Lakeview Mental Health Services, Inc.
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 Case Management, Housing and ACT services. 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 these programs, 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. The individual may have a secondary drug and alcohol diagnosis, if he/she is willing and motivated to work toward abstinence and recovery.

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 settings for one to three individuals. Staff is available to assist individuals during day and evening hours and is also available by phone during nighttime hours for emergency purposes. Individuals 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. Rental assistance is provided to individuals who are eligible for the Section 8 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 the federal Section 8 Rental Assistance Program.

Case Management: Lakeview and Elmira Psychiatric Center provide case management services to assist individuals involved with a rehabilitation process in order to continue living independently in the community. This program's focus is to link individuals to surrounding resources in the community, supporting the individual's ability to handle periods of stress that might otherwise overwhelm them.

ACT (Assertive Community Treatment) Team: Elmira Psychiatric Center offers ACT services to individuals who have not been successful in working with more traditional providers. 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 the multiaxial diagnosis (Axis I-V) completed **within the past year**.

- ☐ Attach a current list of medications and dosages.

- ☐ Complete and sign the funding verification form.

Mail completed referral packet to:

Lakeview Mental 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
___ Case Management ___ Finger Lakes ACT Program

Client Name: ______________________ **DOB:** ________________
Home Address: ______________________ **Social Security #:** ________-______-________
______________________ **Age:** __________ **Gender:** ____ **M** ____ **F**
Telephone Number: ____________________ **Medicaid # (If applicable):** ________________

Referral Agency : ______________________**Address:** ____________________________
Telephone Number: ______________________**Contact Person:** ________________________

Referral Source: (Check one)

[ ] Self, Family, or Friend
[ ] State Psychiatric Center I.P. ________________
[ ] General Hospital I.P. ______________
[ ] MH Residential ______________
[ ] Mental Health O.P. ______________
[ ] Emergency Nonresidential Program. ________________
[ ] CSP Mental Health Program ______________
[ ] Local MH Practitioner ______________
[ ] General Hospital ER ______________
[ ] Other Medical Provider ________________
[ ] MR/DD Facility ______________
[ ] Substance Abuse Program ______________
[ ] Police ______________
[ ] Family Court ________________
[ ] Criminal Court ______________
[ ] Jail ______________
[ ] Probation ______________
[ ] Parole ________________
[ ] Homeless Shelter ______________
[ ] Penitentiary ______________
[ ] Other: ______________

Client's County of Origin: ________________________

What is the client's level of acceptance of the need for this referral? [ ] accepts [ ] interested in pursing it further
[ ] resistive [ ] does not accept

Person to Notify in Case of Emergency:

Name: ________________________
Address: ________________________
Telephone: ________________________

Primary Care Physician:

Name: ________________________
Address:________________________
Telephone:________________________

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Reasons for referral: housing and case management needs ______________________________

____

____

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?__________________________

Ability to tolerate Group Situations: [ ] Yes [ ] No (explain)______________________________

Previous Residential History____

Interpersonal Skills____

Social Supports (include family) ____

Family's interest in supporting this referral and becoming involved in the planning: _______________

____

Effective counseling approaches to use with the client: ____________________________________

____

Cultural issues that may impact treatment and treatment planning: __________________________

____

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: ___________________________
Contact: Probation or Parole Officer: Phone:

________________________________ ________________________________

Primary Language:

[ ] English [ ] Other: _______________

English Proficiency: (If primary language is other than English):

[ ] Does not speak English [ ] Poor [ ] Fair [ ] Good [ ] Excellent

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

Current or Last Services (check all that apply):

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

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		

Indicate the client's willingness to participate in Day Programs:

[ ] Not Applicable [ ] Independent [ ] With Prompting [ ] Needs to be taken to program [ ] Rejects Services

Currently receives Case Management : [ ] Yes [ ] No
Current AOT: [ ] Yes [ ] No Receives ACT: [ ] Yes [ ] No

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	[ ] Yes	[ ] No	______________
Sexual offense	[ ] Yes	[ ] No	______________
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	______________
Aggressive /assaultive behavior	[ ] Yes	[ ] No	______________
Suicidal ideation	[ ] Yes	[ ] No	______________
Suicide attempts/gestures	[ ] Yes	[ ] No	______________
Destruction of property	[ ] Yes	[ ] No	______________
Victim of physical abuse	[ ] Yes	[ ] No	______________
Victim of sexual abuse	[ ] Yes	[ ] 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 Problems: (Check all that apply)
[ ] None [ ] Incontinent [ ] Impaired ability to walk [ ] Impaired vision
[ ] Hearing impairment [ ] Requires special medical equipment [ ] Other Medical
Explanation: ____

Use/engagement in medical services: (annual physical, and if applicable, taking medications, making appointments, adherence to regimen/programs, special diets, etc.)
[ ] Independent [ ] Partially Dependent [ ] Fully Dependent [ ] Rejects Services

Special diet: [ ] Yes [ ] No If yes, Explain: ____
____
____

Known Allergies:
Medications:____
Food:____
Other:____

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

Community Survival Skills: (**CHECK APPROPRIATE RESPONSE**)

	Independent	**Can do with help**	**Dependent**
1. Activities of Daily Living (ADLs)			
Eating			
Dressing			
Grooming			
Toileting			
2. Personal Safety:			
Crossing Street Safely			
Exit in Emergency			
Smoking Safely			
3. Community Living:			
Using Public Transportation			
Shopping			
Cleaning			
Cooking			
Manage Own Money			

Any explanation of above information you want to make: ______________________________________
____

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)

[ ] None
[ ] Crack
[ ] Sedative/hypnotic
[ ] Cocaine
[ ] PCP
[ ] Cannabis
[ ] Methamphetamines
[ ] Inhalant: Sniffing glue
[ ] Hallucinogens
[ ] Prescription drugs
[ ] Alcohol
[ ] Benzodiazepines
[ ] Any IV drug use
[ ] Heroin/Opiates
[ ] 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
If yes, how many per day? ____________________

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:____
____
____

This client is medically and psychiatrically stabilized, does not need or continue to need an inpatient setting, and is considered appropriate for admission to a non-medical community residential placement.

_______________________________ _____________________________ ____________
Signature of Person completing the form Print Name Date

____
Relationship to Person Referred

FUNDING VERIFICATION FORM

Client Name: ___________________________

	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 3rd 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**:____

____

Other resources (**Circle all that Apply**): Checking/Savings/Certificates of Deposit/ Retirement Accounts/ Mutual Funds/Burial Funds/Stocks/Bonds/Life Insurance/Motor Vehicle(s)/Property/Other

Employed By: ____ Telephone #: __________________________

If Rep Payee, Name: ____________________________________ Address: ________________________________

____

Agency: ____Telephone #: __________________________________

Signature of person completing this form: ____

Print Name: _____________________________________ Relationship to Client: __________________________

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ADULT SINGLE POINT OF ACCESS (SPOA) SERVICES
CONSENT TO RELEASE INFORMATION

I hereby authorize the use or disclosure of my protected health information as follows:

1. Client Name: ____
   Last First Middle Initial

   Social Security Number: ____________________________ Date of Birth: ___________________________

2. The information that may be used or disclosed includes (check all that apply):
   - ☐ Mental health records
   - ☐ Alcohol/Drug records
   - ☐ School or Education records
   - ☐ Health records
   - ☐ All of the records listed above

3. This information may be disclosed by:
   - ☐ Any person or organization that possesses the information to be disclosed
   - ☐ Any persons from Lakeview Mental Health Services, Elmira Psychiatric Center, Clifton Springs Hospital & Clinic, Soldiers & Sailors Hospital, Newark-Wayne Hospital, Ontario County Mental Health, Seneca County Community Counseling Center, FLACRA.
   - ☐ The following persons or organizations:

   ____________________________________ ____

4. The information may be disclosed to Ontario or Seneca County Mental Health and their contract agencies (Lakeview Mental Health, Elmira Psychiatric Center) providing Housing or Case Management services, or other community agencies that may contribute to planning for my care.

5. The purpose of disclosure is to assist in my care and to obtain payment for my care from insurance companies, government benefit programs and others participating in the Residential or Case Management services.

6. This permission will be valid during the SPOA application and waiting list process. This permission expires upon completion of SPOA.

7. It is understood that this permission may be revoked. To revoke this permission, a written request should be made to the provider(s) listed above. Information disclosed before permission is revoked may not be retrieved. If action was taken in reliance on this permission, the person who relied on this permission may continue to use or disclose protected health information as needed to complete the work that began because this permission was given.

8. Psychiatric and chemical dependency information is protected under Federal and State Regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further release of information is prohibited by law. If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations the information indicated above could be re-disclosed. The release of HIV-related information requires additional authorization.

I am the person whose records will be used or disclosed. I understand and agree to this authorization.

__________________________________ _____________________ __________________________________
Print Name Date Signature

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is

_________________________. I understand and agree to this authorization.

Representative________________________ _____________________ __________________________________
Print Name Date Signature

Witness_______________________________ _______________________ __________________________________
Print Name Date Signature

Revised 12/1/2011