Cayuga County Community Mental Health Center

ADULT SINGLE POINT OF ACCESS (SPOA) APPLICATION

Send completed checklist and application to: Katie Montroy SPOA Coordinator
146 North Street Auburn, New York 13021
Phone: (315) 253-0341 Fax: (315) 253-1687

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 and eligibility requirements. If ineligible or if application is incomplete, SPOA Coordinator will email referring person.

Eligibility Requirements

Residence: Applicants must reside in Cayuga County for all services. Please check:

☐ Resides in Cayuga County

Care Management: Applicant must be diagnosed with SMI *or* HIV/AIDS *or* two chronic conditions *and* have risk factors. Please check below:

☐ Serious Mental Illness Diagnosis OR ☐ HIV/AIDS Diagnosis OR ☐ Two Chronic Conditions

☐ Presence of significant behavioral, medical or social risk factors

Residential Services: Please check the two eligibility criteria required for residential services:

☐ 18+ years of age ☐ Mental Health Diagnosis

Application Requirements

☐ Referral Application/Determination of Program Need

☐ Cayuga County Community Mental Health Center Multiple Party Release Form

☐ Psychosocial or **Initial** Comprehensive Assessment *and updates dated within the last 90 days*. (Include current treatment plan, referral reason, and known risk factors)

☐ Hospital admission and discharge summaries (only required if no psychosocial or assessment included)

For residential services application, the following additional documents are required:

☐ Unity House Respite Apartment Program Expectations (only if applying for respite unit)

☐ Restorative Services Authorization (Must have original signature and mailed or delivered to CCCMHC)

☐ Chemical Dependency Evaluation

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 (47 beds)

Transitional program offers support to individuals needing assistance to develop skills and improve functional limitations which are currently compromised due to their mental illness. Developing a plan to transition to independent living in the community is the primary goal. Levels of support are individualized based on need. Co-located apartments with 24 hour on site staff and scattered site apartments with staff supports available 7 days a week.

- Independent Housing Program (81 beds)

Supported Housing provides housing access and support to individuals who have a psychiatric illness. 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. Staff provides support and services specific to housing needs. More general case management needs are met through existing community services. The services provided by Supported 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.

- Respite Bed (Must be authorized by Cayuga County Community Mental Health Center)

Respite services are designed to provide emergent temporary shelter to adult residents of Cayuga County diagnosed with a mental illness for one or more days (up to a maximum of 21 days). Services include the provision of stable housing with 24/7 staff support in a residential setting. Note that although the Respite Program will accept “Crisis” Referrals, it is preferable that “Planned” respite be utilized in order to initiate services with the least disruption possible. The Care Manager and applicant should exhaust all other possibilities before seeking respite services (family, friends etc.) due to the critical need of consumers in crisis and shortage of respite beds available in the community.

- 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.

Referral Application

Date of referral:	
Applying for:	☐ Care Management ☐ Residential Services (please select which service ☐ Treatment Apartment Program ☐ Independent Housing Program ☐ Respite Bed (must be authorized by CCCMHC) ☐ Evergreen
Referring person contact information	Name_____ Title_____ Organization_____ Phone_____ Email_____

If the referral is for a youth between the ages of 18_21 please complete the following

1. Is the youth in foster care? If yes please contact your LDSS
2. Is the youth receiving preventive services? Yes ☐ No ☐
3. Is the parent(s) of the youth enrolled in a Health Home? Yes ☐ No ☐
4. Have you been in communication with the member and want to enroll them into Outreach or Enrollment? Yes ☐ No ☐

Identifying 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: _____		

Eligibility Category Information – Check <u>All</u> that Apply

Must meet either <u>A only</u> or <u>B only</u> or <u>two C</u> to be eligible

Check		Category	**Specify Diagnosis; Provide Available Detail**
☐	A	Serious mental illness / Primary Diagnosis	
☐	B	HIV/AIDS	
☐	C	Mental Health condition *(other than SMI diagnosis)*	
☐	C	Substance Abuse Disorder	
☐	C	Asthma	
☐	C	Diabetes	
☐	C	Heart Disease	
☐	C	BMI > 25	
☐	C	Other Chronic Conditions (Specify)	

Risk Factors – Check All that Apply

Check	Category	**Detail** Indicating How Referral Meets the Risk Factor
☐	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
☐	Lack of or inadequate social/family/housing support	
☐	Lack of or inadequate connectivity with healthcare system	
☐	Non-adherence to treatments or medication(s) or difficulty managing medications	
☐	Recent release from incarceration	
☐	Recent release from psychiatric hospitalization	
☐	Deficits in activities of daily living	
☐	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:_____

Determination of Program Need

Legal Involvement (check all that apply)	**Comments**
☐Legal involvement (CPS, Family Court)	
☐Criminal involvement	
☐Current charges pending	
☐Currently on Probation	
Probation Officer	
☐Currently on Parole	
Parole Officer	
☐Involved In Treatment Court	
☐Drug Court	
☐Behavioral Health Court	
☐Monitoring Court	

Housing

Homeless: ☐Streets ☐Friends/Family ☐Shelter ☐Hotel

Housed: ☐Unsafe structure ☐Unsafe situation ☐Unstable Housing ☐Completing Program ☐No needs

Reason for Housing referral at this time (please state specifically how these services will benefit the applicant):

Financial

No Income: ☐Needs to apply ☐Sanctioned

Income From/Amount: ☐Employment $_____ ☐SSI $_____☐SSD$_____☐Public Assistance $_____ ☐Other $_____

Medical

Provider: PCP_____ Specialist_____ ☐Needs Provider
Mental Health Provider: Provider_____
Psychiatrist_____ Therpaist _____ ☐Needs Provider
Substance Abuse (list past and present treatment): ☐Provider_____ ☐Needs Provider

Tuberculosis status: ☐ Positive ☐ Negative ☐ Unknown

If positive PPD, Chest X-Ray date: _____Unknown

Cayuga County Community Mental Health Center

CCCMHC
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
OMH licensed facilities
Peers in Cayuga County
St. Joseph's Care Coordination Network
Syracuse Recover
Unity House – Treatment Apartment Program
Unity House – Independent Housing Program
Andy Catalone
Peter Ragonese

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 & Case Management 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 Refused Copy of Release

Respite Apartment

Unity House Program Expectations

Rev. Jan/2012

Unity House is a not-for-profit residential facility in the community of Auburn, NY. The Respite program serves as a temporary placement for individuals in crisis in need of immediate housing to prevent homelessness.

If you enter into Unity House Respite Services, you will be expected to comply with the following:

1. You will be responsible for cleaning and upkeep of the respite apartment during your stay.
2. You will be responsible for participating in meal preparation and purchasing food.
3. Work with Cayuga County Mental Health Case Manager to secure ancillary services and transition or permanent housing.
4. No possession of weapons of any kind permitted within the Respite Apartment.
5. No alcohol or illicit drug use or possession is allowed on or off the premises.
6. No pets are allowed on the premises.
7. No overnight visitors. All guests must sign in on the "visitor's log".
8. All medications must be checked in with Respite staff for assistance with Medication Monitoring during your stay. Copies of all prescriptions are required including all PRN and over the counter medications.
9. Residents are expected to return to their apartment by 10pm each night unless approved by staff.
10. Accept responsibility for any additional bills incurred such as due to damages to the room and/or its furnishings.
11. Respect the staff and other resident's as well as their personal property.
12. Engage in absolutely no physical violence with staff or other residents.
13. Smoke only in the designated smoking areas. There is absolutely no smoking in your apartment.

In return, Unity House agrees to:

1. Provide staff that will treat you with dignity and respect.
2. Provide you with safe housing.
3. Provide support in accessing emergency services should they become necessary (fire/police/ambulance).
4. Provide medication monitoring.

Note: **Behavior not in keeping with the above rules can result in immediate discharge from the Unity House Respite Program.**

Please describe in your own words your request for services and sign.

_____

_____

_____

I have read, understand, and agree with the Unity House Expectations listed above.

_____ _____

Consumer Signature Date

_____ _____

Staff Signature Date

Authorization for Restorative Services of Supportive Apartments

____Initial Authorization

Consumer's Name: _____

Consumer's Medicaid Number: _____

I, the undersigned licensed physician, have reviewed and explained the program I am authorizing

To _____. Based on my review of assessments made available to
Client Name

me and this face to face interview, I have determined that _____ would
Client Name

benefit from the provision of Mental Health Restorative Services known to me and defined pursuant to Part 593.4 (b) of

14 NYCRR.

____/____/_____--12 months

Mo. Day Yr.

_____ _____

Signature Licensure Number and Type

_____

Printed Name