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 (Ontario only):** 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 (Ontario & Seneca):** 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.

**Supportive Housing (Ontario & Seneca):** Lakeview has an independent Supportive 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.

**Supportive SRO Housing (Ontario only):** DePaul Community Services offers independent housing through Trolley Station Apartments in the Town of Canandaigua. Supportive Housing staff are on site, with office hours Monday through Friday from 8am to 5 pm. Services include collaboration with providers and providing necessary linkage toward community integration.

**Care Management (Ontario & Seneca):** Lakeview and Elmira Psychiatric Center provide non-Medicaid 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 (Ontario & Seneca):** 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. Please do not leave any blanks. **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. This includes DSM-V psychiatric diagnoses completed **within the past year**, along with **documentation to confirm functional impairment due to a designated mental illness over the past twelve months**.

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.

☐ **Please note: this referral is specific for services in Ontario and Seneca Counties only.** For others, please contact the SPOA/SPOE Coordinator in that county for a copy of their referral packet.

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

   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):
____ Ontatio County  _____ Seneca County

SPOA Received Date: ___________________________
Received By: ________________________________

Programs Requested: See p. 1 for descriptions
___ Community Residence (Ont) ___ Licensed Apartment Program ___ Independent Supportive Housing
___ Trolley Station SP SRO (Ont) ___ Non-Medicaid Care Mgmt. ___ Finger Lakes/Mid Lakes ACT Team

Client Name: _______________________________ DOB: ____________________________
Home Address: ______________________________ Social Security #: _______ - _______ - _______
Age: _______ Gender identity: ____________________________
Received By: ____________________________

Telephone Number: ___________________________ Medicaid CIN ____________________________
Client’s County of Origin: ______________________________

Referral Agency: ____________________________ Address: ____________________________
Telephone Number: ___________________________ Contact Person: ____________________________

Person to Notify in Case of Emergency:          Primary Care Physician:
Name: ______________________________ Name: ______________________________
Address: ______________________________ Address: ______________________________
Telephone: ______________________________ Telephone: ______________________________

List the specific needs/reasons for referral:
____________________________________________________________________________________________
____________________________________________________________________________________________

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 _____________

Start date for current living situation: ____________________________

Any adult history of homelessness?  [ ] Yes          [ ] No

Does the client need 24-hour supervision?  [ ] Yes  [ ] No  If yes, why? __________________________________________________________________

Previous Residential Program 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  [ ] Pending: ___________________________
Probation/Parole Officer name and phone number:

Current or Last Services (check all that apply):
[ ] No prior service  [ ] MH residential  [ ] General hospital
[ ] State Psychiatric Center  [ ] MH outpatient  [ ] Care management
[ ] Emergency MH

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

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

<table>
<thead>
<tr>
<th>Current</th>
<th>Planned</th>
<th>Current</th>
<th>Planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist/Clinic</td>
<td>Health</td>
<td>Alcohol/Drug Treatment</td>
<td>Education</td>
</tr>
<tr>
<td>Psychiatric Day Program</td>
<td>Vocational Services</td>
<td>OMH Housing</td>
<td>AA/NA</td>
</tr>
<tr>
<td>OASAS Housing</td>
<td>Family Support Services</td>
<td>Care Management</td>
<td>Respite Services</td>
</tr>
<tr>
<td>Child Preventative Services</td>
<td>Adult Care/SNF</td>
<td>Adult Protective Services</td>
<td>Psychosocial Club</td>
</tr>
<tr>
<td>Representative Payee</td>
<td>Transition Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current CM name/agency ________________________________________________

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

<table>
<thead>
<tr>
<th>Fire setting</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual offense</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Violent acts</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Destruction of property</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Victim of physical abuse</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Victim of sexual abuse</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

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)

- [ ] None
- [ ] Respiratory disease
- [ ] Cardiovascular disease
- [ ] Diabetes /metabolic
- [ ] BMI over 25
- [ ] HIV/AIDS
- [ ] Incontinent
- [ ] Impaired ability to walk
- [ ] Hearing impairment
- [ ] Impaired vision
- [ ] Special medical equipment
- [ ] 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 smoke cigarettes? [ ] Yes [ ] No

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
- [ ] Cocaine
- [ ] Methamphetamines
- [ ] Prescription drugs
- [ ] Any IV drug use
- [ ] Crack
- [ ] PCP
- [ ] Inhalant: Sniffing glue
- [ ] Alcohol
- [ ] Heroin/Opiates
- [ ] Sedative/hypnotic
- [ ] Cannabis
- [ ] Hallucinogens
- [ ] Benzodiazepines
- [ ] 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:** ______________________________________________________________________

**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**

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

**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 #: ___________________________
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 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, HHUNY & affiliates, DePaul Community Services.
   - [ ] The following persons or organizations:
     ____________________________________________________________

4. The information may be disclosed to Ontario or Seneca County Mental Health and their contract agencies (Lakeview 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. 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. 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 April 2019