Integrated Single Point of Access (SPOA) for Adults

Description: The Single Point of Access (SPOA) is a centralized integrated committee that accepts referrals for high-intensity mental health services for adults who have been diagnosed with a serious mental illness and whose illness interferes with their ability to function in the community, home, school, and/or work. This also includes individuals who are transitioning from institutional settings back into the community (i.e. psychiatric hospitalization or incarceration) and individuals that have a high risk of future or a history of high utilization of emergency services (i.e. psychiatric or medical ER visits or hospitalization, homelessness, mobile crisis services, or incarceration).The overall goal of the integrated SPOA Committee is to fostering independence while improving the quality of life for consumers of mental health services in Cortland County.

Purpose: The integrated SPOA committee is designed to manage access to mental health services, provide a forum for improved collaboration among community service providers, and identify and promote community-based alternatives to residential treatment and psychiatric hospitalization. As a part of the SPOA process, stakeholders in the community mental health service system meet on a regular basis to ensure that individuals who are referred are matched to the appropriate level of service based on need. Provisions are made to incorporate and consider recipient preferences and choices.

Services Offered:

1.) *Housing Referrals:* Catholic Charities of Cortland County: Community Residence, Supportive Apartment Program, Supportive Housing Program, and the Riverview SP-SRO.
2.) *Health Home Care Management:* There are multiple providers in Cortland County that provide this service. The choice is the consumers and referrals are accessed directly through the Health Homes.
3.) *Complex Care Planning:* Meetings involve individuals and their care team members with the purpose of discussing barriers and gaps in care that may be preventing them from improving their quality of life.

Eligibility Requirements:

- Individual must be at least 18 years of age.
- Individuals must be Seriously Mentally Ill (SMI)
- The following documents must be included
    - Integrated SPOA referral
    - Signed consent form
    - Psychosocial or Psychiatric Assessment with DSM Diagnosis.
- Residential Program requirements are listed on their applications, but must include
    - Service Authorization Form
    - SPMI Form
    - Updated medication list

Descriptions of Programs and Services:

To qualify for housing, the individual must have a primary mental illness diagnosis and meet the SPMI criteria outline in attached forms. In addition, they must be willing to participate in the services that are being offered.

Community Residence: Catholic Charities offers a community residence program. This rehabilitative program is a homelike setting for individuals seeking daily guidance and support while learning to manage their mental illness. This program is staffed 24 hours a day. The community residence program is a transitional program with time-limited lengths of stay. Individuals must be capable of self-preservation and medically suited for the program. Lawrence House & Supportive Apartment Referral

Supportive Apartment Program (Treatment Apartments): Catholic Charities offers a Treatment Apartment Program. These are smaller, individual apartment settings. Staff are available to assist residents during the day and evening hours, as well as by phone during nighttime hours for emergency purposes. Participants work on rehabilitation to develop skills to live more independently. These apartments are turn-key once the program is complete. This program is transitional with time-limited lengths of stay. Lawrence House & Supportive Apartment Referral

Supportive Housing: Catholic Charities' Supportive Housing Program provides on-going rental subsidies to individuals who qualify due to a serious and persistent mental illness (SPMI) documented by a qualified professional and who meet income guidelines. Individuals meet with a Housing Case Manager monthly to discuss their progress and any housing issues. Supportive Housing Referral

Riverview SP-SRO: Catholic Charities offers a SP-SRO housing program that provides on-going rental subsidies to individuals that meet the (SPMI) criteria and who meet income guidelines. Applicants must be capable of independent living. This program is a part of a mixed-used apartment complex partnering with Christopher Communities as the property manager. On-site Peer services are available for clients who desire Peer Support. Participants meet with a Housing Case Manager at least monthly to discuss their progress and any housing issues. Riverview SP-SRO

Non-Medicaid Case Management: Catholic Charities offers community-based support to adults with serious mental illness (SMI) who do not have Medicaid. These services help clients focus on improving mental and physical health, avoiding hospitalization, managing episodes of illness, and maintaining stability at home and in the community. This service uses a person-centered approach to help clients achieve their individual goals. It consists of collaboration with clients and other members of their support network. By coordinating necessary resources, non-Medicaid case management can help support the client in times of crisis and to facilitate a plan for long term recovery.

STEPS: Catholic Charities works with young people to help them lead healthy and successful lives. This program offers support, guidance, and care coordination to adolescents and young adults, including those who are pregnant and/or parenting. Catholic Charities encourage healthy living, positive social interactions, and planning for long-term success with relationships, education, and careers. STEPS uses a person-centered approach to help clients achieve their individual goals. STEPS Referral

Cortland County
Integrated Adult SPOA Referral Packet

Referral Date: _____

Programs Requested: (See previous page for descriptions)

☐ Community Residence	☐ Supportive Apartment Program	☐ Supportive Housing Program
☐ Riverview SP-SRO	☐ Non-Medicaid Case Management	☐ Complex Care Planning
	☐ STEPS (Ages 16-24)	

Referral Source:

Name:	**Referring Agency:**
Telephone #:	**Address:**

Client Information:

Name:		DOB:	Age:
Home Address:		County of Origin:	Phone Number:
Ethnicity:		Medicaid CIN #:	
Gender Identity:		Social Security #:	
Marital Status:		Custody of Children Status:	
☐ HARP Eligible	☐ HARP Enrolled	☐ Unknown HARP Status	
Emergency Contact:	Phone Number:	Address:	Relationship:

Current Diagnosis

Primary Diagnosis: _____
Secondary Diagnosis: _____

Housing:

What is the current living situation of this individual? _____
How long as the individual been living in this situation: _____
Is there any history of homelessness as an adult? ☐ Yes ☐ No
Is there a need for 24-hour supervision? ☐ No ☐ Yes - If yes, why? _____
Has this individual lived in any type of Residential Program before? ☐ No ☐ Yes
If yes, which one and where? _____

Vocational Status:

Highest Completed Education**:** _____
Sheltered workshop: _____
Supportive Employment: _____
Vocational Training: _____
Special Education: _____
Competitive Employment: _____
Other: _____

Criminal Justice Status:

☐ None ☐ Currently Incarcerated Release Date: _____

☐ CPL ☐ Released from jail/prison in the last 30 days ☐ Pending: _____

☐ Parole Officer: _____ ☐ Probation Officer: _____

Does this client own any firearms? ☐ Yes ☐ No

Financial Status:

Currently Receives: ☐ SSI ☐ SSD ☐ VA Benefits ☐Wages

Pending:☐ SSI ☐ SSD

Other: _____

Family and Social Supports:

Family: _____

Friends: _____

Religious: _____

Support Groups: _____

Other: _____

Community Services:

	Needs	Active	Previous (provide dates)	Location /With Whom
Mental Health Residential	☐	☐	☐	
Mental Health Outpatient Treatment	☐	☐	☐	
Psychiatric Hospitalization	☐	☐	☐	
State Psychiatric Center In-Patient	☐	☐	☐	
Care Management	☐	☐	☐	
Mobile Crisis Services	☐	☐	☐	
Horizon House Day Treatment Program	☐	☐	☐	
Substance Use Treatment	☐	☐	☐	
OASAS Housing	☐	☐	☐	
Alcoholics Anonymous/Narcotics Anonymous	☐	☐	☐	
Child Protective Services	☐	☐	☐	
Adult Protective Services	☐	☐	☐	
Representative Payee	☐	☐	☐	
Peer Services	☐	☐	☐	
Health Education	☐	☐	☐	

Domestic Violence Services	☐	☐	☐	
Veteran Services	☐	☐	☐	
Family Support Services	☐	☐	☐	
Respite Services	☐	☐	☐	
Adult Care/SNF	☐	☐	☐	
Skilled Nursing Facility	☐	☐	☐	
OPWDD Care Coordination	☐	☐	☐	
OPWDD Waiver Services	☐	☐	☐	

Mental Health Service Utilization over Last 12 Months:

Number of Mobile Crisis Responses: _____
Number of Law Enforcement Reponses due to Mental Health: _____
Number of Psychiatric Emergency Room Visits: _____
Number of Inpatient Psychiatric Admissions: _____
Facilities & Dates of Previous Psychiatric Treatment/Hospitalizations:

_____

History:

Fire Setting	☐Yes ☐ No ☐ Unknown	If yes, when:
Sexual Offense	☐Yes ☐ No ☐ Unknown	If yes, when:
Violence (causing injury)	☐Yes ☐ No ☐ Unknown	If yes, when:
Aggressive/Assaultive Behaviors)	☐Yes ☐ No ☐ Unknown	If yes, when:
Suicidal Ideations	☐Yes ☐ No ☐ Unknown	If yes, when:
Suicide attempts/gestures	☐Yes ☐ No ☐ Unknown	If yes, when:
Destruction of Property	☐Yes ☐ No ☐ Unknown	If yes, when:
Victim of Physical Abuse	☐Yes ☐ No ☐ Unknown	If yes, when:
Victim of Sexual Abuse	☐Yes ☐ No ☐ Unknown	If yes, when:
Sexually Deviant Behavior	☐Yes ☐ No ☐ Unknown	If yes, when:

Health Care:

Primary Care Physician: _____ Phone Number: _____
Address: _____

Medical Conditions/diagnosis: _____
Mental Health Conditions/diagnosis: _____

Substance Use:

	None	Current Use	Previous Use	
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	Age of first use: _____ Date of last use: _____ Frequency of Use: _____ Longest period of sobriety: _____
Non-Prescribed Substances	☐	☐	☐	Age of first use: _____ Date of last use: _____ Substance of choice: _____ Frequency of Use: _____ Longest period of sobriety: _____

FUNDING VERIFICATION

	Case #	Currently Receives	Amount Received	Pending Application	Unknown
Social Security		☐ Yes ☐ No		☐ Yes ☐ No	☐
SSI		☐ Yes ☐ No		☐ Yes ☐ No	☐
SSD		☐ Yes ☐ No		☐ Yes ☐ No	☐
Public Assistance		☐ Yes ☐ No		☐ Yes ☐ No	☐
Veteran's Benefits		☐ Yes ☐ No		☐ Yes ☐ No	☐
Medicare		☐ Yes ☐ No		☐ Yes ☐ No	☐
Medicaid		☐ Yes ☐ No		☐ Yes ☐ No	☐
Food Stamps		☐ Yes ☐ No		☐ Yes ☐ No	☐
Pension		☐ Yes ☐ No		☐ Yes ☐ No	☐
Wages/Earned Income		☐ Yes ☐ No		☐ Yes ☐ No	☐
Unemployment		☐ Yes ☐ No		☐ Yes ☐ No	☐
Private Insurance		☐ Yes ☐ No		☐ Yes ☐ No	☐
Other 3rd Party Payer		☐ Yes ☐ No		☐ Yes ☐ No	☐
Trust Fund		☐ Yes ☐ No		☐ Yes ☐ No	☐
Medication Grant		☐ Yes ☐ No		☐ Yes ☐ No	☐

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

_____

All referrals and supporting documentation can be sent to Cortland County SPOA Committee for review.

Attn: Cortland County SPOA Committee
7 Clayton Avenue, Cortland, NY 13045
or
Fax: (607) 758-6116

If you are requesting housing assistance, you need to <u>also</u> send the referral to

Attn: Catholic Charities of Cortland County
33-35 Central Avenue, Cortland, NY 13045
or
Fax to the appropriate program below
Lawrence House & Supportive Apartments: (607) 756-4697
Supported Housing: (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: _____

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 Community Residence or Supportive 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: 6 months from date of signature.
Supportive Apartments: 1 year from date of signature.

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.