

1. Complete the Eligibility Checklist (page 2)

**Brigid Pigott, SPOA Chair
 Adult Mental Health Services
 Rockland County Department of Mental Health
 50 Sanatorium Road, Bldg. F
 Pomona, NY 10970**

2. Please review REQUIRED DOCUMENTATION FORM below. Referrals will NOT be considered complete without:
Complete SPOA Application
Clinical Information as specified below.
3. Upon receipt, application will be reviewed by RCDMH for completeness. Incomplete Applications will be delayed until completed by the referring party. Mail (address above) or **Fax** applications to:
845 364 2381

For questions regarding the SPOA Application, please **call 845 364 2399**.

REQUIRED DOCUMENTATION

Required Documents	ACT	Care Mngt	Housing		
			CR	TX APT	SH
Eligibility Determination – Pg. 2	X	X	X	X	X
Referral Form – Pg. 3-5	X	X	X	X	X
Psychiatric Evaluation (Current within 90 days and Including ICD-10 diagnosis)	X	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X	X
Physical Exam & Immunization Record			X	X	
Authorization for Restorative Services – Pg. 6 (MUST BE ORIGINAL)			X	X	

Please Note: The SPOA Committee reserves the option to require the completion of a Functional Assessment Form to assist in the SMI determination or other eligibility needs.

In order to be eligible for services through RCDMH, applicants for Housing, Case Management or ACT Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **1 must be met. In addition, 2 or 3 must be met:**

Yes No **1. The applicant is 18 years of age or older and currently meets the criteria for a primary **ICD-10-CM diagnosis** other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions.**

Please complete: Primary **ICD-10-CM code:** _____

AND

Yes No **2. The applicant is currently enrolled in SSI or SSDI *DUE TO A DESIGNATED MENTAL ILLNESS.***

OR

Yes No **3. Extended Impairment in Functioning due to Mental Illness.**
The applicant has experienced at least two of the following four functional limitations *due to a designated mental illness over the past 12 months on a continuous or intermittent basis.*

(Documentation in psychosocial assessment required.)

- Yes No **a. Marked difficulties in self care.**
- Yes No **b. Marked restrictions of activities of daily living.**
- Yes No **c. Marked difficulties in maintaining social functioning.**
- Yes No **d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school setting.**

Yes No **4. Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates & facility must be documented in Referral Form).**

Yes No One six month stay in an inpatient psychiatric unit

Yes No Two stays of any length in an inpatient psychiatric unit in the preceding two years.

Yes No Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.

Yes No Three or more contacts Crisis or emergency mental health services or a combination of any 3 contacts within the preceding 18 months.

Yes No Six months consecutive residency in a designated Adult Home.

Yes No Six months consecutive residency in a Residential Care Center for Adults (RCCA)

Yes No Six months consecutive residency in a Residential Treatment Facility (RTF)

Applicant Information

Name: _____ Date of Birth: _____
Social Security #: _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Telephone _____ Citizenship: Yes ___ No (if no, immigration status): _____

Identify as: Male: _____ Female: _____ Transgender: _____

Race/Ethnicity

Primary Language

White (Non-Hispanic) Black (Non Hispanic) English
Latino/Hispanic Asian/Asian American Other _____
Native American Pacific Islander
Other _____

Custody Status of Children

Current Living Situation

____ No children
____ Children are all above 18 years of age
____ Minor children currently in client's custody
 Number of children: _____ Gender: _____
____ Minor children not in client's custody but have access
____ Minor children not in client's custody – no access

____ Room
____ Own apt
____ Supervised Living
____ Supported Housing
____ Lives with spouse
____ Correctional facility

____ Homeless (shelter)
____ Homeless (streets)
____ Nursing Home
____ Psychiatric Hospital
____ Lives with Parents
Other _____

Insurance and Financial Information: Currently Receives (give amount)

SSI \$ _____ Earned Income/Wages \$ _____
SSD \$ _____ Food Stamps \$ _____
Public Assistance \$ _____ VA Benefits \$ _____
Private Insurance # _____ Representative Payee \$ _____
Medicaid # _____ Other _____ \$ _____

Medicare # _____ MA/MC Managed Care _____
Health Home _____ HARP Enrolled _____

Referral Source:

Name: _____ Phone: _____
Agency: _____ Fax: _____
Address: _____ E-mail: _____
Program: _____ Relationship: _____

Psychiatric Information:

Diagnosis

ICD - 10 Code

Current Medical Problems: _____

List any psychosocial and environmental problems: _____

Current Medications: Please List

Medications	Dosage	Frequency

Outpatient Treatment Provider:

Agency: _____ Program: _____
 Contact: _____ Telephone: _____

Substance Abuse History : Please List Drugs of Choice _____

Length of Time Recipient Has Been Substance Free: _____

List Psychiatric Hospitalizations within the last 2 years:

Facility	Dates of Stay	Reason for Admission

Criminal Justice – Current Status

None Incarcerated-Jail Incarcerated-Prison CPL 330.20/730
 Probation Parole TASC/MHATI Other _____

P.O. Name: _____ Telephone: _____

Number of arrests/incarcerations in past year: _____ Number of lifetime arrests: _____

Reason for Arrest: _____ Date of Arrest: _____

Assisted Outpatient Treatment:

Does the person have court ordered AOT under Kendra's Law? Yes No

Is an AOT under Kendra's Law currently being pursued? Yes No

Care Management Service Requested:

Care Management Care Management with AOT Peer Supports

PLEASE LIST CURRENT CM AGENCY: _____

Act Services Requested:

Residential Services Requested:

Congregate Treatment Residence Supported Housing Subsidy
 Congregate Treatment Residence MICA Treatment Apartment –Single Site
 Congregate Treatment Residence MI/IDD Treatment Apartment – Scatter Site

Recipients Requests: _____

Recipient's Signature: _____ Date: _____

Referring Party's Signature: _____ Date: _____



CONSENT FOR RELEASE OF INFORMATION

PLEASE PRINT CLEARLY

Patient's Name (Last, First, Middle Initial)

Gender

Date of Birth

Facility Name

Unit/Ward No.

PART I – Consent To Release Information

Extent or nature of information to be disclosed:

- Most Recent Complete Psychiatric Evaluation
- A Psychosocial Summary
- A Psychological Evaluation (If Available)
- Current Medical Report w/ TB Status within 1-year
- Single Point of Accountability Application

Purpose or need for information:

A referral to Case Management, Residential Housing or ACT

This section must be completed by the party releasing the information

From: _____

Name: _____

Address _____

To: **Rockland County Adult SPOA Committee**

Dr. Robert L. Yeager Health Center

50 Sanatorium Rd. Bldg. F

Pomona, NY 10970

Telephone: 845-364-2399 Fax: 845-364-2381

Title of Person/Org./Facility/Program

which Disclosure is to be made:

Attention: Single Point of Access & Accountability
Of Rockland County

A. I hereby authorize a one-time release of the above information to the person/organization/facility/program identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my Permission to Release Information @ any time.

My Consent to Release will expire when acted upon, or 90-days from this date, whichever occurs first.

Signature of Patient/Person Acting For Patient

Relationship

Date

Signature of Witness

Title

Date

B. I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above, as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my Permission to Release Information at anytime.

My Consent to Release Information to the person/organization/facility/program identified above will expire when I am no longer receiving services from such person/organization/facility/program, or 1-year from this date, whichever occurs first.

Signature of Patient/Person Acting for Patient

Relationship

Date

Signature of Witness

Title

Date

Signature of Staff Person Releasing Information

Title

Date

AUTHORIZATION FOR COMMUNITY SERVICES

Initial Authorization

Semi – Annual Authorization

Annual Authorization

CLIENT’S NAME: _____

MEDICAID NUMBER: _____

ICD-10 CODE AND DIAGNOSIS: _____

I, the undersigned licensed physician, based on my review of the assessment made available to me, have determined that _____, would benefit from the provision
(Applicant's Name)

of mental health restorative services known to me and defined pursuant to Part 593 of 14

NYCRR. This determination is in effect from the period starting from _____ to
(Start Date)

_____, at which time there will be an evaluation for continued stay.
(End Date)

I, the undersigned licensed physician, certify that I have registered with the NYS Medicaid program.

_____/_____/_____
Month Day Year

Name (Please Print) M.D.

License Number

Signature