Cattaraugus County Department of Community Services
Single Point of Access (ADULT SERVICES)
Referral Form

PLEASE COMPLETE ENTIRE FORM AND ATTACH A COPY OF A RECENT PSYCHOSOCIAL EXAM, ANY AVAILABLE ASSESSMENTS OR MENTAL STATUS EXAM.

1. REFERRAL INFORMATION	Referral is for: ☐ Health Home Care Coordination ☐ ACT Team (Assertive Community Treatment) ☐ Non-Medicaid Care Coordination ☐ Medication Grant ☐ Housing ☐ Other
Client Name: Gender: ☐ M ☐ F	Date of Referral:
Client Street Address: City/State/Zip:	Referring Agency and Address:
Client Phone Number:	
Client SSN: Client DOB:	Referral Contact Telephone #:
Client Medicaid # (include Sequence #) _________________Seq._______ Private Insurance Name and Policy #_______________________________	Referring Person:
EMERGENCY CONTACT, ADDRESS & PHONE #:	Alternate Contact, Address and/or Phone # for Client

Primary Referral Organization Affiliation:

☐ Mental Health Outpatient
☐ Local MH Practitioner
☐ Mental Health Residential
☐ State Psychiatric Ctr (inpt)
☐ CSP Mental Health Program
☐ Emergency Non-residential Program
☐ ACT (Assertive Community Treatment) Team
☐ General Hospital ER
☐ General Hospital (inpt)
☐ MR/DD Facility
☐ Substance Abuse Program
☐ Other Medical Provider
☐ Social Services
☐ Other (specify) ____
☐ Family Court
☐ Criminal Court
☐ Probation/Parole
☐ Jail/Prison
☐ Shelter for the homeless
☐ Self, family, friend

Reason for Referral: ____

____

____

2. PERSONAL & DEMOGRAPHIC INFORMATION

Race/Ethnicity:

☐ 1. White, Non-Hispanic
☐ 2. Black, Non-Hispanic
☐ 3. Hispanic
☐ 4. Asian
☐ 5. American Indian or Native
☐ 6. Other (specify)__________________

Primary Language

☐ 1. English
☐ 2. Spanish
☐ 3. American Sign Language
☐ 4. Other______________

English Proficiency
(if primary language is other than English)

☐ 1. Does not speak English
☐ 2. Poor
☐ 3. Fair

Additional Information/Comments: ____

____

____

____

REFERRAL INFORMATION SPOA- **Adult**	NAME: Last First MI

3. LIVING ENVIRONMENT/ SUPPORT SYSTEM

Current Marital Status

☐ Single, never married
☐ Currently married
☐ Cohabiting with significant other/domestic partner
☐ Divorced/separated
☐ Widowed

Custody Status of Children

☐ No children
☐ Have children all > 18yrs.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

Living Situation at Time of Referral:

☐ Lives alone
☐ Lives with spouse
☐ Lives with parents
☐ Lives with other relatives

☐ Assisted /supported living (specify) ______________________________
☐ Nursing home/medical setting (specify) ______________________________
☐ Supervised Apartment Program (specify) ______________________________
☐ Supervised group home (specify) ______________________________
☐ Psychiatric hospital (specify) ______________________________
☐ Correctional setting (specify) ______________________________

IS THERE ANY ADULT HISTORY OF HOMELESSNESS? ☐ ***Yes*** ☐ ***No***

4. EDUCATION & EMPLOYMENT VOCATIONAL STATUS

Current Education Level

☐ No formal education
☐ Some grade school (1-8th grade)
☐ Completed grade school
☐ Some HS (9-12th grade, but no diploma)
☐ HS diploma or GED
☐ Vocational, business training
☐ Some college, no degree
☐ College degree
☐ Masters degree
☐ Other:______________________________

Current Employment Status

☐ No employment
☐ Full-time
☐ Part-time
☐ Sheltered workshop
☐ Has job coach
☐ VESID involvement
☐ Other ______________________________

Additional Information, Support Networks, Comments: ______________________________

____

____

____

REFERRAL INFORMATION SPOA-Adult	NAME: Last	First	MI

5. ENTITLEMENTS & INCOME
(check all that apply)

Benefits or Insurance	Currently receives (Enter amount)	Pending - application submitted	Eligible - no application submitted	Ineligible	Unknown	Caseworker
Social Security						
SSI/SSD						
Public Assistance						
Veteran's Benefits						
Medicare/Medicaid (inc. #)						
Food Stamps						
Pension						
Wages/earned income						
Worker's Compensation						
Unemployment						
Private insurance (inc. #)						
Trust Fund						
Medication Grant						
Alimony						

Representative Payee

☐ Yes (Name): ____

☐ No

☐ Needs

Ability to budget money

☐ Independently

☐ Needs help

☐ Unable

☐ Unknown

6. PSYCHIATRIC INFORMATION

Diagnosis	*DESCRIPTION (include primary and secondary dx)* (DSM IV-ICD.9 or DSM V-ICD.10 Diagnosis Description)	*CODE*
Primary		
Secondary		
Other		

Current or last services *(check all that apply)*:

☐ **No prior service**

	HISTORIC	*CURRENT*	*LOCATION/AGENCY*	*DATES*	*CIRCUMSTANCES*
State Psych. Center (inpt)					
General Hospital					
Mental Health Residential					
Mental Health Outpatient					
CSP Mental Health Program					
Emergency Mental Health (non-residential)					
Prison, jail, court					
Local mental health practitioner					
Case management OR Care Coordination (specify type)					
ACT (Assertive Community Treatment) Team					

REFERRAL INFORMATION SPOA-Adult	NAME: Last First MI

Current medications (psychiatric and medical) ***LIST ALL KNOWN ALLERGIES***

____

____

Prescribing Doctor: ____

Number of psychiatric hospitalizations in past 12 months: ______

Number of psychiatric ER visits in the past 12 months: ______

Current Care Management/ACT ☐ No ☐ Yes, specify ____________________________
Current AOT investigation/court order ☐ No ☐ Yes, specify ____________________________
Compliance with treatment ☐ No ☐ Yes, specify ____________________________
Compliance with medications ☐ No ☐ Yes, specify ____________________________

7. LETHALITY/DANGEROUSNESS/ RISK FACTORS *(check all that apply)*

	History	Current	Date of most recent event	Dates of previous attempts	Method
Suicidal ideation					
Suicidal attempts					
Violence to others					
Arson					
Destruction of property					
Victim of abuse					
Perpetrator of abuse					

8. LEGAL
(Current Criminal Justice Status)

☐ None
☐ Released from jail/prison in last 30 days
☐ Currently incarcerated – prison
☐ Currently incarcerated-jail
☐ Other ______________________________
☐ Alternative to incarceration (any voc. or addictions treatment)
☐ PPL 33.20
☐ Parole, Officer: ______________________ ph # ______-_________
☐ Probation, Officer: ______________________ph # ______-_________

Number of arrests in past 12 months: __________

Number of incarcerations in past 12 months: __________

9. SUBSTANCE ABUSE HISTORY

☐ **None**

Drug **Frequency**

	Not in last month	**Daily**	**1-2x/week**	**1-3x in the last month**	**3-6x/week**
Any IV drug use					
Alcohol					
Marijuana/Cannabis					
Cocaine					
Crack					
Heroin/Opiates					
Hallucinogens					
Amphetamines					
PCP					
Sedative/hypnotic					
Benzodiazepines					
Prescription drugs					
Inhalants (sniffing glue, other household products)					
Other					

Longest period of sobriety: ______________________

History of overdose – unintentional: ☐ **Yes** ☐ **No** **If Yes, Number of Times:** ______________________________

History of chemical dependency treatment: ☐ **Yes** ☐ **No**

IF YES…

☐ Inpatient (specify where and dates) ____ # of treatment episodes _____________

☐ Outpatient (specify where and dates) ____

10. MEDICAL

Functional medical problems (check all that apply)

☐ None ☐ Hearing impairment

☐ Impaired ability to walk ☐ Deaf

☐ Requires special medical equipment ☐ Impaired vision

☐ Incontinent ☐ Blind

☐ Other medical problem/condition: ____

____

Primary Physician: ____

Address: ____Phone #: ______-______________

REFERRAL INFORMATION SPOA-Adult	NAME: Last First MI

11. COMMUNITY LIVING SKILLS

SKILL LEVEL	INDEPENDENT (requires no assistance)	NEEDS HELP	UNABLE	REJECTS
ADL's (eating, hygiene, grooming, dressing, toileting)				
Personal safety (crossing streets, not getting lost, respond appropriately in an emergency)				
Use of public transportation and other community resources				
Plan, shop, prepare meals and clean				
Use/engagement with mental health services (taking medications, making appts, adherence to regimen/programs)				
Use/engagement in medical services (annual physical, and if applicable, taking meds, making appts, adherence to regimen, special diets, etc.)				
Social relationships (ability to establish or maintain satisfactory relationships with peers)				
Self-direction (impulse control, decision-making, judgment and value system)				

12. ADDITIONAL COMMENTS

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____

____

____

____

13. SIGNATURE OF CLIENT:	Mail or fax completed referral and release to: **Single Point of Access** **Cattaraugus County Dept of Community Services** **212 Laurens St., Olean NY 14760** **Phone: (716) 373-0980 Fax: (716) 372-2965**
Signature/Title/Agency of Person Completing Referral: (Title/Agency):	**Date:**

Revised 6/20/08

OBTAINING AND RELEASING OF PSYCHIATRIC AND/OR SUBSTANCE ABUSE INFORMATION for SINGLE POINT OF ACCESS PROGRAM for ADULTS

NAME:_______________________________

DOB:_______________________________

Single Point of Access Program is hereby granted permission to release and/or obtain information from my referral to and from committee representatives from: **Buffalo Psychiatric Center, Cattaraugus County Dept. of Community Services, Cattaraugus County Council on Addiction Recovery Services, Inc. (CAReS), Spectrum Health & Human Services (ACT Team), Southern Tier Environments for Living (STEL), Mental Health Association, Department of the Aging, Directions in Independent Living, Housing Options Made Easy, Inc. (HOME), Catholic Charities, Olean General Hospital, The Rehabilitation Center, Cattaraugus County Department of Social Services, Probation, and Community Action, Department of Social Services, Children's Protective Services, Adult Protection Services, WCA, Bradford Regional Medical Center, Elmira Psychiatric Center, NY Connects, VA Clinic, VA Administration**

OTHER: _______________________________ **EXCEPTIONS:** _______________________________
(to above)

I understand that information in my referral may contain information about my identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis. I understand the only information disclosed will be pertinent and necessary to determine housing and case management needs. I further understand I have the right to attend the SPOA committee discussion regarding the appropriate level of care for my needs. The purpose or need for disclosing and obtaining information is:

To allow the SPOA Committee to determine appropriate level of care and coordinate treatment.

I am not giving permission for any re-disclosure of this information other than specified above.

INSTRUCTIONS: Patient or person acting for patient **must** sign **A** and **B** to give permission for the release of information and to authorize permission for review by the SPOA Committee. **C** is signed only when there is denial of permission.

A. *My consent will expire 365 days as I grant permission for the exchange of information to the parties authorized for the period of one year. I also understand that I have the right to cancel my permission to release or obtain information at any time.*

Signature of patient/person acting for patient	Relationship	Date	Signature of Witness	Title	Date

B. *I hereby authorize the SPOA Committee review of my SPOA application and all relevant records obtained by the Single Point of Access Program, for the purpose of determining eligibility for services and level of care. I understand the Committee is comprised of representatives of various human service agencies in Cattaraugus County, and that Committee members will hold all information in confidence. The information will be disclosed to you from records protected by Federal Confidentiality Rules & the Health Insurance Portability and Accountability Act of 1996. These regulations prohibit any further disclosure of information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under these regulations. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client/patient.*

Signature of patient/person acting for patient	Relationship	Date	Signature of Witness	Title	Date

C. *I hereby refuse to authorize the release of information to the person/organizations, facilities, or programs above.*

Signature of patient/person acting for patient	Relationship	Date	Signature of Witness	Title	Date

Cattaraugus County Department of Community Services is not responsible if information is further disclosed in any way.

Revised 05/15/18

SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) ADULT CHECKLIST

Client Name: ______________________________ **Client Code: __________**

In order for a client to be considered SPMI, the following conditions must be met (A and either B or C or D:)

A. 18 year or older and
DSM-IV / ICD-9-CM diagnosis other than alcohol and drug disorders, developmental disorders, dementia or mental disorders due to a medical condition except those with predominant psychiatric features or V codes.

Diagnosis: ________________________

AND:

B. Receive SSD / SSI due to a mental condition

OR:

C. Extended impairment in functioning. Must meet 1 or 2 below:

1) Has experienced two of the following 4 functional limitations due to a designated mental illness over the past 12 months continuously or intermittently:
   a) Difficulties in self-care
   b) Marked restriction in activities of daily living
   c) Marked difficulties in social functioning
   d) Difficulties in completing tasks in a timely fashion in work, school or home.

2) GAF of 50 or less due to a mental illness in the past twelve months, continuously or Intermittently

OR:

D. Reliance on psychiatric treatment, rehabilitation and supports to maintain current functioning. Client has a documented history of past symptoms and / or functioning problems which are currently controlled because of treatment, including psychiatric medications or rehabilitation and supports.

__________________________________ ______________________________________
Supervisor's Signature Therapist's Signature

______________________ _________________________
Date Date

Department of Community Services

Mary H. O'Leary, LCSW
Director

AFFILIATION AGREEMENT FOR INDIVIDUALS PARTICIPATING IN CASE REVIEW MEETING FOR SINGLE POINT OF ACCESS FOR ADULTS / ASSISTED OUTPATIENT TREATMENT

Participants in the above meeting each bring their expertise and function as consultants within their specialtuies. These specialties include case management, care coordination, clinical/psychiatric experience, peer services, housing, emergency services, forensic issues, and administration.

Information discussed in the meeting is privileged and confidential with the intended purpose being decision making regarding case assignments / status and discussion of information related to individuals referred for services. The information will be disclosed to you from records protected by Federal Confidentiality Rules & the Health Insurance Portability and Accountability Act of 1996. These regulations prohibit any further disclosure of information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under these regulations. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client/patient.

Signature of this agreement indicates my willingness to abide by and cooperate with the above expectations.

____
Print Name

____
Signature   Date

____
Title

Contact Information:

Agency: ______________________________________

Address: ______________________________________

____

Phone: __________________Fax: _______________

E-Mail: ______________________________________

Vision:* *Promote a higher quality of life for those we serve through effective treatment and prevention, nurturing cooperative relationships, and continued development of programs and services.

Olean Counseling Center	Salamanca Counseling Center	North County Counseling Center	Foundations for Change	Care Coordination Programs
Adult & Children's Services	Adult & Children's Services	Adult & Children's Services	PROS Program	Care Management, SPOA, MTST
1 Leo Moss Drive, Suite 4308	117 1/2 Main Street	9824 Route 16	203 Laurens Street	212 Laurens Street
Olean, NY 14760	Salamanca, NY 14779	Machias, NY 14101	Olean, NY 14760	Olean, NY 14760
Phone (716) 373-8040	Phone (716) 945-5211	Phone (716) 353-8241	Phone (716) 373-8080	Phone (716) 373-0980
Fax (716) 701-3728	Fax (716) 945-5267	Fax (716) 353-8617	Fax (716) 373-8093	Fax (716) 372-2965

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