Community Housing Referral Form

Permanent Supportive Housing, Permanent Supportive Housing MRT, Supported Housing & Riverview SP-SRO

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.

<table>
<tr><td rowspan="3">AUTHORIZATION FOR
RELEASE OF INFORMATION</td><td>Client's Name (Last, First, M.I.)</td><td>Medicaid Number</td></tr>
<tr><td>Sex ______</td><td>Date of Birth ______</td></tr>
<tr><td>Agency Name:
Catholic Charities of Cortland County</td><td>Unit/Ward:
Community Housing</td></tr>
</table>

This authorization must be completed by the client or their 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 of 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 Clinic, Cortland City Police Department, Guthrie Cortland Medical Center, Cortland County Probation Department

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:

Agency Name Catholic Charities (Cortland County)	Client's Name (Last, First, M.I.)	Medicaid Number

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

Signature of Client or Personal Representative ____________________ Date ____________________

Client's Name (Printed) ____________________

Personal Representative's Name (Printed) ____________________

Description of Personal Representative's Authority to Act for the Client (*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 client and/or the client'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 Client or Personal Representative ____________________ Date ____________________

Client's Name (Printed) ____________________

Personal Representative's Name (Printed) ____________________

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

Recommendation for Rehabilitative and Tenancy Support Services

Determination of Medical Necessity

**This form is required when making a referral to Supported Housing or Riverview SP-SRO.

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 supports 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.