

Instructions for Completing Clinton County Adult SPOA Application

Single Point of Access

SPOA is an OMH initiative that oversees and manages Medicaid funded intensive community specialized based services including Case Management, Community Residence, Apartment Treatment Program, and Supportive Housing. SPOA has a committee that meets to review all referrals and manages access to these services. To make a referral you must complete a referral form and send it to the appropriate coordinator as explained below.

Referral Process:

Complete the attached referral form for Clinton County Single Point of Access for Adult Services and return to:

Clinton County Mental Health and Addiction Services
 Attn: Erica Leonard, SPOA Coordinator
 130 Arizona Avenue
 Plattsburgh, NY. 12903
erica.leonard@clintoncountygov.com
 Phone: 518-565-4090 fax: 518-566-0168

Referrals will be reviewed to ensure that they are completed and will be sent forward to appropriate program manager.

- Care Management- Mary Baker, Director of Case Management and AOT Coordinator, Behavioral Health Services North. 518-563-8000, mbaker@bhsn.org
- Care Management- Sara Arnold, Care Manager, St. Lawrence Psychiatric Center Sara.Arnold@omh.ny.gov
- Supportive Housing- Jacinthe Rivers, Program Coordinator for Supportive Housing (Helping Hands, Homestead on Ampersand, and NorthWoods), Behavioral Health Services North. 518-563-8000 ext. 2108, jrivers@bhsn.org
- Breakthrough II Community Residence/Apartment Treatment Program- Ashley Pickering, Breakthrough II Program Coordinator, Behavioral Health Services North, 518-563-8000 ext. 2182, apickering@bhsn.org.
- Residential Services- Elizabeth Carpenter-Director of Housing, Behavioral Health Services North, 518-563-8000 x. 2045, lcarpenter@bhsn.org

Once the appropriate program manager receives the referral they will contact you to obtain more information related to the service if needed.

For Care Management Services- individuals can be enrolled independently of the SPOA committee's approval if they are receiving Medicaid. If they do not receive Medicaid they must be prioritized through the SPOA process.

The SPOA committee meets twice a month where referrals are discussed and determined eligible or ineligible. Once a decision is made the individuals are referral source will be notified by letter. There may be a waitlist and services may not be available immediately. You will be notified when service is available. It is your responsibility to keep committee updated with your contact information during that wait period.

*All Referrals Should

- Have a qualifying diagnosis within last year documented
- ROI should be signed within 2 months of the application if the ATP or CR. For SH, HOA, and CM the ROI should not be more than 30 days difference.
- For physician authorization the date of the physician's signature and client's signature should be the same.

Clinton County Adult Single Point of Access Application Form

Check all services that you are applying For		
	Services	Description
	Care Management	Communicates with other providers to ensure individual's needs are being met. Oversees and provides access to all medical, social and behavioral health care services. Eligibility: Must have two chronic conditions (MH, SUD, Asthma, Diabetes, and BMI over 25) or, one Qualifying chronic condition, or one serious Mental illness.
	Supportive Housing- HHH	Permanent housing program that assists those recovering from MI secure/retain safe, affordable housing in Clinton County. Services include: support services to maintain housing/wellbeing, financial supports (i.e. rental subsidies, security deposits, assistance with purchasing furniture/household items necessary for dwelling); limited case management, advocacy to access/receive variety of services within the community. At minimum, meet with participants face to face monthly, and at home once a quarter, assist participants to develop individual support plans identifying resources available. Eligibility- Applicants must be at least 18 years old and have a SPMI. No physician's authorization required.
	Homesteads on Ampersand	Permanent housing program that assists those recovering from MI to reside in safe affordable permanent quality housing while receiving financial and support services. Services include: support services 24/7 to maintain housing and wellbeing, financial supports including rental subsidies, security deposit, assistance with purchasing furniture/household items necessary for dwelling; limited case management, advocacy to access and receive variety of services within the community. At minimum, meet with participants face to face monthly, and at home once a quarter. Assist participants to develop individual support plans identifying resources available. Eligibility- Applicants must be at least 18 years old and have a SPMI. No physician's authorization needed.
	Northwoods ESSHI	"Permanent housing program that assists homeless households that are seriously mentally ill, have a substance use disorder, between ages of 18-25 or are chronically homeless reside in safe affordable permanent, quality housing while receiving financial and support services. Services include: support services 24/7 to maintain housing and wellbeing and financial supports to establish dwelling, limited case management, advocacy to access and receive variety of services within the community. At minimum, meet with participants face to face monthly, and at home once a quarter. Assist participants to develop individual support plans identifying resources available. Eligibility- applicants must meet the NYS ESSHI criteria for homeless or sheltered homeless and have a SMI, SUD, be 18-25 years old, or chronically homeless. No physician's authorization needed."
	Apartment Treatment Program	Transitional housing program that assists individuals recovering from MI by meeting with participants on average of 2-3 times per week to provide supportive services. Apartments are fully furnished/equipped with household items. Majority of units are single 1 BR units, some 2 BR units in which 2 participants share living room, kitchen, and bathroom but have separate bedrooms. Services include assistance in developing individualized service plan that addresses services needed such as daily living skills, symptom management, medication management, health services, skill development, parenting training, socialization, and substance abuse services. Eligibility- Applicants must be at least 18 years old and have a SPMI, primary diagnosis of psychiatric illness with acute psychiatric symptoms adequately controlled with or without medications. Physician's authorization in required. Must be signed by an MD or DO.
	Community Residence	Transitional housing program that assists individuals recovering from MI live in a safe structured, supervised environment while developing the skills to live more independently. Staff are on site 24/7. Services include assistance in developing an individualized service plan that addresses services needed such as: daily living skills, symptom management, medication management, health services, skill development, parenting training, assertiveness/self-advocacy training, and community integration. Rehabilitation counseling, socialization, and substance abuse services. Eligibility- Applicants must be at least 18 years old and have a SPMI, primary diagnosis of psychiatric illness with acute psychiatric symptoms adequately controlled with or without medications, unable to live independently in the community, and potential to improve fundamental independent living skills. Physician's authorization is required. Must be signed by an MD or DO.

Basic Client Information		Application Date:	
Client Name:		Previous Name:	
Address:			
County:		SSN:	
Phone #:		DOB:	
Age:	Gender:	Marital Status:	
Ethnicity:		Primary Language	

Financial Information

_ Monthly Income: _____ _ Employment: Employer Name: _____

_ SSI _ SSD _ PA _ VA _ Alimony _ Child Support _ Retirement Income _ Other: _____

Existing Representative Payee? _ Yes _ No : (who) _____

Health Insurance

_ Medicaid # _____ Medicare # _____ _ Other Plan: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Referral Information

Person Making Referral (name, title, relationship): _____

Representing which agency/Committee: _____

Address: _____ Phone: _____

Fax: _____ Email: _____

Mental Health Information

Current mental health treatment? (Where, with whom?) (Medications?) (Compliance?)

Involvement with any other agencies?

Medical information: Describe any significant current physical health conditions and treatment being received, including medications and treatment provider and compliance with treatment.

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Primary Care Physician: _____

Risk Factors:	No History	Past	Present	Comment
Suicidal (ideation, attempts)				
Physical harm to others/History of Violence				
Destruction of property				
Fire setting				
Sexually abusive / inappropriate to others				
Reckless behavior				
Drug and alcohol abuse/use				
Non-Compliance with Treatment				
Mild or Moderate Stress Creates Exacerbation of Symptoms				
Command Hallucinations				
Difficulty Coping with Major or Multiple Medical Problems				
Self-Injurious Behavior				
Trauma				
Frequent Crisis Contacts				
Temper Outbursts				
Incarceration				
Chronic Housing Problems				
Chronic Legal Problems				

Recent Deterioration of functioning, if any?

History of Mental Health Treatment*Inpatient hospitalizations* (Where? Dates? For how long? Why?)*Psychiatric ER visits* (Where? Dates? Why?)*Health Home Care Management* *Community residence/supported housing:*

Court Ordered Treatment (AOT, MH Court, Drug Court)

Other (E.g. Self-help groups, psychosocial club, crisis center calls)

Current Living Situation (For Supported Housing Applications Only)

Do you wish to stay at your current location? Yes No

Do you have a lease? If so when does it expire? Yes No _____

Who is your Landlord? _____ Rent for this location? _____

Are you getting help to pay rent? If Yes, Who? Yes No _____

Describe physical living space of current residence and any problems with living conditions.

Has client ever had problems with housing in the past (eviction, inability to live alone, homelessness?)

Current Living Arrangements

Household Composition (name)	Age	Relationship to client

Safety Concerns:

Any safety issues around this person or others in the household? Yes No

Firearms, Swords, Weapons in the home? Yes No

Animals in the Home? Yes No

Statement of Need

In the individuals own words- what do they see as their care management needs in terms of advocacy, linkage, monitoring, or state reason for requested level of housing.

Strengths/Needs & Problems

Clients Strengths and Interests:

Client Needs (Areas affected by psychiatric illness)	None	Low	Medium	High	Explanation
<u>Self care</u> (ADL's, hygiene, grooming, hygiene, nutrition, shopping, cooking, completing chores)					
<u>Money management</u>					
<u>Housing</u> (obtaining adequate housing, furniture, appliances)					
<u>Home management</u> (cleaning, use of appliances, household organization)					
<u>Transportation</u>					
<u>Psychiatric services</u> (getting access, keeping appointments, appropriate use)					
<u>Medical services</u> (getting access, keeping appointments, appropriate use)					
<u>Medication management</u>					
<u>Legal</u> (help dealing with the legal system)					
<u>Social security</u> (obtaining, keeping)					
<u>DSS</u> (Medicaid, PA, food stamps, etc.)					
<u>Work / School</u> (attendance, ability to function in the work / learning environment and complete assigned tasks)					
<u>Social Relationships</u> (Establishing or maintaining satisfactory & appropriate relationships with peers)					
<u>Handling emergencies</u> / solving problems					
<u>Other</u> (describe)					

- **Send Referral form to: Clinton County Mental Health & Addiction Services, Adult SPOA Coordinator, Fax # 518-566-0168**

Diagnosing Clinician: _____

Diagnostic Impression

(Mental Health Dx date within last year)

CODES ARE REQUIRED		
ICD 10 DSM 5 Dx Code	Description	Mental Health Diagnosis last Reviewed (date within last year)

If diagnosis was established less than one year ago, did the client exhibit symptoms prior to the official diagnosis?

Yes ___ No ___

**If yes, then what date did symptoms begin: _____

Does Client meet Severe and Persistent Mental Illness/Severe Mental Illness (SPMI/SMI)?

Clinician Signature: _____ Date: _____

This form must be completed in full with dates and Clinician, Psychiatrist, PCP or other treating professional signature attesting to the diagnosis eligibility.

Clinton County Adult Single Point of Access Application Form

Request for Intensive Mental Health Services
And Information Release Authorization
To Single Point of Access Committee

Name: _____ DOB: _____

I request that I be considered for the following intensive mental health services: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Care management | <input type="checkbox"/> Community residence program
(Physician's Authorization Required) |
| <input type="checkbox"/> Supported Housing | <input type="checkbox"/> Apartment Treatment Program
(Physician's Authorization Required) |
| <input type="checkbox"/> NorthWoods | <input type="checkbox"/> Homesteads on Ampersand |

I am knowledgeable of what the above named services consist of and understand what services are requested on my behalf.

I understand that acceptance into one of the above programs is decided by Clinton County's Single Point of Access Committee. I understand that this committee is composed of representatives of community agencies and consumer advocates. Community agencies represented include, but are not limited to, Clinton County Mental Health and Addiction Services, Behavioral Health Services North, CVPH Medical Center, Department of Social Services, Department of Probation, Office for People with Developmental Disabilities (OPWDD), Office for the Aging, ETC Housing Corp., Champlain Valley Health Network and National Alliance on Mental Illness (NAMI). I understand that the members of this committee have agreed in various signed agreements to be bound by the highest standards defined by law (42 C.F.R. Part 2) to maintain the confidentiality of the information presented to the committee and to not discuss that information outside the scope of the committee.

I understand that it is the role of the committee to oversee the use of the above named services in Clinton County and to decide what level of service is most appropriate for each client in light of the demands for those services. The committee's decision will be based on information about me from a variety of sources available to the committee.

With this understanding, I give my permission for members of the Clinton County Single Point of Access Committee to share information regarding me in order to determine my eligibility for the services named above. I further understand that I may withdraw this request and permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future application for these services. Unless my permission is withdrawn I understand that this request / authorization will remain in effect as long as I continue to receive the services covered by this committee.

Signature: _____ Date: _____

Witness: _____ Date: _____

Withdrawal of Request / Authorization

I voluntarily withdraw my request for case management or housing services and in so doing withdraw my authorization for the Clinton County Single Point of Access Committee to continue to share information regarding me. I understand that this withdrawal does not cover actions that have already been taken by this committee.

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Signature: _____

Date: _____

Witness: _____

Date: _____

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Initial Authorization for Restorative Services
Of Breakthrough II Community Residence Programs

(Community Residence & Apartment Treatment Program Applications Only)

(To be signed by a licensed physician and the individual requesting consideration for housing services on the same date)

I have ***met with my physician on this date*** and discussed the Breakthrough II Residence Program and the services and supports it has to offer. By signing this form I have consulted with my physician and I am asking for consideration to have my application reviewed by the SPOA committee for admission to the program.

Applicants Name: _____

Applicants' Signature _____ Date _____

Applicants Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me and having ***met face to face on this date with this individual*** to discuss the Breakthrough II Residential Program, have determined that the above named person would benefit from the provision of mental health restorative services* as known to me and defined pursuant to Part 593 of 14 NYCRR.

Physician's Signature: _____ Date: _____

Print Physician's Name: _____ (Must Be a MD., DO. or NPP.)

License #: _____

* Mental Health Restorative Services include:

- Assertive / Self Advocacy Training
- Community Integration Services
- Daily Living Skills Training
- Medication Management / Training
- Parenting Training
- Skill Development Services
- Rehabilitation Counseling
- Socialization
- Health Services
- Symptom Management
- Substance Abuse Management

****ALL SIGNATURE DATES MUST MATCH FOR AUTHORIZATION TO BE VALID****