REFERRAL PACKET FOR ACT SERVICES IN CAYUGA COUNTY

ACT Team

- The ACT team that serves Oswego County also serves Cayuga County (rather than Cayuga County having its own team).
- In order to be considered for ACT services in Cayuga County, an Oswego County referral form must be completed and submitted to the Cayuga County SPOA Coordinator. The Cayuga County SPOA Coordinator will review. If criteria is met and application is complete, Cayuga County SPOA Coordinator will forward to the Oswego County SPOA Coordinator. If an individual is also seeking housing in Cayuga County, a separate Cayuga County SPOA referral form must be completed.

Instructions for referral

- Complete attached Oswego County SPOA referral packet.
- All pages must be completed and signed. If packet is incomplete, the referral process will be delayed. Follow instructions on the next page of this packet.
- All three consents must be signed:
  1. Oswego County SPOA Referral Process Consent for Release of Information Cayuga County Multi Party Release Form.
  2. Request for Restriction of Disclosures of Protected Health Information (If no restrictions are required, write in N/A. Applicant must sign form, even if indicating no restrictions.)
  3. Cayuga County Multi Party Release Form
- Send completed application to the attention of Cayuga County Adult SPOA Coordinator. Application can be sent via:

  1. Mail to
     Cayuga County Community Mental Health Center
     ATTN: Adult SPOA Coordinator
     146 North Street
     Auburn, NY 13021 *or*

  2. Fax to 315-253-1687; ATTN: Adult SPOA Coordination *or*

  3. Encrypted email to: AdultSPOA@cayugacounty.us (with "ACT Referral" in subject line)

Questions/More information

Contact Cayuga County Adult SPOA Coordinator at AdultSPOA@cayugacounty.us

Revised July 2021

Oswego County
REFERRAL FORM
ADULT SINGLE POINT OF ACCESS (SPOA)
www.oswegocounty.com/mentalhygiene

SPOA Coordinators will review referral and assess individual for program eligibility. The process to arrive at an eligibility determination may include direct contact with the referred person, collecting information from the referral source, and reviewing records. SPOA Coordinators may also review referrals with program supervisors.

To request that someone currently enrolled in a program receive a different level of service, first discuss the concerns with the current program.

TO MAKE A REFERRAL:
Submit the following forms

- ☐ Adult Mental Health Referral Form **(submit pages 1 – 4)** **AND**
- ☐ Signed Referral Process Consent Form **AND**
- ☐ Signed Authorization for Release of Information to obtain additional information from current or most recent MH Clinical provider **AND**
- ☐ Completed Eligibility Form **AND**
    - ☐ For Referrals made by Inpatient Facilities: Discharge Summary, Psychosocial Assessment, &/or Psychiatric Assessment

URGENCY OF NEED/LEVEL OF RISK:	☐ LOW	☐ MEDIUM	☐ HIGH

Service(s) Requested:
Adult:

☐ Transition Support Services Case Management (TSS) (approx. 90 days)
☐ Care Management (CM)
☐ Psycho-Social Rehabilitation (NON-HARP)
☐ Peer Support Services (NON-HARP)
☐ Vocational Support Services (NON-HARP)
☐ Assertive Community Treatment Team (ACT)
  ☐ **Oswego Co. Resident**
  ☐ **Cayuga Co. Resident**
☐ Unknown

**** Missing or Incomplete Forms will Delay the Referral Process****

Oswego County
Adult SPOA
REFERRAL FORM

Is Individual aware of this referral and consents to the SPOA process: ☐ Yes ☐ No

****Signed 'Referral Process Consent Form' is Required to Complete the Referral Process****

Referred Person: ______________________________ **DOB**: ____________ **Current Age:** ______

Gender: ☐ M ☐ F **SS#:** _______-_______-________ **County**__________________________

Address:____

City: ____________________________ **State**: ___________________ **Zip**: _____________________

Phone: h: (_____)__________________ c: (_____)__________________ w: (_____)________________

Describe Current Living Situation

☐ Homeless
☐ With spouse/significant other
☐ Adult Home
☐ Correctional Facility
☐ Alone, Independent Setting
☐ With family member(s)
☐ Supervised/Supported
☐ Currently Inpatient, Needs Housing
☐ Shelter
☐ MH Crisis Respite
☐ Other

Is Individual Homeless? ☐ Yes ☐ No ***IF INDIVIDUAL IS HOMELESS, PLEASE PROVIDE INFORMATION ABOUT LOCATIONS CLIENT MAY FREQUENT:** ____

Education Level: (Highest grade or degree/diploma completed) ________________________

Ability to read/write English: ☐ None ☐ Fair ☐ Good

Proficiency in language(s) other than English: ___________________ **Preferred Language:** ____________

Medical Insurance: ☐ No Coverage ☐ Medicaid #________________ ☐ Medicare ☐ Private Insurance

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Referral Source

☐ Psych Inpatient - State
☐ Psych Inpatient - General
☐ MH Clinic Provider
☐ Private MH Practitioner
☐ Care Management or ACT
☐ Peer or Family Advocate
☐ Other MH Program
☐ OASAS Provider
☐ OPWDD Provider
☐ Physician, Primary Care
☐ Emergency Room/CPEP
☐ Mobile Crisis
☐ Crisis Respite Program
☐ Residential Treatment Facility
☐ Housing Provider
☐ Correctional Facility
☐ Probation or Parole
☐ School/education system
☐ Social Services (DSS)
☐ Family/legal guardian
☐ Friend
☐ Self
☐ Other, *specify:* ____________________

Name: ____ **Agency :** ________________________________

E-Mail____________________________________ **Secure E-Mail:** ________________________________

Address: ____

Phone: w: (____)__________________ c: (_____)___________________ **Fax**: (_____)_______________

REASON FOR REFERRAL

(It is **MANDATORY** to complete the following—Please write legibly)

- ☐ Alcohol/Substance Abuse
- ☐ Current Mental Health Symptom(s)
- ☐ Accessing, Engaging w/ Support & Services
- ☐ Daily/Community Living Skills
- ☐ Frequent Crisis/Use of ERs
- ☐ Potential Harm to Self/Others
- ☐ Personal Safety
- ☐ Employment Supports
- ☐ Economic Self-Sufficiency
- ☐ Housing or Homelessness
- ☐ Legal Issues, Criminal Justice Concerns
- ☐ Management of Chronic Health Problems

Please specify the areas in which the individual is experiencing functional limitations and explain the individual's needs

____
____
____
____

Areas of Special Concern:

	Yes	No	Unk.
Access to Weapons	☐	☐	☐
Animals in the Home	☐	☐	☐
Childhood Violence	☐	☐	☐
Cruelty to Animals	☐	☐	☐
Disruptive Behaviors	☐	☐	☐
Criminal History	☐	☐	☐
Violent Behaviors	☐	☐	☐
Sexually Assaultive Behavior	☐	☐	☐
Fire Setting	☐	☐	☐
Hallucinations or Delusions	☐	☐	☐
Severe Depression	☐	☐	☐
Suicidal Ideation/Attempts	☐	☐	☐
Chronic Self-Harm	☐	☐	☐
Homicidal Ideas/Attempts	☐	☐	☐
Trauma History	☐	☐	☐
Homelessness	☐	☐	☐
Other: ______________	☐	☐	☐
Other: ______________	☐	☐	☐

If "Yes" to any of the above, please provide a brief description: ____________________________________
____
____
____

Natural Support System: ☐ Family ☐ Friends ☐ Clergy ☐ Other______________________________

Please describe: ____
____
____
____
____

Current Medical Provider(s): ____

Chronic Health Conditions: ____

Current Services & Supports	Provider	Name/Contact #
Outpatient Mental Health Clinic		
Private/Community Clinical Provider		
Mental Health Residential Program		
Supported Housing Program		
Inpatient, Community Hospital		
Inpatient, State Psychiatric Center		
Hospital/Psychiatric Emergency Room		
Outpatient Substance Abuse Services, OTP		
Inpatient Substance Abuse Services		
Peer Provider		
Planned Respite Services		
Crisis Respite Services		
Probation or Parole		
Prison/Jail/Drug Treatment/Intervention Court		
DSS Preventive or Protective Services		
Case Management/ACT Team		
AOT Involvement		
Other:		
Other:		

Clinical Providers:

Psychiatrist: ______________________________ **Agency:**____________________ **Phone :** ____________________

Therapist: ________________________________ **Agency:**____________________ **Phone :** ___________________

Behavioral Health Diagnoses **Codes**

____ _____________________

____ _____________________

____ _____________________

____ _____________________

Number of Emergency Mental Health presentations to ER or CPEP in past 6 months: ______________

Number of Psychiatric Hospitalizations within the past 12 months: _______________

If Referral is from Inpatient, Jail, Community Residence, Etc.: Anticipated Discharge Date: __________________

Cognitive Impairment, or DD: ☐ Yes, IQ: _____ ☐ No ☐ Unknown

Has individual been determined eligible for OPWDD services? ☐ Yes ☐ No ☐ Unknown

If yes, please identify OPWDD services and providers with whom the individual is involved: __________________

____

___________________________________ ____________________________________ __________________

Signature of Person Completing Referral **Print Name** **Date**

Please attach any supporting documentation you would like to include.

APPLICANT'S NAME:____ DATE OF BIRTH__________________________

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SERIOUS MENTAL ILLNESS AMONG ADULTS

TO BE CONSIDERED AN ADULT DIAGNOSED WITH SERIOUS MENTAL ILLNESS, **CRITERIA A MUST BE MET. IN ADDITION, CRITERIA B OR C OR D MUST BE MET**. PLEASE CIRCLE LETTER OR NUMBER OF ALL THAT CURRENTLY APPLY. *A LICENSED PROFESSIONAL QUALIFIED TO DIAGNOSE AND TREAT MENTAL ILLNESS MUST VERIFY THAT THESE CRITERIA ARE MET.*

A. Designated Mental Illness Diagnosis ____________________________________ ___________________
Description Code

The individual is 18 years of age or older and currently meets the criteria for At least one DSM 5 psychiatric diagnoses as listed below: Psychotic Disorders (F21-F23, F20.81, F20.9, F25.0-F25.1, F06.0-F06.2, F28-F29), bipolar disorders (F31.11-F31.12, F31.14, F31.2, F31.73-F31.74, F31.9, F31.0, F31.31-F31.32, F31.4-F31.5, F31.75-F31.76, F31.81, F34.0, F06.33-F06.34, F31.89), obsessive-compulsive disorder (F42), depression disorders (F34.8, F32.0-F32.5, F32.9, F33.0-F33.2, F233.3, F33.41-F33.42, F33.9, F34.1, N94.3M F06.31-F06.32, F06.34, F32.9-F32.9, F34, F32.08), anxiety disorders (F41.9, F41.0-F41.1, F44.81, F40.0, F43.10, personality disorders (F60.0-F60.1, F60.3-F60.6, F60.9, F60.81, F21). Alcohol and/or Substance diagnosis, organic brain syndromes, development disabilities or social conditions **are not** qualifying diagnosis for serious mental illness.

AND

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

OR

C. Extended Impairment in Functioning due to Mental Illness

1. The individual has experienced one or more of the following four functional limitations as a result of their qualifying diagnosis.

   a. Marked difficulties in self-care (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
   b. Marked restriction of activities of daily living (maintaining a residence; using transportation; day to day money management; accessing community services).
   c. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
   d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (Ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; 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 tasks, or require assistance in the completion of tasks).

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 twelve months on a continuous or intermittent basis.

OR

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

DATE ____________________ CLINICIAN NAME (PRINT)____

CLINICIAN SIGNATURE___________________________________ TITLE___________________________

COUNTY OF OSWEGO
DEPARTMENT OF SOCIAL SERVICES/ DIVISION OF MENTAL HYGIENE

(315) 963-5361
FAX (315) 963-5530

Stacy Alvord, MSW
Commissioner

OSWEGO COUNTY BUILDING
100 SPRING STREET, PO BOX 1320
MEXICO, NEW YORK 13114

Nicole Kolmsee - Director of Community Services
Nicole.Kolmsee@oswegocounty.com

Oswego County Single Point of Access (SPOA)
REFERRAL PROCESS
CONSENT FOR RELEASE OF INFORMATION

I consent to use and disclosure of protected health information about me for arranging services, treatment, payment, and health care operations as described below. This means that information about my health will be used by the staff of Oswego County Division of Mental Hygiene or disclosed to other people or organizations whenever needed to:

- Provide services to me or arrange for services by another health care or mental health service provider.
- Refer me to a Medicaid Health Home for access to Comprehensive Care Management Services
- Arrange for payment for services to me.
- Operate the business of Oswego County Single Point of Access Referral Process
- Enable Oswego County Division of Mental Hygiene to review the quality and appropriateness of care I receive from mental health organizations that provide services to me.

I understand that information I choose to disclose pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed. I agree to use and disclosure of my health information as described in this consent.

______________________________ __________________________

Signature Date

____

Print Name

I am the parent/guardian of the person whose records will be used or disclosed. I agree to the use and disclosure of the health information of (Child's Name) ____________________________ as described in this consent.

______________________________ __________________________

Signature Date

____

Print Name

Request for Restriction of Disclosures of Protected Health Information

I hereby request that Oswego County Division of Mental Hygiene restrict disclosure of protected health information about ________________________________ (name of individual) in the manner described below.

☐ Please do not disclose protected health information to (name of person or organization).

____

____

☐ Please do not use protected health information for the purposes listed below, organization).

____

____

I understand that Oswego County Division of Mental Hygiene will honor this request for restriction of use and disclosure of protected health information, unless an emergency situation requires disclosure for life safety reasons.

I am the person who is the subject of the health records that will be restricted.

_______________________________________ _________________________________

Signature Date

____

Print Name

I am the parent/guardian of the person whose records will be used or disclosed. I agree to the use and disclosure of the health information of (Child's Name) _______________________________________ as described in this consent.

_______________________________________ _________________________________

Signature Date

____

Print Name

Rev. 8/15/2017

Cayuga County Community Mental Health Center
146 North Street • Auburn, NY 13021-1831
Phone 315-253-2746 • Fax 315-253-1687

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

Other (write in):____

____

the following information pertaining to myself:

Drug/Alcohol History
Financial Status
Medical Records
Mental Health Housing Referral Package
Psychiatric Assessment
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.

Signature of Client	Date	Signature of Parent/Guardian	Date	Relationship to Client

Signature of Witness	Date

- ❑ Copy of release given to client
- ❑ Client declined copy of release