



Lakeview Health Services
611 West Washington St.
Geneva, NY 14456
315-789-0550 FAX: 315-789-0555

Thank you for your interest in referring to SPOA of Ontario and Seneca Counties for Housing, ACT services, and non-Health Home Care Management. This referral form is for several programs. The following information should assist you in choosing an appropriate level of care and sending the required information.

To qualify for housing, the individual must have a primary mental illness diagnosis and meet the SPMI criteria outlined on page 3. In addition, he/she must be willing to participate in the services that are offered.

Descriptions of Programs and Services:

Community Residence: Lakeview offers a community residence program. This rehabilitative program is a homelike setting for individuals seeking daily guidance and support while learning to manage a mental illness. Staff is on site 24 hours. The community residence program is transitional with time-limited lengths of stay.

Licensed Apartment Program: Lakeview offers a treatment Apartment Program. These are smaller, individual apartment settings. Staff is available to assist residents during day and evening hours, and is also available by phone during nighttime hours for emergency purposes. Residents work on rehabilitation plans to develop skills to live more independently. These programs are transitional with time-limited lengths of stay.

Supported Housing: Lakeview has a Supported Housing Program. This program assists individuals and families in finding and maintaining independent housing in the community. A rent stipend is provided to those who are eligible for the federal Section 8 Rental Assistance program. Staff has contact with individuals on a monthly basis and offers assistance with all housing related needs. This program is transitional, with a primary goal of linkage to Section 8.

Supported SRO Housing: DePaul Community Services offers housing through Trolley Station Apartments in the Town of Canandaigua. Supported Housing staff are on site to provide services to up to 26 tenants, with office hours Monday through Friday from 8am to 5 pm. Services include collaboration with community providers to learn independent living skills, and providing necessary linkage toward community integration.

Care Management: Lakeview and Elmira Psychiatric Center provide care management services to assist with linkage to surrounding resources in the community, supporting the individual's ability to handle periods of stress that might otherwise overwhelm them. **Medicaid recipients may access CM services via HHUNY, rather than through the SPOA process. Please contact the SPOA Coordinator for more info as needed.**

ACT (Assertive Community Treatment) Team: Elmira Psychiatric Center offers ACT services to individuals who have not been successful in working with clinics and other traditional forms of treatment. The program is designed specifically to serve those with high service needs, such as high use of psych emergency/crisis services and acute psych hospitals; severe symptomology; coexisting substance abuse disorder, and high risk of criminal involvement.

Instructions & Checklist:

- Complete and sign all designated areas. **Page 11, the client's consent to release information, is required in order to process the referral.**

- Attach the client's complete psychosocial history and psychiatric assessment, including DSM-V psychiatric diagnoses completed **within the past year**. Acceptable documents include initial psych evaluations and updates, clinic or hospital intake, admission, and/or discharge notes, and other history and diagnoses written by a Qualified Mental Health Professional (QMHP).

- Attach a current list of medications and dosages.

Mail completed referral packet to:

**Lakeview Health Services, Inc.
Attention: SPOA, Betsy Fuller
611 W. Washington St.
Geneva, NY 14456
Phone: (315) 789-0550
Fax: (315) 789-0555**

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness, “1” below must be met, in addition to either “2, “3, or “4.”

1. Designated Mental Illness Diagnosis.

The individual is 18 years of age or older and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx, 292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx, or social conditions. ICD-CM categories and codes that do not have an equivalent in DSM-IV are also included mental illness diagnoses.

AND

2. SSI or SSDI Enrollment due to Mental Illness.

The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*.

OR

3. Extended Impairment in Functioning due to Mental Illness.

A. Documentation that 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:

- i. **Marked difficulties in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- ii. **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- iii. **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).
- iv. **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).

OR

4. Reliance on Psychiatric Treatment, Rehabilitation, and Supports.

A documented history shows that the individual at some prior time met the threshold for 3 (above), but the 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 (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

Adult SPOA Referral Packet

Services requested for (check one):

Ontario County

Seneca County

SPOA Received Date: _____

Received By: _____

Programs Requested (check all applicable; see p. 1 for descriptions)

Community Residence Licensed Apartment Program Supported Housing
 Trolley Station SP SRO Care Management Finger Lakes/Mid Lakes ACT Program

Client Name: _____ DOB: _____

Home Address: _____ Social Security #: _____ - _____ - _____

Age: _____ Gender: M F

Telephone Number: _____ Medicaid # (If applicable): _____

Client's County of Origin: _____

Referral Agency : _____ Address: _____

Telephone Number: _____ Contact Person: _____

Person to Notify in Case of Emergency:

Primary Care Physician:

Name: _____
Address: _____
Telephone: _____

Name: _____
Address: _____
Telephone: _____

Reasons for referral: Housing and Care Management needs: _____

What is the client's level of acceptance of the need for this referral?

Accepts Interested in pursuing further Resistive Does not accept

Living Situation at time of referral:

Lives alone Lives with parents Lives with other relatives Psychiatric Center
 Homeless (street) Lives with spouse Assisted/supported living Correctional Facility
 Homeless (shelter) Supervised living Nursing home/medical setting Other _____

Length of time in current living situation (move in date) _____

Any adult history of homelessness? Yes No

Does the client need 24-hour supervision? Yes No If yes, why? _____

Previous Residential History _____

Current Marital Status:

- Never Married Married Separated Divorced Widowed
 Living with significant other/domestic partner

Custody Status of Children: (check all that apply)

- No children Have children all > 18 yrs old Minor children currently in client's custody
 Minor children not in client's custody but have access Minor children not in client's custody – no access

Ethnicity:

- White (non-Hispanic) Latino/Hispanic Black (non-Hispanic) Native American
 Asian-Asian American Pacific Islander Other or dual (specify):

Current Educational Level:

- Some grade school 1-8th grade Some HS 9-12th grade, but no diploma GED HS Grad
 Some college, but no degree College Degree Masters Degree Not graded
 Vocational, business training No formal education Other: _____

Current Employment Status:

- Employed full-time Employed part-time Not employed Training program Other: _____

Current Criminal Justice Status:

- None Currently incarcerated Release date: _____
 CPL 330.20 Parole Probation
 Released from jail/prison in the last 30 days Other: _____
Name of Probation or Parole Officer: _____ Phone: _____

Current or Last Services (check all that apply):

- No prior service MH residential Case Management Prison, Jail, or Court
 State Psychiatric Center (Inpt) MH outpatient General hospital
 Emergency MH (nonresidential) Local MH practitioner CSP MH program

If no current services, specify date of last services: _____

Outpatient Services Current or Planned: (CHECK ALL THAT APPLY)

	Current	Planned		Current	Planned
Health			Psychiatrist/Clinic		
Education			Alcohol/Drug Treatment		
Day Treatment Program			AA/NA		
Psychiatric Day Program			Case Management		
Vocational Services			Intensive Case Management		
Community Residence			Family Support Services		
Halfway House			Children's ICM		
Adult Care Facility			Respite Services		
Child Preventative Services			Child Residential Treatment		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		

Currently receives Care Management : Yes No

Receives ACT: Yes No

Current AOT: Yes No If yes, please attach copy of AOT orders.

Mental health service utilization in past 12 months:

_____ # Of Psych. ED Visits
_____ # Of Inpatient Psych. Admissions _____ # of days
_____ Admission to Outpatient clinical services (counseling/psychiatry)

Facilities & dates of previous psychiatric treatment and/or hospitalizations:

Use/engagement with mental health services:

Does the client understand and accept the need for prescribed medications? Yes No

Rate client compliance with medication regime:

Independent With Prompting Needs Assistance Resistive

Rate client follow through with Mental Health Appointments:

Independent With Prompting Needs Assistance Resistive

Cognitive impairment? Yes No Explain: _____

Behavior/circumstances precipitating most recent hospitalization:

Signs/symptoms of decompensation (please be specific): _____

Does the client have a history of any of the following?

			If Yes, Dates
Fire setting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sexual offense	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Violent acts causing injury or using weapons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Aggressive /assaultive behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicidal ideation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide attempts/gestures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Destruction of property	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Victim of physical abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Victim of sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____

Are there any guns or weapons in the client's home? Yes No

Medical Health: (Check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes /metabolic |
| <input type="checkbox"/> BMI over 25 | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Impaired ability to walk |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Special medical equipment | <input type="checkbox"/> Other Medical |

Number of medical emergency room visits over the past 12 months: _____

Explanation of medical/emergency issues: _____

Known Allergies:

Medications: _____

Food: _____

Other: _____

Are there any specific Emergency Procedures/Protocols to be used by residential staff? What are they?

Substance Use History:

Does the client have a history of drug/alcohol abuse/dependency? Yes No

If yes, at what age did use begin? _____ Date of last use: _____

Drugs of Choice: (check all that apply)

- | | | | | |
|--|-----------------------------------|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Any IV drug use |
| <input type="checkbox"/> Crack | <input type="checkbox"/> PCP | <input type="checkbox"/> Inhalant: Sniffing glue | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heroin/Opiates |
| <input type="checkbox"/> Sedative/hypnotic | <input type="checkbox"/> Cannabis | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Other _____ |

Frequency of Drug Use:

- none in past month 1-3 times in past month 1-2 times/week 3-6 times/week daily

Longest period of Sobriety: _____

Does the client smoke cigarettes? Yes No

Chemical Dependency Treatment: Yes No

If yes: Services within the past 12 months? Yes No

inpatient programs & dates: _____

outpatient programs & dates: _____

If client is currently in a chemical dependency treatment Program, anticipated discharge date? _____

Previous chemical dependency treatment:

inpatient programs & dates: _____

outpatient programs & dates: _____

FUNDING VERIFICATION FORM

	Case #	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security					
SSI					
SSD					
Public Assistance					
Veteran's Benefits					
Medicare					
Medicaid					
Food Stamps					
Pension					
Wages/Earned Income					
Unemployment					
Private Insurance					
Other 3 rd Party Payer					
Trust Fund					
Medication Grant					

Court mandated expenses/debts (i.e., alimony, child support, student loans, utility bills). **Please list all known and amounts:** _____

If Rep Payee, Name: _____ **Address:** _____

Agency: _____ **Telephone #:** _____

