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

Our 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 a serious and persistent mental illness (SPMI) documented by qualified staff and who meet income guidelines. Individuals meet with a Housing Case Manager monthly 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.

☐ Highest Grade Level Completed_____
☐ Sheltered Workshop _____
☐ Supported Employment _____
☐ Vocational Training _____
☐ Special Education _____
☐ Competitive Employment _____
☐ GED _____
☐ College Degree_____
☐ VESID _____
☐ Other _____

CRIMINAL JUSTICE SYSTEM

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

☐ Probation _____
☐ Parole _____
☐ Conviction of a Crime
☐ Charges Pending
☐ CPL Date _____
☐

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 (IF AVAILABLE)

****Primary must be Mental Health.**

	ICD 10 Codes	Diagnosis
Primary	__ __ __ - __ ___ ___	_____
Secondary	__ __ __ - __ ___ ___	_____

****REFERRALS MUST INCLUDE:**

SPMI DOCUMENTATION

LPHA FORM

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Mail:
Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
Attn: Community Housing Programs Manager

By Fax: (607) 756-5999

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 33-35 Central Avenue Cortland, New York 13045 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 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: Supportive Housing

☐ 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*

Recommendation for Rehabilitative and Tenancy Support Services

Determination of Medical Necessity

Individual's Name: _____

Individual's DOB: _____

Part 2: Recommendation for Services

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#*

_____ _____

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.

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.