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**DEPARTMENTS OF MENTAL HEALTH
SOCIAL SERVICES AND YOUTH BUREAU**

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For Putnam County SPOA applications, for Care Management and Housing, please fax application and all required materials to (845) 225-8635 or send to the following address:

**Putnam County Department of Mental Health
110 Old Route 6, Building 2
Carmel, NY 10512
Attention: Renee Prato, SPOA Coordinator**

**If you have any questions regarding this application, please contact Renee Prato at
(845)
808-1500 ext. 45276.**

**DONALD B. SMITH COUNTY GOVERNMENT CAMPUS — BLDG. #2
110 OLD ROUTE SIX — CARMEL, NEW YORK 10512 (845) 808-1500 FAX (845) 225-8635**

MEDICAID UNIT FAX (845) 225-0947
YOUTH BUREAU (845) 808-1600

Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 3)

SPOA UNIT
Adult Mental Health Services
Putnam County Department of Mental Health
Donald. B. Smith County Government Campus 110 Old Route 6, Building 2
Carmel, NY 10512

2. Please review REQUIRED DOCUMENTATION FORM below.

Referrals will NOT be considered complete without:

Complete SPOA Application

Clinical Information as specified below.

3. Upon receipt, application will be reviewed by PCMH for completeness. Incomplete applications will be returned to the referring party.

For questions regarding the SPOA Application, please call (845) 808-1500 ext. 45276.

REQUIRED DOCUMENTATION

Required Documents	Care Management	Housing		
		CR	TX APT	SH
Eligibility Determination	X	X	X	X
Referral Form	X	X	X	X
Psychiatric Evaluation (Including DSM-V and Current within 90 days)	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X
Physical Exam W/ PPD & Immunization Record		X	X	X
Authorization for Restorative Services (MUST BE ORIGINAL)		X		

Eligibility Determination:

In order to be eligible for services through PCMH, applicants for Housing or Care Management Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, **B, C, or D** must be met.

Yes ___ No ___ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary DSMV diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except for those with predominately psychiatric features, or social conditions (V-codes).

Please complete: DSM-V code: _____

Yes ___ No ___ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI ***DUE TO A DESIGNATED MENTAL ILLNESS.***

Yes ___ No ___ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant 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. (Documentation in psychosocial assessment required.)

Yes ___ No ___ a. Marked difficulties in self-care.

Yes ___ No ___ b. Marked restrictions in maintaining social functioning.

Yes ___ No ___ c. Marked difficulties in maintaining social functioning.

Yes ___ No ___ d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school setting.

2. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-V) due to a designated mental illness over the past 12 months on a continuous or intermittent basis.

Yes ___ Date: From _____ To: _____ Score: _____

Yes ___ No ___ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)

Yes ___ No ___ One six month stay in an inpatient psychiatric unit.

Yes ___ No ___ Two stays of any length in an inpatient psychiatric unit in the preceding two years.

Yes ___ No ___ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.

Yes ___ No ___ Six months consecutive residency in a designated Adult Home.

Yes ___ No ___ Six months consecutive residency in a Residential Care Center for Adults (RCCA)

Yes ___ No ___ Six months consecutive residency in a Residential Treatment Facility (RTF)

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #: _____ Military Service: Yes ___ No ___

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Male ___ Female ___ Transgender ___

Citizenship: Yes ___ No ___ (if no, immigration status): _____

Ethnicity

Primary Language

___ White (Non-Hispanic) ___ Black (Non-Hispanic) ___ English ___ Spanish ___ Chinese ___ French
___ Latino/Hispanic ___ Asian/Asian American ___ Italian ___ Russian ___ German ___ Japanese
___ Native American ___ Pacific Islander ___ Other
Other _____

Custody Status of Children

Current Living Situation

___ No children ___ Room ___ Homeless (shelter)
___ Children are all above 18 years of age ___ Own apt ___ Homeless (streets)
___ Minor children currently in client's custody ___ Supervised Living ___ Nursing Home
Number of children: ___ Gender: ___ ___ Supported Housing ___ Psychiatric Hospital
___ Minor children not in client's custody but have access ___ Lives with spouse ___ Lives with Parents
___ Minor children not in client's custody - no access ___ Correctional facility Other _____

Insurance and Financial Information That Applicant Currently Receives:

Social Security Earned Income
SSI/SSD Food Stamps (SNAP)
Public Assistance VA Benefits
Medicaid Representative Payee
Medicare Other _____

Referral Source

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program: _____ Relationship: _____

Psychiatric Information: Please List All

Diagnosis

ICD 10 (F Code)

Current Medical Problems: Please List All

Risk Assessment

Cruelty to Animals	<input type="checkbox"/>	Suicidal Behavior	<input type="checkbox"/>
Fire Setting	<input type="checkbox"/>	Severe Violence	<input type="checkbox"/>
Homicidal Behavior	<input type="checkbox"/>	Sexual Offense	<input type="checkbox"/>

Current Medications: Please List All

Outpatient Treatment Provider

Agency: _____ Program: _____

Contact: _____ Telephone: _____

Substance Abuse History: Please List Drugs of Choice

Length of Time Recipient Has Been Substance Free: _____

Criminal Justice – Current Status

___ None ___ Incarcerated-Jail ___ Incarcerated-Prison ___ Probation ___ Parole Other _____

P.O. Name: _____ Telephone: _____

Number of arrests/Incarcerations in past year _____ Number of lifetime arrests _____

Reason For Arrest: _____ Date: _____

Assisted Outpatient Treatment

Does the person have a court ordered AOT under Kendra's Law? ___ Yes ___ No

Is an AOT under Kendra's Law currently being pursued? ___ Yes ___ No

Care Management Services Requested ___ Yes ___ No

Residential Services Requested in Putnam County ___ Yes ___ No

Type of Housing Requested

Community Residence Apartment Treatment Program Supported Housing

Recipient Requests: _____

Recipient Signature: _____ Date: _____

Referring Party Signature: _____ Date: _____

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

- Initial (Face to Face Assessment) Authorization (must be completed by Physician only)
- Semi-Annual Authorization
- Annual Authorization

Client Name:	
Client Medicaid Number:	
Diagnosis ICD.10:	

I, the undersigned authorized licensed physician/Nurse Practitioner in Psychiatry/Physician's Assistant, have determined that the above named client would benefit from provision of community rehabilitation services as defined pursuant of 14 NYCRR Part 593.4(b).

This authorization is in effect from _____ to _____
Month/Date/Year Month/Date/Year

 Physician/Nurse Practitioner in Psychiatry/Physician's Assistant Signature

 Date of Signature

 Provider's Name (Please Print)

 DEA #

 NYS Provider Licensure #

 National Provider ID # (NPI)