

Danielle Figura, LCSW-R

Director of Community Services

Alyssa Thomas, LMHC Melinda Rhim, LMSW

 Assistant Clinic Coordinator/ Coordinator of Care Management/

 SPOE Coordinator AOT Coordinator

 14014 Route 31, Albion, NY 14411 ~ Phone: 585-589-7066 ~ Fax: 585-589-6395

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

Please submit all SPOE Applications to Alyssa Thomas, Orleans County SPOA Coordinator, at: alyssa.thomas@orleanscountyny.gov (scan and securely email) or by fax (585-589-6395).

Also please reach out with any questions or concerns to Alyssa Thomas at 585-589-2875.

**Orleans County Adult SPOE (Single Point of Entry) Referral**

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source (Individual):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services requested: Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Housing Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Care Management Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Both

**Client Contact Information**

|  |
| --- |
| First Name: MI: Last Name: |
| DOB: Primary Language: Gender: |
| Medicaid CIN #:  |
| Address:  |
|  |
| City: State: Zip Code: |
| Home Phone: Cell Phone: |

**Family/Significant Other Contact:**

|  |
| --- |
| First Name: MI: Last Name: |
| Address (if different from client): |
|  |
| City: State: Zip Code: |
| Home Phone: Cell Phone: |

**Additional Household Members:**

|  |  |
| --- | --- |
| Name:  | Relationship to Client: (Spouse, child, etc.) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Household Dynamics: (If Applicable)**

|  |
| --- |
|  |

**Marital Status: (Choose One)**

|  |  |  |
| --- | --- | --- |
| □ Single, Never Married | □ Divorced/Separated | □ Living with Significant Other |
| □ Currently Married | □ Widowed | □ Unknown |

**Custody Status: (Choose One)**

|  |  |  |
| --- | --- | --- |
| □ No children | □ Minor children, currently in client’s custody | □ Minor children not in client’s custody, no access |
| □ Have children, all over 18 years of age | □ Minor children not in client’s custody, have access | □ Unknown |

**Client’s Race:**

|  |
| --- |
| □ White/Caucasian |
| □ Black |
| □ American Indian/Alaskan Native |
| □ Asian/Pacific Islander |
| □ Other (please specify) |

**English Proficiency:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Excellent | □ Good | □ Fair | □ Poor | □ Does not speak English |

**Highest Level of Education Completed:**

|  |  |  |
| --- | --- | --- |
| □ Highest grade completed | □ High School Diploma | □ GED |
| □ Business, Vocational, technical training | □ College Degree: (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | □ Unknown |

**Current Living Situation: (Choose One)**

|  |  |
| --- | --- |
| □ Private residence alone  | □ Correctional Facility (Jail or Prison) |
| □ Private residence with others | □ Substance Use residence or inpatient facility |
| □ Mental health residence: (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | □ DOH Adult Residence (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| □ State Operated Residence: (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | □ Homeless (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| □ Inpatient, State Psychiatric Facility | □ Child/Youth Residential (RTF, RTC, CR, Crisis) |
| □ Inpatient, hospitalized, private psychiatric facility | □ Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

**Income or Benefits Currently Receiving (Check all that apply)**

|  |  |
| --- | --- |
| □ Wages/salary or self-employment | □ Medicare |
| □ Supplemental Security Income (SSI) | □ Medicaid (CIN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| □ Social Security Disability Income (SSDI) | □ Medicaid Pending |
| □ Veteran’s Benefits | □ Hospital Based Medicaid |
| □ Worker’s Compensation or Disability Insurance | □ Medication grant |
| □ Any public assistance cash benefits: (SNAP, TANF, Safety Net, Temporary Disability) | □ Private Insurance, Employer Coverage, No Fault, Third Party Insurance |
| □ Social Security Retirement, Survivor’s, or Dependent’s benefits (SSA) | □ None or Unknown |
| □ Unemployment or Union Benefits | □ Other: |

**Criminal Justice Status: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| □ Client is not a criminal justice consumer | □ Under Probation Supervision | □ Bail; released ROR, conditional discharge or other alternative to incarceration status |
| □ Released from jail or prison within the last 30 days | □ Under Parole Supervision | □ Currently Incarcerated (Name of Facility: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| □ Other: (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | □ | □ |
| If current Court involvement, date of next anticipated Court appearance & which Court? |
| Briefly describe legal involvement (Active Orders of Protection, Police contact, Number of arrests in past 12 months, etc.) |

**Client Services within last 12 months: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| □ Crisis Services (Crisis Line, MIT, etc.) | □ Outpatient mental health therapy | □ Prison/ Jail |
| □ Assisted Outpatient Treatment (AOT) | □ Psychiatric medication management | □ Substance use outpatient treatment |
| □ Care Management or any form of case management | □ Mental Health outpatient: Partial hospitalization, Day Treatment | □ Substance use inpatient treatment |
| □ Self-help/peer support groups | □ Respite Bed Housing | □ None |
| □ Mental health housing/housing support | □ State psychiatric inpatient unit | □ Unknown |
| □ Emergency housing (Emergency/Crisis Housing through local county) | □ Hospital Psychiatric unit (Strong, ECMC, WCCH)  | □ Other: (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

**Enter Number Only for Information Requested Below: (As of Referral Date)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of Psychiatric ED visits over last 12 months |  | Number of psychiatric hospital admissions over last 12 months |  | Number of physical health hospital admissions over last 12 months |  |
| Briefly describe the most recent hospital experience (MHA, Admission, Duration, Circumstance, etc.) |

**Therapist Information**

|  |
| --- |
| Organization/Agency: |
| Therapist & Credentials: |
| Address: |
| City: State: Zip Code: |
| Phone: Fax:  |
| Email:  |

**Prescriber Information: (Psychiatrist or Primary Doctor)**

|  |
| --- |
| Organization/Agency: |
| Prescriber & Credentials: |
| Address: |
| City: State: Zip Code: |
| Phone: Fax: |
| Email: |

**Diagnosis (DSM-5)**

**Please include clinical diagnoses, other conditions of clinical attention, personality disorders, intellectual disabilities, learning disorder, etc.**

|  |  |
| --- | --- |
| F/Z Code | Description |
|  |  |
|  |  |
|  |  |
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|  |  |

**Physical Diagnosis: General Medical Conditions**

**Please include name of condition (i.e. COPD, Diabetes, Blindness, Hearing Impairment, etc.) and the code IF you have it.**

|  |  |
| --- | --- |
| Code | Description |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Contagious Diseases:**

**Please include any contagious diseases/descriptions which may impact housing or living situation.**

|  |
| --- |
| Name of condition: |
|  |
|  |

**Allergies:**

**Please include any allergies to medications, foods, etc.**

|  |  |
| --- | --- |
| Allergy | Reaction |
|  |  |
|  |  |
|  |  |
|  |  |

**Is the client currently prescribed any medications for psychiatric conditions?**

|  |  |  |
| --- | --- | --- |
| □ Yes | □ No  | □ Unknown |

**Is the client compliant with taking prescribed medications?**

|  |  |  |
| --- | --- | --- |
| □ Yes | □ No | □ Unknown |
| Describe any difficulty with medication adherence: |

**Suicidal/Homicidal Ideation or Intent**

|  |  |  |  |
| --- | --- | --- | --- |
| Expression of suicidal thought, intent, attempt(s) - present | □Yes | □No | □Unknown |
| Expression of suicidal thought, intent, attempt(s) - past | □ Yes | □ No | □ Unknown |
| Physical abuse or assault of others – present  | □ Yes | □ No | □ Unknown |
| Physical abuse or assault of others - past | □ Yes | □ No | □ Unknown |

**Substance Use History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Substance | Past Use | Present Use | Substance | Past Use | Present Use |
| Alcohol |  |  | Heroin/Opiates |  |  |
| Cocaine |  |  | Marijuana/THC |  |  |
| Amphetamines |  |  | Hallucinogens |  |  |
| Crack |  |  | Sedatives/Hypnotics/Anxiolytics |  |  |
| Inhalants |  |  | Other prescription Drugs |  |  |
| OTC Medications |  |  | Other (specify) |  |  |

**Reason for Referral and Current Service Needs:**

**Please describe presenting issues and what has been identified as helpful to improve the situation. Include Client’s perspective and general goals (not therapeutic goals) as/if applicable.**

|  |
| --- |
|  |

Referral Source Signature and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client stated preferred service provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Service Providers**

**Please complete for all current services and providers**

|  |  |
| --- | --- |
| **Service Provided** |  |
| **Organization Name** |  |
| **Provider Name** |  |
| **Provider Address** |  |
| **Provider Phone #** |  |
| **Provider Fax #** |  |
| **Provider Email** |  |

|  |  |
| --- | --- |
| **Service Provided** |  |
| **Organization Name** |  |
| **Provider Name** |  |
| **Provider Address** |  |
| **Provider Phone #** |  |
| **Provider Fax #** |  |
| **Provider Email** |  |

|  |  |
| --- | --- |
| **Service Provided** |  |
| **Organization Name** |  |
| **Provider Name** |  |
| **Provider Address** |  |
| **Provider Phone #** |  |
| **Provider Fax #** |  |
| **Provider Email** |  |

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| --- | --- |
| **Service Provided** |  |
| **Organization Name** |  |
| **Provider Name** |  |
| **Provider Address** |  |
| **Provider Phone #** |  |
| **Provider Fax #** |  |
| **Provider Email** |  |

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| --- | --- |
| **Service Provided** |  |
| **Organization Name** |  |
| **Provider Name** |  |
| **Provider Address** |  |
| **Provider Phone #** |  |
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 **Re: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**Release of / Request for Confidential Information**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby provide my consent for Orleans County Mental Health/SPOE (Single Point of Entry) to obtain and/or release to authorized agencies any information or records, including but not necessarily limited to financial; treatment plans, diagnosis, assessments for psychiatric, psychological, or psychosocial treatment; parole, probation, legal records; substance abuse material; or admission/discharge summaries; health and medical records related to myself.

I understand that all information/materials will be treated as confidential and that the SPOE committee, designated by Orleans County Mental Health Services, will review and evaluate this information for the purpose of determining my eligibility for services. This includes, but is not limited to services provided through Orleans County Mental Health SPOE Coordination. There may be referrals to other programs which may benefit me. I am aware that recommendations for a different level of care may also be made.

I further consent to release the information gathered to one of the associated programs, if deemed appropriate, for completion of the assessment and application process for that specific program. I understand the purpose of such disclosure of information is to expedite access to such services.

I also understand that I have the right to cancel my permission to access/release the information or withdraw from the SPOA process any time before the information is released.

**This consent to release information will expire twelve (12) months after termination of SPOE monitoring.**

|  |  |
| --- | --- |
| **Applicant Signature** | **Date** |
| **Witness Signature** | **Date** |



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**Orleans County Mental Health ~ Single Point of Entry**

**Client Rights - Provide Copy to Client**

The Orleans County Mental Health Services provides a Single Point of Entry to individuals in the county who have a mental illness and are in need of housing and/or care management supports.

As a consumer of this service, you are entitled by law to the following rights:

1. Coordination of systems, services, and an individualized plan of care.
2. The right to take part in the planning process.
3. A full explanation of the services to be provided.
4. Voluntary participation in services except for the following:
	1. Cases of court ordered services;
	2. When consent of a court-appointed conservator or committee is needed;
	3. In the case of conduct which poses a risk of physical harm to yourself or others.
5. To object to all or any point of your service plan without fear or termination from services, unless that objection is considered clinically contraindicated or endangers the safety of yourself or others.
6. Your information/records will be kept confidential.
7. Opportunity to request your records.
8. To receive care and services in a respectful, dignified manner that is appropriate to your needs and delivered in a safe, humane, and skillful manner.
9. To be treated in a way which acknowledges and respects your cultural environment.
10. To privacy that will allow effective delivery of services.
11. To freedom from abuse and mistreatment by employees.

If you have a question, complaint or objection concerning your services, you may seek assistance using the following procedures:

* 1. If you feel your service plan is inappropriate or that the service provider treated you in an unacceptable manner, you should contact the supervisor of the program where you are receiving services. The program supervisor will make a full inquiry as to your complaint(s), and will attempt to resolve the situation in a timely manner so that you can resume appropriate services.
	2. If you are not satisfied with the response you receive from the program supervisor, you may contact the Program Administrator of the service you are receiving.
	3. If you are still unable to resolve the problem, you may contact the:

Coordinator of SPOA service at 585-589-7066

Director of Community Services at 585-589-7066

* 1. If you feel the problem has not been resolved through the above procedures, you may contact the:

Western NY Field Office of Mental Health in Buffalo, NY at 716-885-4219.

My signature verifies that I was provided a copy of the **Orleans County Mental Health Services ~ Single Point of Entry Client’s Rights** information.

The purpose of this information is to ensure me of my rights as a client throughout the time I am receiving services.

|  |  |
| --- | --- |
| Date | Client Signature |

|  |  |
| --- | --- |
| Date | Witness Signature |

**(Please return this original signature page with the referral packet.)**

Please submit all SPOE Applications to Alyssa Thomas, Orleans County SPOA Coordinator, at: alyssa.thomas@orleanscountyny.gov (scan and securely email) or by fax (585-589-6395).

Also please reach out with any questions or concerns to Alyssa Thomas at 585-589-2875.