Catholic Charities of Cortland County

# Community Housing Referral Form

Supported Housing, Permanent Supportive Housing, Permanent Supportive Housing MRT, Riverview

Referral Source: ________________________________ Date: ____________

QHP Signature: ________________________________ Referral Phone: ____________

**APPLICANT INFORMATION**

Name of Applicant(s): ____________________________ DOB: ____________

Address (If applicable): ____________________________ SSN: ____________________

____________________________________________ Applicant phone: ______________

Male ___ Female ____ Has applicant been referred to us before? Yes No

Emergency Contact: ____________________________ Relationship: __________________

Address: ____________________________________ Phone: _______________________

Current living situation: ____________________________ Living alone: Yes No

Is applicant homeless or at risk of homelessness? Yes No Disabled: Yes No

Is applicant able to engage in any level of employment?____________________________________

Highest level of education completed__________________________________________________

Legal history__________________________________________________________________

**FINANCIAL INFORMATION**

Income Source (circle any applicable): Current monthly income: ________

SSI SSD VA Benefit Wages SNAP TA—County of Origin: ___________

Other: _________________ Current Rep Payee (if applicable) __________________

Does applicant need a Rep Payee? Yes No

Medicaid: Yes No Medicaid #: __________________

**MEDICAL**

Chronic medical conditions ______________________________________________________

Hospitalizations in the last 365 days (including ER visits & rehabilitation): ____________________

______________________________________________________________________________

______________________________________________________________________________

Chemical dependency and/or mental health diagnoses: ____________________________________

______________________________________________________________________________

Does client meet criteria for Serious and Persistent Mental Illness (SPMI): Yes No

**If yes, attached SPMI form must be completed.**

## NYS OMH - SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

**This form must be completed by a licensed clinician or other mental health professional.**
**Information can 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

Principle 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 Yes No
i.e.: personal hygiene, diet, clothing, avoidance of injury, securing appropriate health care and/or compliance with medical advice

b.) Marked Restriction of Activities of Daily Living (ADLs) Yes No
e.g.: maintaining a residence, using transportation, day-to-day money management, accessing community services

c.) Marked Difficulties in Maintaining Social Functioning Yes No
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

d.) Frequent Deficiencies of Concentration, Persistence or Pace, Resulting in Failure to Complete Tasks in a Timely Manner Yes No
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

***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.

| AUTHORIZATION FOR RELEASE OF INFORMATION | Patient's Name (Last, First, M.I.) | "C" No. |
|---|---|---|
| | Sex | Date of Birth |
| | Facility Name: Catholic Charities of Cortland County | Unit/Ward: 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:

☐ Contact Information ☐ Current Medications ☐ Current Services ☐ Daily Living Skills ☐ Diagnosis
☐ Education ☐ Entitlements ☐ Emergency Contact Info. ☐ Functional Abilities ☐ Mental Health Status
☐ Psychosocial information ☐ Characteristics/ Photograph ☐ Electronic Files
☐ Other: ______

**Purpose or Need for Information:**

1. 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)

☐ Screening/Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Coordinating Services
☐ Electronic Database
☐ Other: ______

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

| Catholic Charities (Cortland County) Residential Services<br>33-35 Central Avenue<br>Cortland, New York 13045<br>Phone: (607) 753-3550 Fax: (607) 756-4697 | (Two Way) ⇔ | Admissions Committee: Including Representatives from Family Counseling Services, Cortland County Mental Health, Cortland Police Department, Cortland Regional Medical Center, Cortland County Probation Department, Catholic Charities Care Coordination Services |
|---|---|---|

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:
   1. Only this information may be used and/or disclosed as a result of this authorization.
   2. This information is confidential and cannot legally be disclosed without my permission.
   3. 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.
   4. 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.
   5. 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.
   6. 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:

| Facility/Agency Name<br>Catholic Charities (Cortland County) | Patient's Name (Last, First, M.I.) | "C"/ID. No. |
|---|---|---|

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☒ When I am no longer receiving services from: Catholic Charities of Cortland County

☐ One year from this date ☐ Other: ________________________________________

C. **Patient Signature**: I certify that I authorize the use of my health information as set forth in this document.

________________________________________ ________________________

Signature of Patient or Personal Representative Date

________________________________________

Patient's Name (Printed)

________________________________________

Personal Representative's Name (Printed)

________________________________________

Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization)*

D. **Witness Statement/Signature**: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: ________________________________________

Staff person's name and title

Authorization Provided to: ________________________________________

Date: ________________________________________

*To be Completed by Facility:*

________________________________________

Signature of Staff Person Using/Disclosing Information

________________________________________

Title Date Released

**PART 2: Revocation of Authorization to Release Information**

I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

________________________________________

________________________________________

________________________________________

I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

________________________________________

________________________________________

________________________________________

________________________________________ ________________________

Signature of Patient or Personal Representative Date

________________________________________

Patient's Name (Printed)

________________________________________

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*