Living Opportunities of DePaul Licensed Housing Application Cover Sheet

Applicant's Name: _____ Date Completed: _____

Please check the type of housing the applicant is interested in:

GENESEE COUNTY	ORLEANS COUNTY	WYOMING COUNTY
☐ Batavia Apartment Treatment Program 555 East Main Street Batavia, NY 14020	☐ Orleans County Apartment Treatment Program Crimson Heights Apts. 345 Crimson Drive Albion, NY 14411	☐ Wyoming County Apartment Treatment Program 35 Culver Avenue Ext. Warsaw, NY 14569

ERIE COUNTY Referrals must be submitted through the Erie County Department of Mental Health SPOA System at: https://familyfirst.secure.force.com/spoa/apex/spoa2_home

Please send completed referrals to:

Intake Department
Living Opportunities of DePaul
2475 George Urban Boulevard, Suite 201
Depew, NY 14043
(716) 391-5400
Fax: (716) 608-0131

In accordance with federal, state and municipal fair housing laws no person shall be denied housing because of his/her race, color, religion, national origin, sex, marital status, age, disability, family status, sexual orientation or income.

Descriptions of Licensed Housing Programs

LICENSED HOUSING

Apartment Treatment Programs provide consumers with the highest level of independence in a program licensed by the New York State Office of Mental Health. Programs offer one- and two-bedroom apartments with staff who make routine visits and are available 24-hours a day in case of an emergency. The programs are designed to be a preparatory step before the consumer begins to live independently within the community. An emphasis is placed on increasing personal initiative and self-reliance. Cash allowances for groceries are provided. Residents are expected to develop individual goals that focus on living more independently. The typical length of stay is eighteen to twenty-four months.

Community Residence-Single Room Occupancy (CR-SRO) Programs provide housing in a service-enriched, recovery-oriented setting to adults with a psychiatric disability. The programs are licensed by the New York State Office of Mental Health and have a residential atmosphere with individual bedrooms, inviting common areas and outdoor courtyards. Other services include 24-hour staffing, daily living skills training, crisis management, medication management; linkages to medical and dental care and health education services; social/recreational assistance, and vocational/educational services among others.

Licensed Congregate Treatment Sites (also known as group homes) provide a comprehensive level of staff support, while encouraging independence, in a program licensed by the New York State Office of Mental Health. The program is sometimes the entry point to all certified programs and provides 24-hour on-site staffing, meals, support, advocacy and recovery-oriented services. Sites house ten residents each who are 18 years of age or older. To further enhance self-esteem and growth, an emphasis is also placed on consumer involvement in activities outside the residential setting including personalized recovery oriented services programs, vocational programs, school, and competitive- and non-competitive employment. These sites are considered transitional and rehabilitative in nature, as the resident's goal is to move to a more independent living environment within twenty-four months.

For Housing Provider Use Only

Date Rec'd: _____ Disposition: _____

*** Items are required fields**

I. **APPLICANT DATA**

*Name: _____ *Social Security Number: _____
(Last) (First) (Middle)

*Current Address: _____ *Telephone #: _____

_____
(City) (State) (Zip Code)

* Months in current living situation: _____

Previous Address: _____ *County: ☐ Erie ☐ Other: _____

* Date of Birth: _____/ _____ / _____ *Sex: _____ Race (optional): _____

* Marital Status: _____ Single _____ Married _____ Divorced _____Separated _____Widowed

Religion (optional): _____

* Highest Level of Education Completed: _____ Literate: ___ Yes ___No

* Family Contact: _____ Relationship: _____

Address: _____ Telephone #: _____

_____ Email: _____

*II. **DIAGNOSIS (DSM V CODE)**

AXIS I AXIS I

AXIS II AXIS II

AXIS III _____ AXIS III _____

AXIS IV (A) Stressor _____ (B) Severity _____ (C) Duration _____

AXIS V (A) Current GAF Score _____ Past Year GAF Score (if available) _____

(ENTER TWO DIGIT SCORES FROM 01-90)

Intellectual Level (IQ) _____ Below 70 _____70-84 _____ Above 84

III. **REFERRED BY**

Name: _____ * Telephone #: _____

Agency: _____

Program: _____ Contact (if other than above): _____

Address: _____ Email: _____

Applicant's Name: _____

IV. **RISK ASSESSMENT**

Is the consumer identified as high-risk, high-need due to any one of the following characteristics?

YES	NO	DON'T KNOW	
☐	☐	☐	A history of sexually abusing others
☐	☐	☐	A history of fire setting
☐	☐	☐	A history of indiscriminate serious assault (consumer arrested and/or victim required medical attention)
☐	☐	☐	A history of homicide
☐	☐	☐	A history of suicide attempts
☐	☐	☐	A history of repeated episodes of serious self-harm requiring medical attention
☐	☐	☐	Three episodes of housing loss in the last 12 months
☐	☐	☐	Medical needs that cannot be addressed by the housing provider
☐	☐	☐	History of alcohol abuse/dependence
☐	☐	☐	History of substance abuse/dependence (if yes, note below, onset and frequency of use, type of substance, date of last use and method of administration)
☐	☐	☐	History of arrests and dispositions (i.e. currently in jail or facing charges, released from jail or prison within the last year, probation/parole supervision, CPL 33.20, Alternative to Incarceration, etc.)

If you answered yes to any of the above, please provide details in the space below or include in psychosocial history:

_____

_____

_____

Describe signs of decompensation and/or prodromal symptoms: _____

_____

_____

V. **FUNCTIONAL STRENGTHS AND DEFICITS**

Does applicant currently:	Independently	Needs Help	Unable	Unknown
● Manage personal needs (grooming/hygiene/laundry)	☐	☐	☐	☐
● Budget money	☐	☐	☐	☐
● Respond appropriately to emergency situations (e.g. fire, First Aid)	☐	☐	☐	☐
● Comply with medication regimen	☐	☐	☐	☐
● Use public transportation and other community resources	☐	☐	☐	☐
● Plan menus, grocery shop, prepare meals	☐	☐	☐	☐
● Self-medicate	☐	☐	☐	☐

VI. **Please attach copies of most recent progress notes, service plan reviews and psychiatric evaluations or psychosocial history.**

Applicant's Name: _____

*VI. **SOURCE OF INCOME/FINANCIAL RESPONSIBILITIES** Please check all that apply

☐ **No Assets or Funding Source**

☐ **Public Assistance**

☐ Active Monthly Amount $ _____ County _____ Telephone # _____

☐ Pending: Application Date _____ Case Worker: _____

☐ **Supplemental Security Income (SSI)**

☐ Active Monthly Amount $ _____ County _____ Telephone # _____

☐ Pending Application Date _____ Overpayment? _____ SSI Worker _____

☐ **Social Security (SSD or SSA)**

☐ Active Monthly Amount $ _____ Type of Benefit (i.e. Disability) _____Claim # _____

***Payee Status** ☐ Self

☐ Representative: Name: _____ Telephone #: _____

Address:_____ Email: _____

☐ **Wages** (including Sheltered Workshop) ☐ Full Time ☐ Part Time

☐ **Union Benefits** $ _____/ month

☐ **Unemployment Insurance Benefits** $ _____/ month

☐ **New York State Disability** $ _____/ month

☐ **Railroad Retirement Benefits** $ _____/ month

☐ **Workers' Compensation Benefits** $ _____/ month

☐ **Pension/Annuity** $ _____ / month

☐ **Veterans Benefits** $ _____/ month

Other Assets

☐ Alimony / Child Support Received $ _____ / month

☐ Homeowner

☐ Bank Account(s) – List Banks: _____

☐ Stocks ☐ Bonds ☐ Trusts ☐ Burial Fund ☐ Motor Vehicle ☐ Life Insurance

Food Stamps

☐ Active Amount $ _____/ month ☐ Pending Application Date _____

Health Insurance

☐ Medicaid # _____ Access # _____ Seq. # _____

☐ Medicare # _____

☐ Other: Type _____ Policy # _____

Financial Responsibilities

☐ No Known Financial Responsibilities ☐ Student Loan $ _____ ☐ Medical Expenses $ _____

☐ Alimony / Child Support $ _____ ☐ Motor Vehicle $ _____ ☐ Other _____

Applicant's Name: _____

*VIII. **PREVIOUS RESIDENTIAL SERVICES**

AGENCY	ADMISSION DATE	DISCHARGE DATE

*IX. **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS / INSTITUTIONALIZATIONS**

FACILITY	SERVICE (I.E. detox)	ADMISSION DATE	DISCHARGE DATE

ER VISITS (list dates over the last 6 months)

_____

_____

*X. **PREVIOUS OUTPATIENT TREATMENT / CASE MANAGEMENT SERVICES**

AGENCY	TYPE OF SERVICE	ADMISSION DATE	DISCHARGE DATE

*XI. **CURRENT OUTPATIENT TREATMENT**

Agency _____ Address _____ Contact _____

Telephone _____ Date Linkage Completed _____

Prescribing Psychiatrist _____ Telephone # _____

*XII. **CURRENT CARE COORDINATION / CASE MANAGEMENT**

☐ None ☐ ACT ☐ ICM ☐ TCM ☐ SCM ☐ Other Case Management

☐ Active Agency _____

Case Manager's Name _____ Telephone # _____

☐ Pending – Referral has been made

☐ Assisted Outpatient Treatment (A.O.T.)

Applicant's Name: _____

MEDICATION	DOSAGE	FREQUENCY

*XIII. **CURRENT COMMUNITY REHABILITATION AND SUPPORTS**

(If an activity or support is pending or recommended, please note in comment section.)

☐ IPRT Agency _____ Contact _____ Tel #

☐ Work Agency _____ Contact _____ Tel #

☐ C.D.T. Agency _____ Contact _____ Tel #

☐ P.R.O.S. Agency _____ Contact _____ Tel #

☐ Peer Services Agency _____ Contact _____ Tel #

☐ Self-Help Groups Agency _____ Contact _____ Tel #

☐ Social Clubs Agency _____ Contact _____ Tel #

☐ Clubhouses Agency _____ Contact _____ Tel #

☐ School Agency _____ Contact _____ Tel # _____

Please note days and hours of activities below:

_____

_____

Comments:

_____

_____

_____

_____

Other Social Supports: ☐ Family ☐ Job ☐ Other _____

* Transportation Access: ☐ Public ☐ Own Car ☐ Program Van ☐ Family ☐ Medicaid Cab

*XIV **CURRENT HEALTH CARE PROVIDER**

Clinic _____ Contact _____ Tel # _____

Primary Care Physician _____

Address _____

Advanced Directive: ☐ Yes ☐ No

Contact Person: _____ Telephone # _____

Email: _____

Applicant's Name: _____

XV. MEDICAL EXAMINATION

Date of most recent medical examination: _____
(Completed by a Physician, Nurse Practitioner or Physician Assistant)

A current (within 12 months) and legible history and physical examination may be substituted for the information requested below.

Please check ALL that are current or historic medical concerns. If yes, please comment:

	Unknown	No	Yes	Comments
Allergies/Medication Sensitivity	_____	_____	_____	_____
Arteriosclerosis	_____	_____	_____	_____
Communicable diseases	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Hearing Impairment	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____
History of Cancer	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Incontinency	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Mobility Limitations	_____	_____	_____	_____
Podiatry	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____
Skin Disorder	_____	_____	_____	_____
Special Diet (s)	_____	_____	_____	_____
Speech Impairment	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Visual Impairment	_____	_____	_____	_____

Other (Please Specify): _____
_____
_____

For any of above conditions checked YES, please indicate specific instructions to be followed by the applicant:
_____
_____

Signature and title of person completing this form: _____
Date: _____

Applicant's Name: _____

XVI. **TUBERCULOSIS TEST RESULTS**
(Completed by a Physician, Nurse Practitioner or Physician's Assistant)

It is necessary that all applications be screened for tuberculosis within *one year* of the referral. The following documentation is required. Medical records verifying administration of the PPD test may be submitted in lieu of this form.

Date of PPD (Mantoux) Test _____

PPD (Mantoux) Test Administered by _____

Results of PPD (Mantoux) Test _____

Date of Chest X-Ray (if indicated) _____

Results of Chest X-Ray _____

Signature and credentials of person completing this form _____

Date _____

PHYSICIAN'S AUTHORIZATION FOR
REHABILITATIVE SERVICES OF COMMUNITY RESIDENCE

DePaul
2475 George Urban Boulevard
Suite 201
Depew, New York 14043
Phone: (716) 391-5400

____Initial Authorization (face to face)
____Semi-Annual Authorization (CR)
____ Annual Authorization (TAP)

Client's Name: _____

Client's Medicaid Number: _____

Based on review of the assessments made available to me, or as the result of a face to face assessment with the client in need of an initial authorization, I, the undersigned licensed physician, have determined that this individual would benefit from the provision of mental health rehabilitation services provided in a congregate care residential setting as defined pursuant to Part 593 of 14 NYCRR.

Period Covered:

_____/ _____/ _____ to _____/ _____/ _____
Month Day Year Month Day Year

_____
Primary Mental Health Diagnosis and ICD-10 Code

_____
M.D. License Number

_____ _____ _____ _____
Print Name of M.D. M.D. Signature Date

COMMUNITY REHABILITATION SERVICES NOTATION CODES

AT - Assertiveness/Self Advocacy Training - Training which promotes the individual's ability to assess his or her needs to make a life status change and to increase self-awareness about his or her values and preferences. Training is intended to increase an individual's ability to respond to medical, safety and other personal problems. Activities are also intended to improve communication skills and facilitate appropriate interpersonal behavior.

CI - Community Integration Services/Resource Development - Activities designed to help individuals to identify skills and community supports necessary for specific environments; to assess their skill strengths and deficits in relationship to environmental demands; to assess resources available to help the individual; to develop a natural support system; by accessing social, educational and recreational opportunities.

DLS- Daily Living Skills Training - Activities which focus on the acquisition of skills and capabilities to maintain primary activities of daily life; services are provided by addressing areas of functioning in categories such as: dressing, personal hygiene and grooming, selection and/or preparation of food, cleaning and washing of clothes, maintenance of environment, budgeting and money management. Training is intended to increase those competencies needed by the individual to live in his or her goal environment.

HS - Health Services - Training to maximize independence in personal health care by increasing the individual's awareness of his or her physical health status and the resources required to maintain physical health; including regular medical and dental appointments, basic first aid skill, basic knowledge of proper nutritional habits and family planning. Also, includes training on special topics such as AIDS awareness.

MMT-Medication Management and Training - The storage, monitoring, record keeping and supervision associated with the self-administration of medication. This does not include prescribing, but does include a certain degree of reviewing the appropriateness of the residents' existing regimen with the appropriate physician. Activities which focus on educating residents about the role and effects of medication in treating symptoms of mental illness and training in the skill of self-medication are also included.

PT - Parent Training - Structured activities intended to promote positive family functioning and enable the resident to assume parenting responsibilities. Activities include peer support groups to foster skills around effective parenting, assistance in selecting and obtaining housing appropriate for families, and linkage with the children's service system. Psycho-education programs on parenting skills, single parenting issues, child care and the nature of mental illness and its effect on the family are also included.

RC - Rehabilitation Counseling - A therapeutic modality which includes assisting the individual in clarifying future directions and the potential to achieve rehabilitation goals; identifying and specifying behaviors that impede goal setting; improving understanding regarding the influence of environmental stress; and helping an individual to apply newly learned behaviors to housing and other situations outside the program structure.

SD - Skill Development Services - Activities which assist clients to gain and utilize the skills necessary to undertake employment or pursue educational opportunities. This may include skills related to securing appropriate clothing, scheduling, work related symptom management, and work readiness training.

S - Socialization - Activities whose purpose are to diminish tendencies toward isolation and withdrawal or overly aggressive behavior by assisting residents in the acquisition or development of social and interpersonal skills. "Socialization" is an activity whose purpose is to improve or maintain a resident's capacity for social involvement by providing opportunities for application of social skills. This occurs through resident/staff interaction in the program and through exposure with staff to opportunities in the community. Modalities used in socialization include individual and group counseling and behavior interventions.

SAS -Substance **Abuse Services -** Services provided to increase the individual's awareness of alcohol and substance abuse and reduction or elimination of its use; including verbal and medication therapies, psycho-educational approaches, and relapse prevention techniques.

SM - Symptom Management - Activities to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of residents' mental illness symptoms and response to treatment, interventions designed to help residents manage their symptoms, and assisting residents to develop coping strategies to deal with internal and external stressors. Services range from providing guidance around everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques.

LICENSED HOUSING CHECKLIST

Please utilize this checklist to ensure the Licensed Housing Referral Application is complete.

☐ Licensed Housing Cover Page (page 1)

☐ Licensed Housing Application Information (page 3)

☐ Housing Risk Assessment (page 4)

☐ Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults (page 5)

☐ Functional Assessment Worksheet (page 6)

☐ Medical and Health Information (page 7 & 8)

☐ Physician Authorization for Rehabilitation Services of Community Residences (page 9 & 10)

☐ Psychiatric Assessment completed within the past 12 months.

☐ Psychosocial History. *To include documentation regarding signs of decompensation and/or prodromal symptoms, risk behaviors, legal history, substance abuse, general health and personal& family history.*

☐ Authorization for release of information

DePaul
AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

A representative from DePaul must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your representative should read the descriptions below before signing this form.

NAME: _____ **DOB:**
I hereby give permission to: Living Opportunities of DePaul
☐ **receive information from: OR** ☐ **release information to:**
PERSON/ORGANIZATION: _____
ADDRESS: _____
TELEPHONE NUMBER:
INFORMATION:

_____Academic Performance/Vocational
_____Financial
_____Discharge Summaries
_____Intake/Screening Assessment
_____Medical History, Physical Findings, Lab reports
_____Medication Record
_____Psychiatric Evaluation/Status
_____Progress Notes
_____Medication Orders
_____Other (please specify) _____

_____Psych/Social Assessment
_____Residential Functioning
_____Treatment Plan (Mental Health)
_____Treatment Plan (Addiction)
_____Legal
_____Insurance
_____Psychological Evaluation
_____Dates in Program
_____Physician's Orders

THIS INFORMATION IS NEEDED FOR:

Psychiatric Treatment Services
Medical Treatment Services
Financial Linkage
Housing Support Services
_____Vocational Linkage/Coordination

_____Family/Significant Other Communication
_____Adult Day Care Coordination
At the request of the individual
_____Other (please specify)
_____

I hereby authorize the release of the above Protected Health Information from my record. I understand that the information to be released from my record is confidential and protected from disclosure by Federal and State Confidentiality Rules. *

My authorization to release information to the person/organization/facility/program identified above, ***WILL EXPIRE ON ____/__/_____ ~~OR WHEN I AM NO LONGER RECEIVING SERVICES~~*** from such person/organization/facility/program, unless otherwise specified. I understand if I sign this authorization, I will have the right to revoke it at any time, except to the extent the program has already taken action based upon my authorization. I also have a right to receive a copy of this form after I have signed it.

_____ _____
Signature of Client/Consumer Date Printed Name of Client/Consumer

_____ _____
Signature of Witness Date Printed Name of Witness

PLEASE NOTE: HIV/AIDS related information cannot be released under this form. A specific form exists for the release of HIV/AIDS information.

- -

FOR CANCELLATION OF AUTHORIZATION

☐ ***I hereby revoke my permission as stated above to release protected health information from my record to the person or organization whose name and address as listed above.***

_____

_____ _____
Signature of Client/Consumer Date Printed Name of Client/Consumer

_____ _____
Signature of Witness Date Printed Name of Witness

*With the exception of Substance Abuse Information, information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule for Substance Abuse Programs –the information disclosed is protected by Federal Law and the recipient cannot make any further disclosure unless permitted by regulations.