ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH

ANTHONY J. PICENTE, JR.
County Executive

ASHLEE L. THOMPSON
Commissioner
Director of Community Services

ADULT SINGLE POINT OF ACCESS & ACCOUNTABILITY (ASPOA-A) REFERRAL FORM

Email to OCMENTALHEALTH@ONEIDACOUNTYNY.GOV or Fax to (315) 768-3670

Name: _____ **DOB:** _____

☐ **Referral form is completed in its entirety. All selections completed or indicate N/A.**

☐ **Referrals are legible or typed with all appropriate signatures.**
- **ASPOA-A consent form is physically or e- signed (with a time stamp) by the individual being referred. (Verbal consent is not accepted).**
- **Individual meets criteria outlined in the ASPOA-A eligibility page, and it is signed by the referral source or provider.**

☐ **Supporting documentation is attached in the form of a psychiatric evaluation or mental health assessment indicating that the individual meets the criteria for a primary mental illness diagnosis and is signed by psychiatrist, medical doctor, nurse practitioner, LMSW, LCSW, LMHC, or LMFT dated within the past 12 months.**
- **Or an additional Release of Information form is completed specifying the provider who can provide this clinical information.**

Referral Source (Name, Title, Agency/Facility): **Phone number/Email:** **Fax number:**

~~OCDMH INTERNAL USE ONLY~~		
ASPOAA Date: SMI Expiration:	Services Referred to #1: Date #1:	OCDMH Staff:
Services Requested:	Services Referred to #2: Date #2:	OCDMH Staff:
OCDMH Return date: Reason:	Services Referred to #3: Date #3:	OCDMH Staff:
Notes:		

SECTION 1 – Demographic Information

First Name: | **Last Name:**

DOB: | **Phone:**

SSN: | **Gender:**

Residential or Temporary Address:

Residential Type:

☐ Independent (Alone)
☐ Rehabilitation Facility
☐ Independent (w/ Family/Friends)
☐ Nursing Home or Assisted Living Facility
☐ Section 8
☐ Homeless Shelter
☐ Street Homeless
Address Prior to Homelessness:

Specialty Temporary Address & Type :

☐ Hospital ☐ Correctional Facility ☐ Other: _____

Address: _____

*Anticipated Release Date:_____

Does the individual have any dependents? ☐ **Yes** ____ **#** ☐ **No**

Are residential services being requested for both client and their dependents? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Other: _____

Can individual understand English?
☐ Yes ☐ No, interpreter needed

Military History:
☐ Yes ☐ No
Branch:_____
Discharge status:_____

Race/Ethnicity (check all that apply):

☐ American Indian Or Alaskan Native
☐ Native Hawaiian Or Other Pacific Islander
☐ White
☐ Other: _____
☐ Hispanic Or Latino
☐ Asian
☐ Black Or African American

Insurance details:

Does Client Have Active Insurance?
☐ Yes ☐ No ☐ Unknown

MEDICAID CIN: _____

MEDICARE #: _____

Other Type/#: _____

Educational/Vocational:

☐ Employed: ☐ Part-Time ☐ Full-Time
☐ Employer (if applicable):
_____
☐ Highest level of education: _____
☐ Currently In School

Current Representative Payee Services?

☐ Yes ☐ No ☐ Unknown

Name/Organization: _____

Phone: _____

Current Benefits Received:

☐ None
☐ Public Assistance
☐ Earned Income
☐ Other: _____
☐ Supplemental Security Income (SSI)
☐ Social Security Disability Insurance (SSDI)
☐ Unemployment

SECTION 2 – ASPOA-A Eligibility

To be eligible for services through the Adult Single Point of Access and Accountability (ASPOA-A) Program, applicants must meet **all** of the following criteria. Please place a checkmark in each field where the answer is true.

☐ **The individual is 18+ years of age;**
☐ **The individual is willing to participate in these voluntary services;**
☐ **The individual has a primary DSM-5 diagnosis of a severe mental illness other than alcohol or substance use disorders, developmental disabilities, dementias, or mental disorders due to a general medical condition;**

1. Primary diagnosis: _____ ICD-10 Code: _____
2. Secondary diagnosis: _____ ICD-10 Code: _____
3. Other diagnosis: _____ ICD-10 Code: _____
4. Other diagnosis: _____ ICD-10 Code: _____
5. Other diagnosis: _____ ICD-10 Code: _____

-AND-

☐ **The individual is currently enrolled in SSI/SSDI due to a designated mental illness;**

-OR-

☐ **The individual must have documentation that they have experienced at least two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:**

☐ Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing healthcare, or complying with medical advice).

☐ Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).

☐ Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).

☐ Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability 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 repeatedly are unable to complete errors in tasks or require assistance in the completion of tasks).

-OR-

☐ **Reliance on Psychiatric Treatment, Rehabilitation, and Supports:** A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. 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.

ELIGIBILITY CERTIFICATION: I certify that this individual, who is eighteen years or older, is functionally disabled due to mental health needs, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the eligibility requirements listed above. I certify that I am the referent, and that this information is further justified in the attached mental health evaluation or other applicable assessment.

_____ _____
Signature Date

SECTION 3 – Reason For Referral *Please Give As Much Detail As Possible*
Describe the individual's current circumstances and needs (including current psychiatric symptoms):
Describe the desired outcome of this referral:
Describe the individuals baseline functioning:
Discuss the individual's current and past adherence with mental health treatment, including any history of noncompliance:
Discuss the individuals' required level of supervision:
Describe the individual's typical interactions with others (staff and peers):
Describe the individual's strengths and supports:
Describe the individual's weaknesses and triggers (including behaviors if/when they decompensate):
Other information:

SECTION 4 – Current Treatment Team

List Name Of Worker, Organization, And Phone Number

Mental Health Treatment

Therapist: _____ **Prescriber:** _____

Care Manager: _____

Substance Use Treatment

Counselor: _____ **Prescriber:** _____

Peer Advocate: _____

Primary Care: _____

Probation: _____ **Parole/Community Supervision:** _____

Other: _____

_____

SECTION 5 – Medical and Behavioral Health History

Functional/Medical Limitations:

- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Impaired ability to walk
- ☐ Special dietary needs
- ☐ Requires special medical equipment
- ☐ Intellectual or developmental disability
- ☐ Traumatic brain injury
- ☐ Learning disability
- ☐ Allergies: _____

_____

☐ Other: _____

_____

_____

☐ Diabetes *(if yes, see below)*

Requires insulin? ☐ Yes ☐ No

Able to self-administer insulin ☐ Yes ☐ No

Medical Conditions:

_____

_____

_____

_____

_____

Community Survival Skills:	**Yes**	**No**
Evacuate a building independently within 3 minutes:	○	○
Independently prepare food:	○	○
Bathe/dress independently:	○	○
Independently maintain hygiene/grooming:	○	○
At risk of falling:	○	○
At risk of wandering:	○	○
Coordinate their own transportation:	○	○

Applicants Capability To Administer Medications (choose one):

- ○ Independently Without Prompts
- ○ Independently With Prompts
- ○ If Administered To Them
- ○ Unable
- ○ Currently Refusing

Is the individual currently medication compliant?

☐ YES ☐ NO

****Please include a complete medication list with psychiatric and medical medications****

Current Mental Health Medications:
(Please indicate if LAI)

_____
_____
_____
_____
_____

Current Medical Medications:

_____
_____
_____
_____
_____
_____

Known inpatient MH hospitalizations
List name, dates, and primary diagnosis

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **None/Not Applicable**

Within past 12 months: _____

Past inpatient/outpatient substance use providers:
List name, dates, and primary diagnosis

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **None/ Not Applicable**

Date of first known inpatient MH Hospitalization:

_____

Date of last known inpatient MH hospitalization:

_____

How many lifetime known inpatient MH hospitalizations**:** _____

Past outpatient mental health Providers:
List name, dates, and primary diagnosis

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **None/Not Applicable**

SUBSTANCE USE HISTORY: Has applicant ever used, or currently using, the following substances?

Substance	History of	Current Use	Est date of last use
Alcohol	☐	☐	
Marijuana	☐	☐	
Synthetic maijuana	☐	☐	
Methamphetamine	☐	☐	
Amphetamines	☐	☐	
Cocaine/Crack	☐	☐	
Opioids	☐	☐	
Benzodiazepines	☐	☐	
Hallucinogens	☐	☐	
Abuse of prescription medication	☐	☐	
Other:	☐	☐	

☐ **No Substance Use History In The Applicant's Lifetime**

SECTION 6 – Legal History

If yes, please provide details and applicable dates

	Current	Past Yr	History		Current	Past Yr	History
Pending charges	☐	☐	☐	**Sexual offenses**	☐	☐	☐
Misdemeanor charges	☐	☐	☐	**Sex offender registration Level: ____**	☐	☐	☐
Felony charges	☐	☐	☐	**Strict and Intensive Supervision and Treatment (SIST)**	☐	☐	☐
Violent felony charges	☐	☐	☐	**Treatment court:**	☐	☐	☐
Probation	☐	☐	☐	**Assisted Outpatient Treatment (AOT)**	☐	☐	☐
Parole	☐	☐	☐	**CPL 730**	☐	☐	☐
Arson charges	☐	☐	☐	**Frequent Police Contact**	☐	☐	☐

☐ **No Legal History**

Explain Additional Information Regarding The Above Forensic History, If Applicable:

_____

_____

_____

_____

_____

SECTION 7 – Individual's Risks & Safety Concerns

Please mark any applicable risk/concern in the corresponding time frame of current, within the past year, or history of risk/concern

	CURRENT	PAST YR.	HISTORY		CURRENT	PAST YR.	HISTORY
Suicidal ideation	☐	☐	☐	**Alcohol/substance use**	☐	☐	☐
Suicide attempt(s)	☐	☐	☐	**Fire setting/arson**	☐	☐	☐
Self-injury	☐	☐	☐	**Cruelty to animals**	☐	☐	☐
Homicidal ideation	☐	☐	☐	**Access to weapons**	☐	☐	☐
Homicide attempt	☐	☐	☐	**Violence/aggression**	☐	☐	☐
Homicide success	☐	☐	☐	**Impulsivity**	☐	☐	☐
Victim of abuse	☐	☐	☐	**Poor decision making**	☐	☐	☐
Perpetrator of abuse	☐	☐	☐	**Gang involved/activity**	☐	☐	☐
Property damage	☐	☐	☐	**Running away/awol**	☐	☐	☐
Sexual inappropriateness	☐	☐	☐	**Other:_____** _____	☐	☐	☐

☐ **No Risk Or Safety Concern History**

Explain additional information regarding the above risk & safety concerns, if applicable:

_____

_____

_____

_____

SECTION 8 – Program Goals

Please mark the following goals you would like assistance with or wish to improve from SPOA services.

- ☐ Compliance with medication/treatment (mental health, substance use, medical
- ☐ Social/communication skills
- ☐ Job skills/education goals
- ☐ Money management/budgeting
- ☐ Cooking/cleaning
- ☐ Access to community resources/transportation
- ☐ Advocacy/assertiveness
- ☐ Other (please indicate): _____

SECTION 9 – ASPOA-A Services Requested

Please review the ASPOA brochure for details on services before requesting

Care Coordination Services:

- ☐ **Health Home Care Management (HHCM)**
- ☐ **Intensive Case Management (ICM) c/o Mohawk Valley Psychiatric Center**
- ☐ **Assertive Community Treatment (ACT) c/o Mohawk Valley Psychiatric Center**
- ☐ **Forensic Assertive Community Treatment (FACT) c/o Upstate Caring Partners**

Residential Services (Group Settings with Programming):

- ☐ **Community Residence c/o Catholic Charities (CR)**
- ☐ **Enriched Living Center (ELC) c/o rescue Mission of Utica**
- ☐ **State Operated Community Residence (SOCR) c/o Mohawk Valley Psychiatric Center**
- ☐ **Transitional Living Center (TLC) c/o Mohawk Valley Psychiatric Center**

Residential Services (Apartment Settings):

- ☐ **Pathways Apartment Program (APT) c/o Catholic Charities** ***program****
- ☐ **Treatment Apartment Program (TAP-UCP) c/o Upstate Caring Partners**
- ☐ **Supported Housing (SH-CC) c/o Catholic Charities** ***rental stipend only****
  - ☐ **Long-Term Supported Housing (LTSH) c/o Catholic Charities**
  - ☐ **Medicaid Re-Design Team (MRT) c/o Catholic Charities**
  - ☐ **Transformation Supported Housing (TSH) c/o Catholic Charities**
- ☐ **Supported Housing (SH-UCP) c/o Upstate Caring Partners**
- ☐ **Supported Housing (SH-DP) c/o Depaul Properties** ***specify:*** ☐ ***Utica -and/or*** ☐ ***Rome***
- ☐ **Supported Housing (SH-RMU) c/o Rescue Mission of Utica**
- ☐ **Supported Housing (SH-HH) c/o Helio Health**
- ☐ **Forensic Supported Housing (FSH-HH) c/o Helio Health**
- ☐ **Forensic Supported Housing phase 1 (FSH-CC1) c/o Catholic Charities**
- ☐ **Forensic Supported Housing phase 2 (FSH-CC2) c/o Catholic Charities**

Social event services:

- ☐ **Transportation Services c/o Catholic Charities (TR-CC)**
- ☐ **Psychosocial Recreation Services c/o Catholic Charities (PSR-CC)**

**CLIENT FIRST NAME:	**CLIENT LAST NAME:

SECTION 10 – Homeless Verification Status (CHOOSE ONE)

Only complete this section if referring to **SUPPORTED HOUSING** programs through Depaul, Catholic Charities, Upstate Caring Partners, Helio Health Or Rescue Mission of Utica.

○	Individual has a primary nighttime residence that is a public or private place not meant for human habitation, such as a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground.
○	Individual is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid by Federal, state or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing.
○	Individual exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
○	Individual is being released from a correctional facility or an inpatient hospitalization.

Provide Details of Homeless Status:

_____
_____
_____
_____
_____
_____
_____
_____
_____

CERTIFICATION:

I verify, to the best of my knowledge, that the above information is true and accurate.

_____ _____

Print Name of Verifier Signature of Verifier

_____

Date of Verification

HIPAA AUTHORIZATION FOR TWO-WAY EXCHANGE OF HEALTH INFORMATION
ADULT SINGLE POINT OF ACCESS (ASPOA)

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160; 45 CFR Parts 164; 42 CFR Part 2; 5 U.S.C. 552a; 38 U.S.C. 5701; and 38 U.S.C. 7332. Your disclosure of the information requested on this form is voluntary. The County of Oneida may disclose the information that you put on the form as permitted by law. Your signature on this form indicates you give the County of Oneida permission to use and/or disclose your Protected Health Information (PHI) identified below with authorized individual(s) and/or agencies. Disclosure of PHI may be written, electronic, or verbal. Authorization of this form includes the communication and disclose to/from/between all organizations that offer services through the Oneida County ASPOA Program to coordinate services on your behalf. These agencies include ACR Health, Building Blocks Learning Center, Catholic Charities Diocese of Syracuse - Oneida/Madison County, Central New York Health Home, Inc., County of Oneida (aka Oneida County Government), DePaul Properties, Inc., Helio Health, Inc., Integrated Community Alternatives Network (ICAN), Mohawk Valley Psychiatric Center, Neighborhood Center, Inc., Presbyterian Residential Community, Rescue Mission of Utica, Salvation Army and Upstate Cerebral Palsy dba Upstate Caring Partners.

**Asterix marked sections are required to be completed.

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**
****DATE OF BIRTH *(mm/dd/yyyy):***	****PHONE #:**
INDIVIDUAL'S MAILING ADDRESS *(including City, State and Zip Code):*	

RECIPENT OF PROTECTED HEALTH INFORMATION (PRE-FILLED**):** ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH (OCDMH) 800 PARK AVENUE, UTICA, NY 13501	
****NAME OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	****PHONE # OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISLOSE PHI TO OCDMH:**
****ADDRESS OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	

THE PURPOSE FOR WHICH THIS INFORMATION MAY BE USED, DISCLOSED, OR REDISCLOSED INCLUDE (PRE-FILLED8**):**

- TO DETERMINE INITIAL AND CONTINUING HOME & COMMUNITY BASED SERVICES SUCH AS RESIDENTIAL, CASE MANAGEMENT, ASSERTIVE COMMUNITY TREATMENT, CRISIS, TRANSPORTATION, VOCATIONAL, AND/OR EDUCATIONAL RESOURCES;
- TO DETERMINE AND MAKE RECOMMENDATIONS FOR APPROPRIATE LEVELS OF CARE;
- TO ASSIGN APPROPRIATE SERVICES OFFERED THROUGH PARTNERSHIPS WITH SINGLE POINT OF ACCESS (SPOA) PROGRAMS;
- TO ACCESS DATA IN PSYCKES TO DETERMINE SERVICE ELIGIBILITY AND LEVEL OF SERVICE NEED; AND
- TO PLAN AND COORDINATE SERVICES AND TREATMENT.

****INFORMATION REQUESTED AND TO BE RELEASED (CHECK EACH APPLICABLE):**

_____ ENTIRE MEDICAL/SERVICE RECORD (INCLUDING PSYCHIATRIC & SUBSTANCE USE RECORDS)

-OR-

_____ BEHAVIORAL/MENTAL HEALTH/OTHER PSYCHIATRIC SCREENINGS/ASSESSMENTS/EVALUATIONS

_____ SUBSTANCE USE RECORDS

800 PARK AVENUE, 7TH FLOOR, UTICA, NY 13501
PHONE: 315-768-3660 | FAX: 315-768-3670 | mentalhealth@oneidacountyny.gov

_____ FORENSIC HISTORY & RECORDS
_____ LEGAL HISTORY & RECORDS
_____ MEDICAL INFORMATION/HISTORY/CONCERNS (INCLUDING LABWORK/CLINICAL PROCEDURES)
_____ LETHALITY/RISK ASSESSMENTS/SCREENINGS/CONCERNS
_____ DIAGNOSIS/PROGNOSIS/PROGRESS IN TREATMENT/SERVICES
_____ HOUSING HISTORY
_____ MEDICATION HISTORY
_____ CASE MANAGEMENT RECORDS
_____ ADMISSION/INTAKE INFORMATION
_____ SERVICE PLAN(S)/IEP
_____ HIV/AIDS RELATED INFORMATION
(For HIV/AIDS disclosure: *I understand I also need to complete Form DOH 2557 found on the NYS Department of Health website.*

_____ OTHER: _____
_____
_____
_____

AUTHORIZATION:
I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. This authorization is signed with the express understanding that the released information shall not be used for any purpose other than to provide and coordinate behavioral health services and shall be used in a confidential manner. I understand that I can receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the County of Oneida – Department of Mental Health. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. **I understand this disclosure includes future generated records 24 months after the date of my signature unless specified otherwise in the "expiration" section. Further, I understand that these records may be redisclosed amongst the providers who provide SPOA services in Oneida County, NY.**

EXPIRATION (IF NONE – SKIP THIS SECTION):
Only fill out this part if you are placing limitations on the expiration of permissions and/or limitations on permission)
UPON THE FOLLOWING DATE: _____
UPON THE FOLLOWING EVENT: _____

****SIGNATURE OF INDIVIDUAL:**

I am the person, or personal representative of the person, whose records will be used, disclosed and/or re-disclosed. I give permission to use, disclose and/or re-disclose my records as described in this document

DATE:

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**