

**Catholic Charities of Cortland County**  
**Supported Housing and**  
**Riverview SP-SRO Referral**

The Supported Housing Program is a mental health housing assistance program and is the least restrictive option in the continuum of residential services. This program provides on-going rental subsidies to individuals who qualify due to having a serious and persistent mental illness (SPMI) documented by qualified staff and who meet income guidelines. Clients are expected to meet with a housing case manager at least once per month to discuss their progress and any housing issues.

**REFERRAL SOURCE**

Contact Name: \_\_\_\_\_ Agency, if applicable: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**CLIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Current Living Situation: \_\_\_\_\_

Female  Male

Has this client been referred to us before?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**FINANCIAL STATUS**

Client currently receives:  SSI  SSD  VA Benefit  Wages

SSI/SSD Pending  PA - County of origin: \_\_\_\_\_

Current Caseworker: \_\_\_\_\_ Caseworker Phone: \_\_\_\_\_

Medicaid # \_\_\_\_\_  Medicare  Private Ins.: \_\_\_\_\_

Current Representative Payee \_\_\_\_\_ Payee Phone: \_\_\_\_\_

Applicant does not currently have, but needs, representative payee services.

Has the client ever been sanctioned by DSS?  Yes\*  No

\*If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is client capable of self-preservation in case of emergency? (Evacuating housing safely)

- Yes       No

**TREATMENT HISTORY**

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

Describe past situations precipitating hospitalizations or professional interventions \_\_\_\_\_

\_\_\_\_\_

**HOUSING**

*Check if applicant has experienced. If checked, give date and location.*

- Homelessness \_\_\_\_\_  
 Group home/Community Residence (OMH) \_\_\_\_\_  
 Group home/Community Residence (OASAS) \_\_\_\_\_  
 Other Supported or Supervised Living Environment \_\_\_\_\_  
 Independent Living, alone \_\_\_\_\_  
 Independent Living, with others \_\_\_\_\_  
 Supported Housing Assistance \_\_\_\_\_  
 Section 8 Application and/or Subsidy \_\_\_\_\_  
 Evictions? If yes, please explain: \_\_\_\_\_

**VOCATIONAL**

*Check applicant's experience. If checked, give dates and locations.*

- |  |   |
|--|---|
| <input type="checkbox"/> Highest Grade Level Completed _____ | <input type="checkbox"/> GED _____            |
| <input type="checkbox"/> Sheltered Workshop _____            | <input type="checkbox"/> College Degree _____ |
| <input type="checkbox"/> Supported Employment _____          | <input type="checkbox"/> VESID _____          |
| <input type="checkbox"/> Vocational Training _____           | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Special Education _____             |   |
| <input type="checkbox"/> Competitive Employment _____        |   |

**CRIMINAL JUSTICE SYSTEM**

*Check if current or past history of the following - Provide name of Probation/Parole Officer if current.*

- |  |  |
|--|--|
| <input type="checkbox"/> Probation _____             | <input type="checkbox"/> Charges Pending<br>CPL Date _____ |
| <input type="checkbox"/> Parole _____                |  |
| <input type="checkbox"/> Conviction of a Crime _____ |  |

Provide Details: \_\_\_\_\_

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

**FAMILY, SOCIAL & COMMUNITY SUPPORTS**

*Check applicant's current supports and note names when possible.*

- Family \_\_\_\_\_
- Friends \_\_\_\_\_
- Religious \_\_\_\_\_
- Support Groups \_\_\_\_\_
- Care Coordinator \_\_\_\_\_

**CLINICAL ASSESSMENT**

**ICD 10 Code**

**Diagnosis**

Principal Diagnosis \_\_\_\_\_

(Must be a mental health diagnosis)

Note any recommendations, or focus of treatment, and why this level of care may be appropriate?

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**MEDICATIONS**

*List all medications used or attach a copy of a current medication list.*

<u>Medication</u>	<u>Dosage</u>	<u>Prescribing MD</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is client capable of self-administration of medications?  Yes  No

**PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:**

**Fax:** (607) 756-5999

**Secure e-mail:**  
smorgan@ccocc.org

**Mail:**

Catholic Charities of Cortland County  
ATTN: Program Manager - Community Housing  
33-35 Central Avenue  
Cortland, New York 13045

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

Patient's Name (Last, First, M.I.) "C" No.

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Facility Name: Unit/Ward:  
Catholic Charities of Cortland County Community Housing

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

**PART 1: Authorization to Release Information**

**Description of Information to be Used/Disclosed:**

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Contact Information      | <input type="checkbox"/> Current Medications         | <input type="checkbox"/> Current Services        | <input type="checkbox"/> Daily Living Skills  | <input type="checkbox"/> Diagnosis            |
| <input type="checkbox"/> Education                | <input type="checkbox"/> Entitlements                | <input type="checkbox"/> Emergency Contact Info. | <input type="checkbox"/> Functional Abilities | <input type="checkbox"/> Mental Health Status |
| <input type="checkbox"/> Psychosocial information | <input type="checkbox"/> Characteristics/ Photograph | <input type="checkbox"/> Electronic Files        |   |   |
| <input type="checkbox"/> Other: _____             |  |  |   |   |

**Purpose or Need for Information:**

- This information is being requested:
  - by the individual or his/her personal representative; or
  - Other (please describe) Catholic Charities (Cortland County)

2. The purpose of the disclosure is (please describe)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Screening/Assessment   | <input type="checkbox"/> Bill Insurance     | <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Emergency Services    |
| <input type="checkbox"/> Establish Entitlements | <input type="checkbox"/> Establish Services | <input type="checkbox"/> Housing           | <input type="checkbox"/> Coordinating Services |
| <input type="checkbox"/> Electronic Database    |   |  |  |
| <input type="checkbox"/> Other: _____           |   |  |  |

Exchange of Information, in either direction, between the parties below  
(Include: Name, Address, Title of person/Organization/Facility/Program)

Catholic Charities (Cortland County) Community Housing Programs 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 756-5992 Fax: (607) 756-5999	(Two Way) ⇔	Admissions Committee: Including representatives from Family & Children's Counseling Services, Cortland County Mental Health, Cortland Police Department, Guthrie Cortland Medical Center, Cortland County Probation Department
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- A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:
- Only this information may be used and/or disclosed as a result of this authorization.
  - This information is confidential and cannot legally be disclosed without my permission.
  - If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
  - I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
  - I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
  - I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

**B-1. One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above.

- My authorization will expire:
- When acted upon;
  - 90 Days from this Date;
  - Other: \_\_\_\_\_



**Recommendation for Rehabilitative and Tenancy Support Services**

*Determination of Medical Necessity*

*Individual's Name:* \_\_\_\_\_

*Individual's DOB:* \_\_\_\_\_

**Instructions:** This section must be completed by a Licensed Practitioner of the Healing Arts (LPHA), as defined by:

- Nurse Practitioner
- Physician
- Physician Assistant
- Psychiatric Nurse Practitioner
- Psychiatrist
- Psychologist
- Registered Professional Nurse
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Marriage & Family Therapist
- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or psychiatrist

Note: The Tenancy Services provider will conduct an intake and engage the individual through person-centered planning to determine frequency, scope, and duration of recommended services.

*Determination of Medical Necessity*

Based on my review of documentation or assessment of the individual, and my clinical expertise, the individual needs and would benefit from Rehabilitative and Tenancy Support Services (defined pursuant to New York State Plan Amendment #20-005 and the Office of Mental Health Supportive Housing Guidelines) for the following reasons:

- Select all that apply:
- To establish or maintain community tenure
  - To improve effective utilization of community resources
  - To restore/rehabilitate functional level
  - To increase ability to identify and advocate for effective supports
  - To facilitate active participation in the individual's community
  - To sustain wellness and recovery-oriented life skills
  - To strengthen resiliency, self-advocacy, self-efficacy and/or empowerment
  - To build and strengthen natural supports, including family of choice
  - To prevent worsening of symptoms

DSM-5 or ICD-10 diagnoses, if known: \_\_\_\_\_

\_\_\_\_\_  
*Signature of LPHA*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Credential*

\_\_\_\_\_  
*NPI#*

**Part 2: Recommendation for Services**

## Instruction for completion of LPHA Recommendation for Rehabilitative and Tenancy Support Services

### **Overview of Tenancy Services**

Tenancy supports are divided into two major categories:

***Community integration skill-building services*** include direct training and supports to assist individuals with community integration, including community resource coordination, treatment planning, and rehabilitative independent living skills training to help individuals transitioning into housing.

***Stabilization services*** include direct services and support to assist individuals living in a community setting, including tenancy support planning, rehabilitative independent living skills training, community resources coordination, and crisis planning and intervention to help individuals remain in housing.

### Completion of LPHA Recommendation

The LPHA recommendation is a determination of medical necessity for Tenancy Services. There is no standardized assessment process or tool necessary to complete the recommendation; the recommendation is based on clinical discretion. The LPHA should review any documentation that demonstrates whether the services referenced above could assist an individual in establishing or maintaining housing stability. These documents could include, but are not limited to psychiatric evaluation, psychosocial history, current residential service plan and progress notes, etc. (note: this list is not intended to imply that an LPHA must review all of these documents). Face-to-face and/or virtual assessment of the individual may also be used to determine medical necessity for these services.

The LPHA Recommendation is documented using the standardized template above. The LPHA Recommendation Form should be kept on file in the individual's residential record.

**NYS OMH - SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) This form must be completed by a licensed clinician or other mental health professional. Information may be requested from collateral sources.**

**Client Name:** \_\_\_\_\_

In order to be considered an adult with Serious and Persistent Mental Illness (SPMI), the individual must meet criteria in “1” *and* either “2” *or* “3” *or* “4” as defined below.

**Circle the answer that applies**

**1. Designated Mental Illness**

The individual is at least 18 years of age and currently meets the criteria for a psychiatric diagnosis, according to DSM 5.

Yes

No

Principal Diagnosis: \_\_\_\_\_

DSM 5 Code: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

**AND**

**2. SSI or SSDI due to Mental Illness**

The individual is currently receiving SSI/SSDI due to a designated mental illness.

Yes

No

**OR**

**3. Extended Impairment in Functioning due to Mental Illness:**

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:

a.) Marked Difficulties in Self-Care

i.e.: personal hygiene, diet, clothing, avoidance of injury, securing appropriate health care and/or compliance with medical advice

Yes

No

b.) Marked Restriction of Activities of Daily Living (ADLs)

e.g.: maintaining a residence, using transportation, day-to-day money management, accessing community services

Yes

No

c.) Marked Difficulties in Maintaining Social Functioning

e.g.: establishing and maintaining social relationships; interpersonal interactions with primary partner, children or other family members, friends, and/or neighbors; social skills; compliance with social norms; appropriate use of leisure time

Yes

No

d.) Frequent Deficiencies of Concentration, Persistence or Pace, Resulting in Failure to Complete Tasks in a Timely Manner

i.e.: inability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they are repeatedly unable to complete tasks or require assistance in the completion of tasks

Yes

No

**OR**

**4. Reliance on Psychiatric Treatment, Rehabilitation and Supports**

The individual has a documented history showing that, at some time prior, he/she met the threshold for “3” (above), but his/her symptoms and/or functioning problems are currently attenuated by medication and/or psychiatric rehabilitation and supports.\*

Yes

No

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_

\***Medication** refers to psychotropic medications, which may control certain primary manifestations of mental disorder (e.g. 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 (e.g. congregate or apartment treatment programs), which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.



Catholic Charities of Cortland County

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to [www.psyckes.org](http://www.psyckes.org), and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.<sup>1</sup> For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. Please check 1 box only.

- I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.
- I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Client

Client's Date of Birth

Client's Medicaid ID Number

Signature of Client or Client's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Client (if applicable)

<sup>1</sup> Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

- 1 **How providers can use your health information.** They can use it only to:
  - Provide medical treatment, care coordination, and related services.
  - Evaluate and improve the quality of medical care.
  - Notify your treatment providers in an emergency (e.g., you go to an emergency room).
- 2 **What information they can access.** If you give consent, Catholic Charities of Cortland County can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
 

• Mental health conditions	• Genetic (inherited) diseases or tests
• Alcohol or drug use	• HIV/AIDS
• Birth control and abortion (family planning)	• Sexually transmitted diseases
- 3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: [www.psyckes.org](http://www.psyckes.org) and see “About PSYCKES”, or ask your provider to print the list for you.
- 4 **Who can access your information, with your consent.** Catholic Charities of Cortland County's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Catholic Charities of Cortland County. Staff members who perform the duties listed in #1 above also can access your information.
- 5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
  - CCOCC's Compliance Officer at (607) 756-5992, or
  - the NYS Office of Mental Health Customer Relations at **800-597-8481**.
- 6 **Sharing of your information.** Catholic Charities of Cortland County may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.<sup>1</sup>
- 7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Catholic Charities of Cortland County, or until the day you withdraw your consent, whichever comes first.
- 8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to Catholic Charities of Cortland County. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **[www.psyckes.org](http://www.psyckes.org)** or from your provider by calling your CCOCC staff member at (607) 756-5992. Please note, providers who get your health information through Catholic Charities of Cortland County while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.
- 9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

<sup>1</sup> Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as “HIPAA”).