

Catholic Charities of Cortland County
OMH Lawrence House Community Residence and Supportive Apartments Referral

The Lawrence House is a 24-hour supervised community residence located close to downtown Cortland. Licensed by the NYS Office of Mental Health, the program serves adults 18 years and older as they transition toward independent community living from higher levels of care, such as hospitals or other inpatient settings. In addition, Lawrence House is known for expertise in working with individuals who suffer from co-occurring mental health and substance use.

The Supportive Apartment Program offers limited supervision living in scattered-site apartments. It is a step toward independent living for those who are transitioning out of a higher level of care. Clients are expected to make positive efforts in treatment, must be capable of self-administering medications, maintaining their apartment, abide by landlord and agency rules, and attend all necessary appointments. Participants agree to meet regularly with the Supportive Apartment Coordinator to develop meaningful and realistic goals that advance recovery and lead to independent living.

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: _____

Client is seriously and persistently mentally ill? Yes* No

**SPMI Form must accompany referral*

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: _____

CURRENT FINANCIAL OBLIGATIONS

List all appropriate bills and amounts

Rent/Housing _____	Heat _____	Electricity _____
Phone _____	Other Utilities _____	Food _____
Child Support _____	Alimony _____	Fines/Restitutions _____
Other _____	Other _____	Other _____

MEDICAL STATUS

Does client have any medical conditions that we should be aware of? (i.e. seizures, allergies, special diet, visual impairment, limited impairment, chronic illness, etc.)

Yes No

If yes, explain: _____

Client's Prescriber(s) Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

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

Yes No

BEHAVIORAL HEALTH HISTORY

Indicate history of the following, as appropriate:

Suicide attempts Date(s): _____	Inappropriate sexual behavior Date(s): _____
Suicidal threats Date(s): _____	Self-injurious behavior Date(s): _____
Fire setting Date(s): _____	Crises requiring frequent readmission Date(s): _____
Violence Date(s): _____	Noncompliance with appts. and/or meds Date(s): _____
Assault Date(s): _____	Substance Use Date(s): _____

If checked, provide brief detail: _____

SERVICE UTILIZATION

Indicate current/past services used; supply dates and providers, if known.

Inpatient treatment: _____

Outpatient treatment: _____

OPWDD Services: _____

Care Coordination: _____

Other: _____

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 |
| <input type="checkbox"/> Parole _____ | <input type="checkbox"/> CPL Date _____ |
| <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 _____

COMMUNITY LIVING/NEEDS

Check needed Services.

- | | | |
|---|---|---|
| <input type="checkbox"/> Outpatient Treatment | <input type="checkbox"/> Transportation | <input type="checkbox"/> Connection to a Psychiatrist |
| <input type="checkbox"/> Psychosocial Rehab | <input type="checkbox"/> Family Support | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> General Health Care | <input type="checkbox"/> Financial Guidance | <input type="checkbox"/> Friends or Social Needs |
| <input type="checkbox"/> Housing (OMH) | <input type="checkbox"/> Other _____ | |

CLINICAL ASSESSMENT

****Primary must be a Mental Health Diagnosis.**

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

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

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

What does the individual think about living in this residential setting?

What are the strengths (skills/personal resources that can be used in this residential setting?)

Are there any areas which might be challenging (i.e., expectations, responsibilities, staff supervision, living with others?) _____

Is the individual willing to share a bedroom? Ever shared a bedroom before? _____

What Program is the individual more interested in? _____

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Mail:
Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
Attn: Lawrence House Program Manager

By Secure E-mail: tcoronato@ccooc.org

By Fax: (607) 299-4800

**Catholic Charities of Cortland County
33-35 Central Avenue Cortland, NY 13045**

Service Authorization for Restorative Services
Pursuant to Part 593 of 14 NYCRR

Initial Authorization (MD ONLY)
(Initial must be "face to face")

Client's Name: _____ **Medicaid CIN:** _____

Program: _____

The above named individual has been referred to a Catholic Charities of Cortland County residential treatment program. In order to be eligible for Rehabilitation Services in our Community Residence, a Physician must authorize services in writing based upon clinical information and a face-to-face assessment for the individual prior to admission.

Based on this face-to-face assessment, please complete the following information and return for authorization of rehabilitative services.

Principle Diagnosis: _____ **ICD 10 Code:** _____

I, the undersigned

Licensed Physician (**Initial Authorization must be signed by MD**)

based on my assessment and clinical records available to me, have determined that the above named client would benefit from the provision of the mental health restorative services defined pursuant to part 593 of 14 NYCRR.

Printed Name: _____ Date: _____

Signature: _____

NPI #: _____ License #: _____

*Authorization Expiration:
Lawrence House: 6 months from date of signature.
Supportive Apartments: 1 year from date of signature

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: Lawrence House

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		

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)

<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		

Other: _____

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

Catholic Charities of Cortland County Residential & Housing Services 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 756-5992 Fax: (607) 299-4800	(Two Way) ⇄	Admissions Committee: Including representatives from Family & Children's Counseling Services, Cortland County Mental Health Clinic, Cortland City 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:

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.
<p>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.</p> <p>My authorization will expire:</p> <p><input type="checkbox"/> When I am no longer receiving services from: <u>Lawrence House</u></p> <p><input type="checkbox"/> One year from this date <input type="checkbox"/> Other: _____</p>		
<p>C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.</p>		
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 <i>(required if Personal Representative signs Authorization)</i>		
<p>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.</p> <p>WITNESSED BY: _____</p> <p style="text-align: center;">Staff person's name and title</p> <p>Authorization Provided to: _____</p> <p>Date: _____</p>		
<p><i>To be Completed by Facility:</i></p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature of Staff Person Using/Disclosing Information</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Title Date Released</p>		
PART 2: Revocation of Authorization to Release Information		
<p>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:</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>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:</p> <p>_____</p> <p>_____</p> <p>_____</p>		
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 <i>(required if Personal Representative signs Revocation of Authorization)</i>		