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DEPARTMENTS OF MENTAL HEALTH
SOCIAL SERVICES AND YOUTH BUREAU

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This is a Putnam County Adult SPOA application for Care Management and Housing. Please send the completed application and ALL required materials to renee.prato@putnamcountyny.gov or to the following address:

Putnam County Department of Mental Health
110 Old Route Six, 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

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)

Applicant Information

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

___White (Non-Hispanic)
___Latino/Hispanic
___Native American
Other_____
____Black (Non-Hispanic)
____Asian/Asian American
____Pacific Islander

Primary Language

____English ____Spanish ____Chinese ____French
____Italian ____Russian ____German ____Japanese
____Other

Custody Status of Children

____No children
____Children are all above 18 years of age
____Minor children currently in client's custody
Number of children:____ Gender:_____
____Minor children not in client's custody but have access
____Minor children not in client's custody - no access

Current Living Situation

____Room
____Own apt
____Supervised Living
____Supported Housing
____Lives with spouse
____Correctional facility
____Homeless (shelter)
____Homeless (streets)
____Nursing Home
____Psychiatric Hospital
____Lives with Parents
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	❑	Suicidal Behavior	❑
Fire Setting	❑	Severe Violence	❑
Homicidal Behavior	❑	Sexual Offense	❑

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)