RENSSELAER COUNTY
MENTAL HYGIENE SERVICES APPLICATION

Application forwarded to: *(check all that apply)*
___ Residential (Level?) ____ ___Y/A or MICA CM (UH) AOT Status:____

Client Name:_____ **Date of Application:_____**
DOB: _____ **Referral Source: _____**
Address: _____ **Primary Clinician:_____**
_____ **Psychiatrist:_____**
Current Living Situation: _____ **Treatment Agency_____**
Phone: _____ **Phone: _____**
County of Origin:_____
Parental Status/ages of kids:_____ **Medicaid #:_____**
_____ **SSN:_____**

DSM V Diagnostic Information: *(Include numerical codes)*

_____

_____

_____

Medical Information:

Medication	Amount

Medical Conditions: _____
_____
Medical Provider Name/#:_____

Allergies:_____

Alerts:

List any factors including danger to self/others, legal involvement, assaultive behavior, AOT, arson, suicide attempts/gestures:
History of substance use/abuse:

RENSSELAER COUNTY APPLICATION

Psychiatric History
Brief History of Illness:_____
_____
_____

Length of current hospitalization:_____ Number of ER contacts (*past year):*_____

Reason for Applying to Program: (*include strengths, needs, and goals; specify per service)*
1._____
2._____
3._____

Many programs require group living and group participation. Please comment on this individual's ability to tolerate such an environment:_____
_____

Other service providers/agencies involved:
____Care Coordination ____Tx Program ____Voc/Educational
____Residential

Consumer Comments and Goals:

I plan to participate in my own recovery.	Yes	No
I agree with the recommendations indicated in this application.	Yes	No
I have read and signed the Authorization to Use and Disclose Protected Health information.	Yes	No
I understand the SPOA process.	Yes	No
I would like more information about peer support services (MHEP).	Yes	No

The main goal I want to work on is:_____

_____

Other comments or concerns:_____

_____

Consumer Signature:_____ Date:_____

Referrent Signature:_____ Date:_____

Attachments required with this application: _____Hospitalization Record
_____Physician's Authorization _____SPMI Determination
_____Financial Information _____Current Psychosocial/MSE

_____(client)

Rensselaer County Mental Hygiene Services Application SPMI Determination

To meet the criteria for Severe and Persistent Mental Illness, the following conditions of A and B, or C or D need to be met.

A. **Designated Mental Illness Diagnosis**:
The individual is 18 years or older and currently meets the criteria for a DSM IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions. ICD-9-CM categories and codes that do not have an equivalent in the DSM IV are also not included as designated mental illness diagnoses.

AND

B. SSI or SSD enrollment due to mental illness:
The individual is currently enrolled in SSI or SSDI 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 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:

a. Marked difficulties in self-care: (personal hygiene; diet; clothing; avoiding injuries; securing health care; or complying with medical advice)
b. Marked restriction of activities of daily functioning: (maintaining a residence; using transportation; day to day money management; accessing community services)
c. Marked difficulties in maintaining social functioning:
(establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, 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 in work, home, or school settings; (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 simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

OR

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

OR

D. **Reliance on Psychiatric treatment, rehabilitation, and supports**
A documented history shows that the individual, at some prior time, met the threshold for item C (extended impairment), but the symptoms and/or functioning problems are currently attenuated by medications or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder (i.e. 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 which may greatly reduce the demands placed on the individual, and thereby, minimize overt symptoms and signs of the underlying mental disorder. The following criteria is met:

___A AND ___B OR ___C OR ___D

Clinical Signature_____ Date_____

Consumer Name_____

Hospital	Admit date	Discharge date	Total days	Comments (Psych, medical, rehab/detox)

FINANCIAL INFORMATION

Complete information is necessary to establish and maintain a source of funding and to assist in the screening process.

INCOME (check all that apply)

	Amount
____SSI	_____
____Social Security Disability (SSD)	_____
____Public Assistance	_____
____Wages	_____
____Workers Compensation	_____
____Unemployment Insurance	_____
____Food Stamps	_____

____Medicaid #_____

____Medicare #_____

____Applications pending for above: (Specify) _____

____Other Income: (Specify) _____

Is the applicant his/her own payee? _____Yes _____No

If no, indicate representative payee: _____

RESOURCES (Check all that apply)

	Value
____Checking account	_____
____Savings account	_____
____Patient Account	_____
____Car	_____
____Life Insurance	_____
____Stocks/Bonds	_____
____Property	_____

____Other Resources (Specify) _____

IDENTIFICATION (check all that applicant has)

____Birth Certificate ____Social Security Card

____Drivers License # _____ Exp Date _____

____Passport ____Sheriff's ID #_____

____Other (specify) _____

LIST OUTSTANDING DEBTS:	Amount Owed
_____	_____
_____	_____