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Director of Community Services

Heather Bell, LMSW
Assistant Clinic Coordinator/
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AOT Coordinator

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

Orleans County Adult SPOE (Single Point of Entry) Referral

Date of Referral: _____ Referral Source:_____
Agency: _____
Phone Number: _____
Email: _____

Client Contact Information

First Name:	MI:	Last Name:
DOB:	Primary Language:	
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
☐	☐ 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

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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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:
    a. Cases of court ordered services;
    b. When consent of a court-appointed conservator or committee is needed;
    c. 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:

a. 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.
b. 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.
c. 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
d. 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.)