



Saratoga County Single Point of Access

Adult SPOA Universal Referral Form

135 South Broadway
 Saratoga Springs, New York 12866
 Telephone: (518) 584-9030
 Fax: (518) 581-1709

Client Information				
Name:	Gender:	D O B:	SSN:	
Home Address:	City:	State:	Zip:	Phone:
Medicaid # required : (ex: BW56248X)		SSD/I Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list amount		
Medicare # (if applicable):		Is the applicant his/her own payee Yes No		
DSS Temporary Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Employment or other income:		

Diagnoses	
Primary ICD.10 Diagnosis listed first (attach supporting documentation)	ICD.10 Code
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults
<p style="text-align: center;">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</p> <p>A. Designated Mental Illness Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No The individual is 18 years of age or older and has a primary DSM-R psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes or developmental disabilities.</p> <p style="text-align: center;">AND</p> <p>B. SSI or SSDI Enrollment due to Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No The individual is currently enrolled in SSI or SSDI due to a designated mental illness.</p> <p style="text-align: center;">OR</p> <p>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 illness over the past 12 months on a continuous or intermittent basis. <input type="checkbox"/> Yes <input type="checkbox"/> No a. Marked difficulties in self-care <input type="checkbox"/> Yes <input type="checkbox"/> No b. Marked restriction of activities of daily living <input type="checkbox"/> Yes <input type="checkbox"/> No c. Marked difficulties in maintaining social functioning <input type="checkbox"/> Yes <input type="checkbox"/> No d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings. 2. <input type="checkbox"/> Yes <input type="checkbox"/> No The individual has met criteria for rating of 50 or less on the Global Assessment of Functioning scale.</p> <p style="text-align: center;">OR</p> <p>D. Reliance on Psychiatric Treatment, Rehabilitation and Supports <input type="checkbox"/> Yes <input type="checkbox"/> 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, eg. hallucinations, but may or may not affect functional limitations 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.</p>

Scale: Select one response for each. Describe responses 1 – 5 in attached psychosocial history.

- 0 – Never
- 1 – Not at all in past 6 months
- 2 – One or more times in past 6 months
- 3 – One or more times in past 3 months
- 4 – One or more times in past month
- 5 – One or more times in past week
- U - Unknown

	0	1	2	3	4	5	U
Homeless	<input type="checkbox"/>						
Imminent risk of homelessness	<input type="checkbox"/>						
Emergency Room (medical)	<input type="checkbox"/>						
Emergency Room (psychiatric)	<input type="checkbox"/>						
ETOH / Substance use	<input type="checkbox"/>						
Expressed suicidal ideation, plan or intent	<input type="checkbox"/>						
Attempted suicide	<input type="checkbox"/>						
Expressed homicidal ideation, plan or intent	<input type="checkbox"/>						
Attempted homicide	<input type="checkbox"/>						
Mental illness that is impeding daily function	<input type="checkbox"/>						
Assaultive Behavior	<input type="checkbox"/>						
Arrested	<input type="checkbox"/>						
Incarcerated	<input type="checkbox"/>						

If yes to any of the following questions, please describe events in attached psychosocial history.

Has the recipient ever been suspected of sexual abuse to child and/or adult? Yes No

Has the recipient ever physically abused and/or assaulted a child and/or adult? Yes No

Has the recipient ever engaged in arson? Yes No

Has the recipient ever been a victim of physical or sexual abuse? Yes No

Sex offender status? Yes No If Yes, Level I Level II Level III

Psychiatric hospitalizations

Hospital Name:	Dates:	Reason for Admission:

Living situations tried in the past 5 years (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Independent living | <input type="checkbox"/> Jail |
| <input type="checkbox"/> Family | <input type="checkbox"/> Private Psychiatric Inpatient |
| <input type="checkbox"/> Community Residence | <input type="checkbox"/> General Hospital Psychiatric Inpatient |
| <input type="checkbox"/> Apartment Program | <input type="checkbox"/> State Psychiatric Inpatient |
| <input type="checkbox"/> Shelter/Emergency Housing | <input type="checkbox"/> Other (specify): _____ |

Significant Other / Emergency Contact

Name:	Relationship:	Address:	Phone:

Medical Information

Current Medical Conditions/Medical Alerts:

Attach list of all prescribed medications

Is the applicant responsible for taking his/her own medications? Yes No If not, explain in attached psychosocial history

Services Requested

- | | |
|--|---|
| <input type="checkbox"/> Care Management (do not check if separate referral sent to AHI) | <input type="checkbox"/> Enhanced Supported Housing |
| <input type="checkbox"/> Community Residence | ESSHI Supported Housing/SMI |
| <input type="checkbox"/> Supportive Treatment Apartment | ESSHI Supported Housing/SUD |
| <input type="checkbox"/> Supported Housing | <input type="checkbox"/> ACT Team |

Please describe why the applicant requires this level of support service. Include service needs, any barriers to meeting those needs, the applicant's strengths and any informal support systems.

The following is a brief description of what I would find most helpful for myself:

This referral will not be processed without the following items attached and all sections of referral completed:

- Current Psychosocial history
- Current Psychiatric assessment
- Signed SPOA Release of Information

Additional information required at intake if found eligible for residential:

- Copy of Medicaid/Medicare Card and Social Security Card
- Current physical/PPD or date of scheduled physical _____
- Physicians Authorization for Restorative Services

**Mail or fax completed referral to SPOA Coordinator, 135 S. Broadway, Saratoga Springs, NY 12866
Fax: 518.581.1709**



Saratoga County SPOA Consent for Release of Information

135 South Broadway, Saratoga Springs, New York 12866

Telephone: (518) 584-9030 Fax: (518) 581-1709

Client Name: _____ Gender: _____ DOB: _____

The Saratoga County Single Point of Access Committee (SPOA) is composed of representatives of community agencies including, but not limited to, Saratoga County (Mental Health, Addiction Services, PROS, Social Services, Adult/Child Protective, Child Preventive, Probation, Aging and Youth Services), Saratoga Hospital, Four Winds Hospital, Ellis Hospital, Glens Falls Hospital, Mohawk Valley Psychiatric Center, Capital District Psychiatric Center, Office of Mental Health, RISE Housing and Support Services, Rehabilitative Support Services, Northern Rivers Family of Services, Captain Community Human Services, Adirondack Health Institute Health Home, Children's Health Home of Upstate NY, Health Home Care Management Agencies serving Saratoga County, Saratoga County School Districts, Shelters of Saratoga, Code Blue, Unlimited Potential, Wellspring, Saratoga County Options for Independent Living, Saratoga County Rural Preservation, Saratoga Springs Housing Authority, Saratoga County Sheriff, Ballston Spa, Mechanicville and Saratoga Springs Police Department and Office for People with Developmental Disabilities. In order to determine the most appropriate level of service based on strengths, needs and availability of program openings, I give my permission for members of the SPOA Committee to exchange information between the agencies listed above and to obtain information from and/or release information to the following Person, Organization, Facility or Program:

Referring Agency (if different from Outpatient Mental Health Provider)

Outpatient Mental Health Treatment Provider (Agency Name)

Referring Agent Name, title

Outpatient Provider Name, title

Address

Address

Phone

Fax

Phone

Fax

The extent or nature of information to be disclosed includes:

- Clinical summaries (i.e. psychiatric evaluations)
- Admission and/or discharge summaries
- Medication records and laboratory results
- Treatment plans and treatment plan reviews
- Notes of psychiatric or other clinic visits
- Other: _____

Affirmation of Release: I understand that treatment will not be refused, but clinical decisions may be affected, if I do not sign any authorizations to release information. I have the right to revoke (take back) in writing this authorization at any time except to the extent that action has been taken in reliance on it and unless receiving services from Alcoholism and Substance Abuse Service as a result of criminal justice involvement, in which case consent for disclosure to the criminal justice system cannot be revoked. The revocation will take effect on the day it is received. Alcohol and drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records as well as the Health Insurance Portability and Accountability Act of 1996. Confidential information cannot be disclosed without my written consent unless otherwise provided for (i.e. suspected child abuse, health or mental health emergency under the above noted regulations). If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may no longer be protected. Alcohol and drug program treatment records are protected.

Expiration: This authorization will expire, when acted upon (one time disclosure),

- 90 days from this date, when I am no longer receiving services from _____, or
- other _____.

Applicant (Print Name)

Applicant (Signature)

Referring Agent (Signature and Title)

Date