Instructions & Checklist:

☐ Complete and sign all designated areas.

☐ Complete and sign the consent to release information.

☐ A complete psychosocial history and psychiatric assessment including the Severe Mental Illness diagnosis completed **within the past year** must be included.

Please use the Livingston County SPOA referral if the adult client:

- needs Case Management and **does not** have medicaid
- needs supported housing (community residences and treatment apartment programs **are not** available in Livingston County)
- has "difficult to serve" challenges that the SPOA committee can help to navigate as a referral source for the client

Please be aware that if the client has Medicaid and is in need of care management services, a HHUNY referral must be completed instead and sent directly to HHUNY.

SPOA referral **cannot** be used for Case Management for Medicaid/Medicaid Managed Care recipients.

Mail, email or fax completed referral packet to: **Amber Hainey, SPOA Coordinator**
Livingston County Mental Health
4600 Millennium Drive
Geneseo, NY 14454
Secure Email: amhainey@co.livingston.ny.us
Phone: 585-243-7250
Secure Fax: 585-243-7264

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

To be considered an adult with severe and persistent mental illness, **A** must be met.
In addition, **B** or **C** or **D** must be met.

A. Designated Mental Illness Diagnosis

___ **YES** ___ **NO** The individual is 18 years of age or older and has a primary DSM-TR psychiatric diagnosis **other than the following:** alcohol or drug disorders, developmental disabilities, dementias, mental disorders due to general medical conditions except those with predominant psychiatric features, or social conditions. DSM-IV categories and codes that do not have an equivalent in ICD-9-CM are not included as designated mental illness diagnoses.

AND

B. SSI or SSDI Enrollment due to Mental Illness

___ Yes ___ NO The individual is currently enrolled in SSI or SSD due to a designated mental illness.

OR

C. Extended Impairment in Functioning due to Mental Illness

The individual must meet **1**or **2** below:

1. 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:

___ YES ___ NO a. Marked difficulties in self-care.

___ YES ___ N b. Marked restriction of activities of daily living.

___ YES ___ N c. Marked difficulties in maintaining social functioning.
___ YES ___ N d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner at work, home or school settings.

2 The individual has met criteria for a rating of 50 or less on the Global Assessment of Functioning Scale.
___ YES ___ NO

OR

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports

___ YES ___NO A documented history shows that the individual, at some prior time, met the threshold for C (above) but 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 limitation imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of underlying mental disorder.

Form completed by:

_____ _____

Signature **Date**

Livingston County
Adult SPOA Referral Packet

Referred By _____
Date _____

Programs Requested:

___ Supported Housing, Is there a preference of:

[ ] Lakeview-Provides rental stipend Client must sign own lease for an apartment. Available on the open rental market. Staff is located in Geneva, so there is minimal in-person contact (usually once a month).

[ ] Arbor Development-Same as Lakeview, except the office is located in Dansville.

[ ] SkyBird Landing-Located in Geneseo, 30 apartments are SP SRO for homeless/pending homeless individuals. The staff office is on site during business hours with basic case management services provided.

___ Non-Medicaid Case Management (If client has Medicaid, please refer them to HHUNY)

___ Other: _____

Client Name: _____ **DOB:** _____

Home Address: _____ **Age:** _____ **Gender:** ____ **M** ____ **F**

_____ **Social Security Number:** _____

Telephone Number: _____ **Insurance Name** _____

Email: _____ **Insurance ID:** _____

Referral Agency : _____ **Address:** _____

Telephone Number: _____ **Contact Person:** _____

Mental Health Provider Name and Phone #: _____

Substance Abuse Provider Name and Phone #: _____

Case Manager Name and Phone #: _____

Person to Notify in Case of Emergency:

Name: _____

Address: _____

Telephone: _____

Primary Care Physician:

Name: _____

Address: _____

Telephone : _____

Client's Mental Health Diagnosis: _____

Client's Substance Abuse Diagnosis: _____

Please list any physical health issues client has: _____

COMPLETE IF HOUSING IS NEEDED

If SH is needed, is client homeless?: [ ] Yes [ ] No

[ ] Homeless (street)

[ ] Emergency housing/shelter

[ ] In respite apartment

[ ] Temporarily staying with friends/relatives

[ ] in eviction process explain circumstances:

If not homeless, what is the living situation?

[ ] Lives with parents

[ ] Lives with other relatives

[ ] Psychiatric Center

[ ] Lives with spouse

[ ] Assisted/supported living

[ ] Correctional Facility

[ ] Supervised living

[ ] Nursing home/medical setting

[ ] Other _____

What does the client need from SH provider?:

[ ] Client needs to find an Apartment and needs stipend to afford it

[ ] Client wants to stay in current residence and needs stipend to afford it

[ ] Furniture

[ ] Help with cooking

[ ] Medication supervision

[ ] Help with shopping

[ ] Getting to appointments

[ ] Help with cleaning

[ ] Help budgeting money

[ ] Help managing symptoms

Who will be in the apartment other than client?

[ ] No one

[ ] Children _____

[ ] Significant Other

[ ] Pets (what type?) _____

[ ] Other_____

Cultural issues that may impact treatment and treatment planning: _____

Ethnicity:

[ ] White (non-Hispanic)

[ ] Asian-Asian American

[ ] Latino/Hispanic

[ ] Pacific Islander

[ ] Black (non-Hispanic)

[ ] Other or dual (specify):

[ ] Native American

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-p [ ] Currently incarcerated [ ] Alternatives to incarcer

[ ] CPL 330.20 [ ] Parole [ ] Probation () Treatment Court

[ ] Released from jail/prison in the last 30 days [ ] Other: _____

Contact: Probation or Parole Officer: Phone:

_____ _____

Primary Language:

[ ] English [ ] Other: _____

English Proficiency: (If primary language is other than English):

[ ] Does not speak English [ ] Poor [ ] Fair [ ] Good [ ] Excellent

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

Does the client have a history of any of the following?:

			If Yes, Dates
Fire setting	[ ] Yes	[ ] No	_____
Sexual offense	[ ] Yes	[ ] No	_____
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	_____
Aggressive /assaultive behavior	[ ] Yes	[ ] No	_____
Suicidal ideation	[ ] Yes	[ ] No	_____
Self abuse/injury	[ ] Yes	[ ] No	_____
Suicide attempts/gestures	[ ] Yes	[ ] No	_____
Destruction of property	[ ] Yes	[ ] No	_____
Victim of physical abuse	[ ] Yes	[ ] No	_____
Attempted homicide	[ ] Yes	[ ] No	_____

Criminal arrests [ ] Yes [ ] No _____

If you answered yes to any of the above, please describe the circumstances and method: _____

_____

_____

Is the applicant subject to a current order of protection?: [ ] Yes No [ ]

Does the client own guns?: [ ] Yes No [ ]

Is the client a registered sex offender?: [ ] Yes No [ ]

Is the client a Veteran?: [ ] Yes No[ ]

Any other information that is important to share: _____

_____

_____

FUNDING VERIFICATION FORM

Client Name: _____

	Case #	County	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security						
SSI						
SSD						
Public Assistance						
Veteran's Benefits						
Food Stamps						
Pension						
Wages/Earned Income						
Unemployment						
Other						

Signature of person completing this form: _____

Print Name: _____ Relationship to Client: _____

Release of Information

I, _____ hereby authorize the release of information to or by the Livingston County Single Point of Access Committee for the purpose of service coordination. This information will be used to arrange needed services. I understand that the release will allow information to be presented to the Committee at an initial review and at needed intervals. Participants in this Committee are listed below. I understand that all Committee members present will share information that pertains to developing the best plan possible me.

I understand that this authorization covers only information required to arrange services and that the Single Point of Access Committee will maintain the confidentiality of this information. This release may be revoked by me at any time with written notification.

I have been invited to attend the meeting at which services will be discussed.

I have read the above or have had it read to me and I understand and agree to what it says.

_____ _____

Client's printed name Client's Signature

_____ _____

Client's Address Date

Participants

Liv./Wyoming Arc
Liv. Co. Department of Social Services
Liv. Co. Council on Alcoholism and Sub. Abuse
Liv. Co. Probation
Center for Dispute Settlement
Noyes Mental Health
Liv. Co. Family Court
NYS Office of Mental Health
Genesee Valley BOCES
Rochester Psychiatric Center
Catholic Charities of Livingston County.
Office of Housing/ Section 8
Chances and Changes, Inc.
Liv. Co. Mental Health Services
Liv. County Youth Advocacy
Liv. Co. Office for the Aging
Liv. Co. Sheriff's Dept.
Depaul Mental Health Services
Lakeview Mental Health Services
VESID
Liv. Co. Dept of Health
Liv. Co. Office of Workforce Development
Arbor Development

Please add below any additional agencies to whom information will be released.

_____ _____

_____