COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

ADULT CARE COORDINATION AND RESIDENTIAL SERVICES

**Applicant Information**

Applicant Name:

Address:

City:       State:       Zip Code:

Home Phone:       Cell:

Email:

Date of Birth:       Social Security Number:

Driver’s License: [ ] Yes [ ]  No State:       Identification Number:

Legal Status: [ ] sex offender [ ] incarcerated [ ] restraining/order of protection [ ] other

Primary Insurance:       Group #:

Secondary Insurance:       Group #:

Emergency Contact:       Phone:

Relationship:

**Applying for:**

[ ] Care Management/Coordination

[ ] Comprehensive Apartment Program - CAP (*apartment settings, staff visits 3x per week min./daily visits maximum)*

[ ] Supported Apartment SHUD (*apartment settings, staff visits 1-4x per month)*

[ ] HUD-Funded Permanent Supportive Housing/PSHP (*apartment settings)*

[ ] 24-hr Supervised Community Residence:

[ ] Clermont [ ] Columbia Street Apartments [ ] High Cliff Terrace [ ] Philmont Hearth

Psychiatric History

Diagnostic Impression

Code:

Code:

Code:

Trauma History: [ ] sexual [ ] physical [ ] emotional [ ] domestic violence [ ] other

Use this space to provide details on age, frequency, duration, perpetrator, etc.

*Other Pertinent Psychiatric Information:*

To accompany my referral, **I have attached one of the following: psychosocial assessment, physical health examination or other professional health evaluation** with relevant treatment information, completed within the past year.

I have reviewed this information and understand that this and other information will be given to the program(s) to which I am applying.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date

To be completed by the Referral Source

Referring Agency:

Contact:

Address:

City:       State:       Zip Code:

Phone:       Ext.       Fax:

Email:

Reason for Referral:

How long have you been working with the applicant?

To the best of your knowledge, what types of services will continue to be provided or have been requested for this individual?

[ ]  Therapy [ ] Psychiatry [ ] Adult Day/PROS [ ] Health Monitoring (WillCare)

[ ] Aging Services (Office for the Aging, Meals on Wheels)

How frequently?

Other Agencies Providing Support (name, type of service, contact information):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Signature Date

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

RELEASE OF INFORMATION

Applicant Name:       DOB:

I hereby authorize the following agencies to release and exchange the following information:

[ ] Capital District Psychiatric Center

[ ] Columbia Memorial Hospital

[ ] Greene Dept. of Social Srvs.

[ ] Greene County Mental Health Ctn

[ ] Greene County Probation

[ ] Mental Health Association

[ ] Office for People with Developmental Disabilities (OPWDD)

[ ] Twin County Recovery Services, Inc

[ ] WillCare

[ ] Other:

[ ] Other:

[ ] Current residential address and phone

[ ] Evaluation results

[ ] Employment records

[ ] Diagnosis, prognosis, treatment status

[ ] Discharge summaries

[ ] DSS assessments

[ ] DSS case type and grant amount

[ ] DSS case status

[ ] Medical records

[ ] Presence in treatment

[ ] Psychological/social assessments

[ ] Treatment plans

[ ] Other:

[ ] Other:

The purpose of this authorization is to assist with care management or residential housing services, or both, provide ongoing communication between the above agencies, fulfill court and DSS mandates, and coordinate care services. The information and/or documents obtained with this consent may be redisclosed only with my expressed written consent. I have read and understand the above and authorize the disclosure of such information as herein contained. I understand that this consent is subject to revocation at any time except to the extent that the person or agency, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon termination of services.

NOTE: CRIMINAL JUSTICE CONSENTS ARE IRREVOCABLE. THEY ARE VALID UNTIL THE DISPOSITION IN QUESTION HAS BEEN TERMINATED. THEREFORE, PROBATION CONSENTS MAY NOT BE REVOKED.

I also understand that any disclosure of the information and/or documentation is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information and/or documentation to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness Date

Prescription for Residential Treatment

***For Residential Service Requests ONLY.***

AUTHORIZATION FOR RESTORITIVE SERVICES

COMMUNITY RESIDENCE PROGRAMS

Initial Authorization

Semi-Annual Authorization (CSR, CCR, HCT)

Annual Authorization (CAP)

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD.9 Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned licensed physician, based on my review of the assessment made available to me, have determined that the above named client would benefit from the provision of *Mental Health Restorative* services defined pursuant to *Part 593 of 14 NYCRR*. A copy of the most recent residential service plan review is attached.

*\*If this is an* ***Initial Authorization****, the prescribing physician must see the client face-to-face prior to authorizing services.*

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Physician Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name and Title

COUNTY OF GREENE

SINGLE POINT OF ACCESS (SPOA)

***To be completed by the Referral Source for Residential Admission***

Day Program Recommendation

*As this Residential Program maintains a rehabilitation focus, it is expected that all residents will engage in gainful activities during the weekday. This activity should be tailored to the individual, addressing his or her individual needs, strengths, goals, etc. Options for day activities include: attending PROS, school, Supported Employment, Supported Education, volunteer work, Sheltered Employment, or any other type of service program offered by COARC or a competitive employment placement. Our goal is to promote independence to the highest degree that the individual is able to attain. We value working collaboratively with the individual consumer, as well as with all collateral services providers in reaching this end.*

The recommended day activity for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This document will become part of the residential service plan.

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Resident Primary Clinician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director Date