Catholic Charities of Cortland County
OMH Supportive Apartment Referral

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. Participants are expected to make positive efforts in treatment, must be self-medicating, maintain 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 _____ Phone _____ Date _____

Contact Name _____

CLIENT INFORMATION

Name _____ Date of Birth _____ Soc. Sec. # _____

Address _____ Phone _____

Male _____ Female _____

Emergency Contact_____ Relationship _____

Address _____Phone _____

Has the applicant been referred to us before? Yes _____ No _____
If yes, explain. When, for what services and circumstances:_____

_____

_____

Current Living Situation: _____

Client is seriously and persistently mentally ill ☐ Yes ☐ No
***SPMI Form must accompany referral**

FINANCIAL STATUS
Client Receives: ☐ SSI ☐ SSD ☐ SSI/SSD Pending ☐ VA Benefit ☐ Wages
☐ PA - If yes, County of origin _____
Caseworker _____Caseworker Phone _____
☐ Other – Explain _____
☐ Medicaid # _____ ☐ Medicare ☐ Private Ins.: _____
☐ Current Representative Payee _____
☐ Applicant needs Representative Payee services
☐ Has the client ever been sanctioned by DSS? If yes, please explain:

_____

Current Financial Obligations

List all appropriate bills and amounts

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

Other (i.e. loans) _____

MEDICAL STATUS

Does applicant 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 _____

_____

Applicant's Doctor(s) Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Is applicant capable of self- preservation in case of emergency? (Evacuating housing safely) ☐ Yes ☐ No

MENTAL HEALTH HISTORY

High Risk Alerts: Check if history of the following

☐ Suicide/Attempts	Date: _____	☐ Inappropriate Sexual Behavior	Date: _____
☐ Suicidal Threats	Date: _____	☐ Self Injurious Behaviors	Date: _____
☐ Fire Setting	Date: _____	☐ Frequent crisis requiring readmission	Date: _____
☐ Violence	Date: _____	☐ Non-compliance with Medication	Date: _____
☐ Assault	Date: _____	☐ Non-compliance with Appointments	Date: _____
☐ Medical Issues	Date: _____	☐ Substance Abuse	Date: _____
☐ Other	Date: _____		

If checked, provide brief detail: _____

_____

_____

_____

_____

SERVICE UTILIZATION

Check any services used. If checked, give dates and provider.

☐ Inpatient treatment: _____

☐ Outpatient treatment: _____

☐ OPWDD Service: _____

☐ 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.

☐ 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_____

COMMUNITY LIVING/NEEDS

Check needed Services.

☐ Outpatient Treatment
☐ Psychosocial Rehab
☐ General Health Care
☐ Housing (OMH)
☐ Transportation
☐ Family Support
☐ Financial Guidance
☐ Other
☐ Connection to a Psychiatrist
☐ Case Management
☐ Friends or Social Needs

_____

_____

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.

Medication	Dosage	Prescribing MD

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? _____

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Mail: Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
ATTN: Supportive Apartment Program Coordinator

By e-mail: info@ccocc.org

By Fax: (607) 756-5999

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")
☐ Semi-Annual Authorization
☐ Annual Authorization

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

Program: Supportive Apartment

The above named individual has been referred to a Catholic Charites of Cortland County residential treatment program. In order to be eligible for Rehabilitation Services in our Apartment Program, 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)**
☐ Physician assistant
☐ Nurse practitioner practicing in psychiatry

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: 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: Supportive Apartment Program

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 Apartment Program

☐ 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)*