_\_\_\_\_

*\*SPOA Applicants must meet eligibility criteria and all required documentation must be attached to application in order for SPOA Coordinator to process. Please check below to indicate eligibility and completeness of application. For more information, see page 2 for descriptions of services. If ineligible or if application is incomplete, SPOA Coordinator will email referring person.*

### Document Requirements for Referral

- Completed SPOA Referral Application Form
- Cayuga County Community Mental Health Center Multiple Party Release Form (page 6)
- Psychosocial assessment or initial comprehensive assessment *updated within the last 90 days.*
- Hospital admission and discharge summaries (only required if no psychosocial or assessment included)

#### **For residential treatment apartments, the following additional document is required:**

- Restorative Services Authorization (Must have original signature from M.D. and mailed or delivered to CCCMHC)

### Eligibility Requirements for Housing Services

- Must reside in Cayuga County
- 18+ years of age
- Mental Health Diagnosis

### Eligibility Requirements for Care Management

- Cayuga County resident
- 18+ years of age
- Serious Mental Illness Diagnosis **OR**  HIV/AIDS Diagnosis **OR**  Two Chronic Conditions
- Presence of significant behavioral, medical or social risk factors

# Program Descriptions

## Care Management

Applicants eligible for care management will be assigned to a care manager who will collaborate with the individual to develop a care plan to address medical and social needs. The care manager and individual identify a care team to help connect to services such as medical care, mental health care, substance use treatment, housing, social services, etc.

In order to qualify for care management in Cayuga County, an individual must:

1. Reside in Cayuga County
2. Be diagnosed with a serious mental illness OR HIV/AIDS OR Two Chronic Conditions
3. Have significant behavioral, medical, or social risk factors that lead to extended impairment in functioning including:
  - (a) Marked difficulties in self-care such as personal hygiene, diet, clothing, avoiding injuries, securing health care, or complying with medical advice; or
  - (b) Marked restrictions of activities of daily living such as maintaining a residence, getting and maintaining a job, attending school, using transportation, day-to-day money management, or accessing community service; or
  - (c) Marked difficulties in maintaining social functioning such as establishing and maintaining social relationships, interpersonal interactions with primary partners, children and other family members, friends, or neighbors, social skills, compliance with social norms, or appropriate use of leisure time; or
  - (d) Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner in work, home, or school setting. Individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in task, or require assistance in the completion of tasks.

## Adult Residential Services

In order to be eligible for residential services, applicants must:

1. Reside in Cayuga County
2. Be 18 or older
3. Have a mental health diagnosis substantiated by a medical professional

Residential programs include:

### ▪ **Treatment Apartment Program**

This is a transitional program that offers support to individuals needing assistance to develop skills in order to live more independently. Developing a plan to transition to independent living in the community is the primary goal. Levels of support are individualized based on need. Apartments with 24-hour on-site staff and scattered site apartments with staff supports available 7 days a week are both available.

### ▪ **Independent Housing Program**

This housing option helps people to remain in the community by using existing county supports and providing assistance and advocacy to retain clean, safe, and affordable housing. Unity House staff members provide support and services specific to housing needs. More general care management needs are met through existing community services. The services provided by housing staff are minimal in comparison to a community residence, adult residence, or apartment program. Therefore, it is important that individuals are capable of living independently. After hours on-call services are provided through the existing county on-call services.

### ▪ **Evergreen**

Central New York Adult Homes Inc., a progressive not-for-profit organization, is committed to providing quality residential services to the elderly, persons with a mental health illness, individuals recovering from chemical addictions, and those who are homeless. Central New York Adult Homes Inc., assists individuals in achieving their optimum level of independence and success in the environment of their choice, while remaining sensitive to community needs and available resources.

## **Respite**

For respite, call 1-855-778-1900. A SPOA application is no longer needed for respite.

## Referral Application

Date of referral:	
Applying for:	<input type="checkbox"/> Care Management <input type="checkbox"/> Residential Services (please select which service) <input type="checkbox"/> Treatment Apartment Program <input type="checkbox"/> Independent Housing Program
Referring Person Contact Information:	Name _____ Title _____ Organization _____ Phone _____ Email _____

### Applicant Information

Name:	Date of Birth:	SS#
Address:	Gender at Birth:	Gender you identify as today:
Medicaid CIN #:	Medicaid Managed Care Organization Name:	
Home Phone:	Medicare #:	
Cell Phone:	County of Residence:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		
Emergency contact: _____		
Relationship: _____		
Phone: _____		

## FOR CARE MANAGEMENT ONLY

### Eligibility Category Information – Check all that apply

Must meet either A only or B only or two C to be eligible

Category			Detail
			<i>Specify diagnosis, provide available detail</i>
<input type="checkbox"/>	<b>A</b>	Serious mental illness/Primary Diagnosis	
<input type="checkbox"/>	<b>B</b>	HIV/AIDS	
<input type="checkbox"/>	<b>C</b>	Mental Health condition ( <i>other than SMI diagnosis</i> )	
<input type="checkbox"/>	<b>C</b>	Substance Abuse Disorder	
<input type="checkbox"/>	<b>C</b>	Asthma	
<input type="checkbox"/>	<b>C</b>	Diabetes	
<input type="checkbox"/>	<b>C</b>	Heart Disease	
<input type="checkbox"/>	<b>C</b>	BMI > 25	
<input type="checkbox"/>	<b>C</b>	Other Chronic Conditions ( <i>Specify</i> )	

### Risk Factors – Check all that apply

To qualify for care management, must have risk factors that lead to extended impairment in functioning

Category		Detail
		<i>Please explain how applicant meets risk factor</i>
<input type="checkbox"/>	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
<input type="checkbox"/>	Lack of or inadequate social/family/housing support	
<input type="checkbox"/>	Lack of or inadequate connectivity with healthcare system	
<input type="checkbox"/>	Non-adherence to treatments or medication(s) or difficulty managing medications	
<input type="checkbox"/>	Recent release from incarceration	
<input type="checkbox"/>	Recent release from psychiatric hospitalization	
<input type="checkbox"/>	Deficits in activities of daily living	
<input type="checkbox"/>	Learning or cognition issues	

Provide any additional information that may be helpful in assignment to a care management agency:

Specify preferred or recommended care management agency, if any: \_\_\_\_\_

**Additional Application Information – For Both Care Management and Housing**

Legal Involvement (check all that apply)	Comments
<input type="checkbox"/> Legal involvement (CPS, Family Court)	
<input type="checkbox"/> Criminal involvement	
<input type="checkbox"/> Current charges pending	
<input type="checkbox"/> Currently on Probation Probation Offices: _____	
<input type="checkbox"/> Currently on Parole Parole Officer: _____	
<input type="checkbox"/> Involved in Treatment Court <input type="checkbox"/> Drug Court <input type="checkbox"/> Behavioral Health Court <input type="checkbox"/> Monitoring Court	
Housing	
<b>Homeless:</b> <input type="checkbox"/> Streets <input type="checkbox"/> Friends/Family <input type="checkbox"/> Shelter <input type="checkbox"/> Hotel	
<b>Housed:</b> <input type="checkbox"/> Unsafe structure <input type="checkbox"/> Unsafe situation <input type="checkbox"/> Unstable Housing <input type="checkbox"/> Completing Program <input type="checkbox"/> No needs	
Reason for Housing referral at this time (please state specifically how these services will benefit the applicant):   	
Financial	
<b>No Income:</b> <input type="checkbox"/> Needs to apply <input type="checkbox"/> Sanctioned	
<b>Income Source/Amount:</b> <input type="checkbox"/> Employment \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> SSD \$ _____ <input type="checkbox"/> Public Assistance \$ _____ <input type="checkbox"/> Other \$ _____	
Medical	
<b>Provider:</b> PCP _____ Specialist _____ <input type="checkbox"/> Needs provider	
<b>Mental Health:</b> Provider _____ Psychiatrist _____ Therapist _____ <input type="checkbox"/> Needs provider	
<b>Substance Use:</b> Provider _____ <input type="checkbox"/> Needs provider	

# Cayuga County Community Mental Health Center

## MULTIPLE PARTY RELEASE FORM Cayuga County S.P.O.A. Assessment Team

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Revoked \_\_\_\_\_ Staff Signature \_\_\_\_\_

I, \_\_\_\_\_ do hereby consent and authorize information to be obtained from and/or released to The Cayuga County S.P.O.A. Assessment Team to include representatives from:

- |  |  |
|--|--|
| ARISE  | Evergreen  |
| Auburn Drug Treatment Center (ADTC)  | Grace House  |
| Auburn Community Hospital (ACH)  | Health Homes of Upstate New York HCR Health            |
| Auburn Community Hospital Behavioral Health Unit (ACH/BHU)                             | Hillside   |
| Auburn Housing Authority   | Homesite   |
| Catholic Charities Cayuga Centers  | Hutchings Psychiatric Center (HPC)                     |
| Cayuga Counseling Services, Inc.   | Liberty Resources                                      |
| Cayuga County Community Mental Health Center (CCCMHC)-                                 | New York State Parole                                  |
| Clinic & Care Management   | Northbrook Heights                                     |
| Cayuga County Health & Human Services  | Onondaga Case Management Services/Circare              |
| Temporary Assistance, Adult Protective Services (APS), Child Protective Services (CPS) | OMH licensed facilities                                |
| Cayuga County Jail   | Oswego County DSS/Div of Mental Hygiene (for ACT only) |
| Cayuga County Probation  | Oswego Health (for ACT only)                           |
| Cayuga Seneca Action Agency  | St. Joseph's Care Coordination Network                 |
| Central New York Health Home Network, LLC  | Syracuse Recovery                                      |
| Chapel House   | Unity House – Treatment Apartment Program              |
| Confidential Help for Alcohol & Drugs (C.H.A.D.)                                       | Unity House – Independent Housing Program              |
|  | Andy Catalone  |
|  | Other: _____   |
|  | Other: _____   |

the following information pertaining to myself:

- |                      |  |
|----------------------|--|
| Drug/Alcohol History | Mental Health Housing Referral Package |
| Financial Status     | Psychiatric Assessment                 |
| Medical Records      | Psychosocial History                   |

### PURPOSE OF THE RELEASE:

TO COMPLETE AND PROCESS REFERRAL FOR ADULT MENTAL HEALTH HOUSING, CARE MANAGEMENT SERVICES AND/OR ACT SERVICES IN CAYUGA COUNTY.  
I understand that my alcohol/or drug treatment records, when associated with a federally funded alcohol/ or drug treatment program, are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. Treatment records from agencies licensed by the NYS Office of Mental Health are protected by Mental Hygiene Law Section 33.13, and by 45 C.F.R. Pts. 160 & 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, This release is otherwise enforced for the duration of the client's enrollment in a SPOA coordinated program.

Client Signature \_\_\_\_\_ Legal Representative Signature \_\_\_\_\_ Relationship to Client \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

- |  |
|--|
| <input type="checkbox"/> Copy of release given to client |
| <input type="checkbox"/> Client declined copy of release |