Instructions & Checklist:

☐ Complete and sign all designated areas.

☐ Complete and sign the funding verification form and the consent to release information.

☐ A complete psychosocial history and psychiatric assessment including the multiaxial diagnosis (Axis I-V) completed **within the past year** may be needed at time of referral for some services.

Please use the Livingston County SPOA referral if the adult client needs care management services and:

- does not have medicaid
- needs supported housing (community residences and treatment apartment programs are not available in Livingston County)
- has “difficult to serve” challenges that the SPOA committee can help to navigate as a referral source for the client

Please be aware that if the client has medicaid and is in need of care management services, a HHUNY referral must be completed instead and sent directly to HHUNY.

Mail or fax completed referral packet to:

Michele Anuszkiewicz
Mental Health Services Coordinator
Livingston County Mental Health
4600 Millennium Drive
Geneseo, NY 14454
Email: manuszkiewicz@co.livingston.ny.us
Phone: 585-243-7250
Fax: 585-243-7264

Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults

To be considered an adult with severe and persistent mental illness, **A** must be met.
In addition, **B** or **C** or **D** must be met.

A. Designated Mental Illness Diagnosis

___ **YES** ___ **NO** The individual is 18 years of age or older and has a primary DSM-TR psychiatric diagnosis **other than the following:** alcohol or drug disorders, developmental disabilities, dementias, mental disorders due to general medical conditions except those with predominant psychiatric features, or social conditions. DSM-IV categories and codes that do not have an equivalent in ICD-9-CM are not included as designated mental illness diagnoses.

AND

B. SSI or SSDI Enrollment due to Mental Illness

___ Yes ___ NO The individual is currently enrolled in SSI or SSD due to a designated mental illness.

OR

C. Extended Impairment in Functioning due to Mental Illness

The individual must meet **1**or **2** below:

1. 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:

___ YES ___ NO a. Marked difficulties in self-care.

___ YES ___ N b. Marked restriction of activities of daily living.

___ YES ___ N c. Marked difficulties in maintaining social functioning.
___ YES ___ N d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner at work, home or school settings.

2 The individual has met criteria for a rating of 50 or less on the Global Assessment of Functioning Scale.
___ YES ___ NO

OR

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports

___ YES ___NO A documented history shows that the individual, at some prior time, met the threshold for C (above) but 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 limitation imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of underlying mental disorder.

Form completed by:

_____ _____

Signature **Date**

Livingston County
Adult SPOA Referral Packet

Referred By _____
Date _____

Programs Requested:

___ Supported Housing Is there a preference of: [ ] Lakeview or [ ] Arbor Development?
___ Case Management
___ Other: _____

Client Name: _____ **DOB:** _____
Home Address: _____ **Age:** _____ **Gender:** ____ **M** ____ **F**
_____ **Social Security Number:** _____
Telephone Number: _____ **Medicaid # (If applicable):** _____
Referral Agency : _____**Address:** _____
Telephone Number: _____**Contact Person:** _____

Referral Source: (Check one)

[ ] Self, Family, or Friend

[ ] Mental Health O.P. _____

[ ] General Hospital ER _____

[ ] Police _____

[ ] Probation _____

[ ] State Psychiatric Center I.P. _____

[ ] Emergency Nonresidential Program. _____

[ ] Other Medical Provider _____

[ ] Family Court _____

[ ] Parole _____

[ ] General Hospital I.P. _____

[ ] CSP Mental Health Program _____

[ ] MR/DD Facility _____

[ ] Criminal Court _____

[ ] Homeless Shelter _____

[ ] MH Residential _____

[ ] Local MH Practitioner _____

[ ] Substance Abuse Program _____

[ ] Jail _____

[ ] Penitentiary _____

[ ] Other: _____

What is the client's level of acceptance of the need for this referral? [ ] accepts [ ] interested in pursing it further [ ] resistive [ ] does not accept

Person to Notify in Case of Emergency:

Name: _____

Address: _____

Telephone: _____

Primary Care Physician:

Name: _____

Address: _____

Telephone : _____

Living Situation at time of referral:

[ ] Lives alone	[ ] Lives with parents	[ ] Lives with other relatives	[ ] Psychiatric Center
[ ] Homeless (street)	[ ] Lives with spouse	[ ] Assisted/supported living	[ ] Correctional Facility
[ ] Homeless (shelter)	[ ] Supervised living	[ ] Nursing home/medical setting	[ ] Other _____

Length of time in current living situation (years & months):_____

Does the client want to remain in current living situation: _____

Current treatment goals to be supported by staff (Reason for Referral) : _____

_____

_____

Does the client need 24-hour supervision? [ ] Yes [ ] No If yes, why _____

_____

Any adult history of homelessness: [ ] Yes [ ] No

If yes, please list all previous incidents of homelessness in the last four years and verify with dates:

_____

_____

_____

Ability to tolerate Group Situations: [ ] Yes [ ] No (explain) : _____

_____

Previous Residential History (include independent and supervised situations): _____

_____

Interpersonal Skills: _____

_____

Social Supports (include family): _____

_____

Family's interest in supporting this referral and becoming involved in the planning: _____

_____

_____

Effective approaches to use with the client:_____

_____

What resources would be helpful to this client in his/her recovery (budgeting, educational, vocational, tenant rights, etc.)?: _____

_____

Cultural issues that may impact treatment and treatment planning: _____

_____

Ethnicity:

[ ] White (non-Hispanic) [ ] Asian-Asian American [ ] Latino/Hispanic [ ] Pacific Islander [ ] Black (non-Hispanic) [ ] Other or dual (specify): [ ] Native American

Current Educational Level:

[ ] Some grade school 1-8th grade [ ] Some HS 9-12th grade, but no diploma [ ] GED [ ] HS Grad
[ ] Some college, but no degree [ ] College Degree [ ] Masters Degree [ ] Not graded
[ ] Vocational, business training [ ] No formal education [ ] Other: _____

Current Employment Status:

[ ] Employed full-time [ ] Employed part-time [ ] Not employed [ ] Training program [ ] Other:_____

Current Criminal Justice Status:

[ ] None [ ] Currently incarcerated-p [ ] Currently incarceratec [ ] Alternatives to incarcera
[ ] CPL 330.20 [ ] Parole [ ] Probation () Treatment Court
[ ] Released from jail/prison in the last 30 days [ ] Other: _____
Contact: Probation or Parole Officer: Phone:
_____ _____

Primary Language:

[ ] English [ ] Other: _____

English Proficiency: (If primary language is other than English):

[ ] Does not speak English [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Current Marital Status:

[ ] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
[ ] Living with significant other/domestic partner

Custody Status of Children: (check all that apply)

[ ] No children [ ] Have children all > 18 yrs old [ ] Minor children currently in client's custody
[ ] Minor children not in client's custody but have access [ ] Minor children not in client's custody – no access

Current or Last Services (check all that apply):

[ ] No prior service [ ] MH residential [ ] Case Management [ ] Prison, Jail, or Court
[ ] State Psychiatric Center (Inpt) [ ] MH outpatient [ ] General hospital
[ ] Emergency MH (nonresidential) [ ] Local MH practitioner [ ] CSP MH program

If no current services, specify date of last services:

_____

Outpatient Services Current or Planned: (CHECK ALL THAT APPLY)

	Current	Planned		Current	Planned
Health			Psychiatrist/Clinic		
Education			Alcohol/Drug Treatment		
Day Treatment Program			AA/NA		
Psychiatric Day Program			Case Management		
Vocational Services			Intensive Case Management		
Community Residence			Family Support Services		
Halfway House			Children's ICM/SCM		
Adult Care Facility			Respite Services		
Child Preventative Services			Child Residential Treatment		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		
Other:			Other:		

Indicate the client's willingness to participate in Day Programs:

[ ] Not Applicable [ ] Independent [ ] With Prompting [ ] Needs to be taken to program [ ] Rejects Services

Currently receives Care Management : [ ] Yes [ ] No

Current AOT: [ ] Yes [ ] No Receives ACT: [ ] Yes [ ] No

Is the applicant mandated to treatment?: [ ] Yes No [ ]

Mental health service utilization in past 12 months:

_____# Of Psych. ED Visits
_____# Of Outpatient MH Admissions
_____# Of Inpatient Psych. Admissions _____# of days
Previous psychiatric treatment/hospitalizations (please provide facilities and dates) : _____
_____
_____

Use/engagement with mental health services:

Does the client understand and accept the need for prescribed medications? [ ] Yes [ ] No

Rate client compliance with medication regime:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Please list any current medications and dosages: _____
_____
_____
_____
_____

Rate client follow through with Mental Health Appointments:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Cognitive impairment? [ ] Yes [ ] No
Explain:_____
_____
_____

Behavior/circumstances precipitating most recent hospitalization:
_____
_____
_____

Signs/symptoms of decompensation (please be specific): _____

Diagnosis: Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis VI _____

Does the client have a history of any of the following?:

			If Yes, Dates
Fire setting	[ ] Yes	[ ] No	_____
Sexual offense	[ ] Yes	[ ] No	_____
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	_____
Aggressive /assaultive behavior	[ ] Yes	[ ] No	_____
Suicidal ideation	[ ] Yes	[ ] No	_____
Self abuse/injury	[ ] Yes	[ ] No	_____
Suicide attempts/gestures	[ ] Yes	[ ] No	_____
Destruction of property	[ ] Yes	[ ] No	_____
Victim of physical abuse	[ ] Yes	[ ] No	_____
Attempted homicide	[ ] Yes	[ ] No	_____
Criminal arrests	[ ] Yes	[ ] No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____
_____

Is the applicant subject to a current order of protection?: [ ] Yes No [ ]

Are there any guns in the client's home?: [ ] Yes No [ ]

Is the client a Veteran?: [ ] Yes No[ ]

Medical Problems: (Check all that apply)

[ ] None	[ ] Incontinent	[ ] Impaired ability to walk	[ ] Impaired vision
[ ] Hearing impairment	[ ] Requires special medical equipment		[ ] Cardiovascular Disease

[ ] BMI over 25 [ ] Respiratory Disease [ ] Diabetes/Metabolic
[ ] Other Medical Explanation:
_____

Use/engagement in medical services : (annual physical, and if applicable, taking medications, making appointments, adherence to regimen/programs, special diets, etc.)

[ ] Independent [ ] Partially Dependent [ ] Fully Dependent [ ] Rejects Services

Special diet: [ ] Yes No [ ]
Known Allergies:
Medications:_____
Food:_____
Other:_____

Community Survival Skills: (CHECK APPROPRIATE RESPONSE)

	Independent	Can do with help	Dependent
1. Activities of Daily Living (ADLs)			
Eating			
Dressing			
Grooming			
Toileting			
2. Personal Safety:			
Crossing Street Safely			
Exit in Emergency			
Smoking Safely			
3. Community Living:			
Using Public Transportation			
Shopping			
Cleaning			
Cooking			
Manage Own Money			

Any explanation of above information you want to make: _____

_____
_____
_____
_____

Substance Use History:
Does the client have a history of drug/alcohol abuse/dependency? [ ] Yes [ ] No
If yes, at what age did use begin? _____ Date of last use:_____

Drugs of Choice: (check all that apply)

[ ] None	[ ] Cocaine	[ ] Methamphetamine	[ ] Prescription drug	[ ] Any IV drug use
[ ] Crack	[ ] PCP	[ ] Inhalant: Sniffing g	[ ] Alcohol	[ ] Heroin/Opiates
[ ] Sedative/hypn	[ ] Marijuana/Canna	[ ] Hallucinogens	[ ] Benzodiazepines	[ ] Other_____

Frequency of Drug Use:

[ ] none in past mon [ ] 1-3 times in past mont [ ] 1-2 times/week [ ] 3-6 times/week [ ] daily

Longest period of Sobriety: _____

Does the client smoke cigarettes? [ ] Yes [ ] No
If yes, how many per day? _____

Chemical Dependency Treatment: [ ] Yes [ ] No
If yes: [ ] inpatient [ ] outpatient Dates:_____
_____

Chemical Dependency Service Utilization in past 12 months:
____# Of Outpatient CD admissions ____# of Inpatient CD admissions

If client is currently in a Chemical Dependency Treatment Program, anticipated discharge date? _____

FUNDING VERIFICATION FORM

Client Name: _____

	Case #	County	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security						
SSI						
SSD						
Public Assistance						
Veteran's Benefits						
Medicare						
Medicaid						
Food Stamps						
Pension						
Wages/Earned Income						
Unemployment						
Private Insurance						
Other 3rd Party Payer						
Trust Fund						
Medication Grant						
Other						

Court mandated expenses/debts (i.e., alimony, child support, student loans, utility bills). **Please list all known and amounts**:_____
_____

Other resources (**Circle all that Apply**): Checking/Savings/Certificates of Deposit/ Retirement Accounts/ Mutual Funds/Burial Funds/Stocks/Bonds/Life Insurance/Motor Vehicle(s)/Property/Other

Employed By: _____ Telephone #: _____

If Rep Payee, Name: _____ Address: _____

Agency: _____Telephone #: _____

Signature of person completing this form: _____

Print Name: _____ Relationship to Client: _____