**SCHENECTADY COUNTY SINGLE POINT OF ACCESS APPLICATION FOR**

**HOUSING AND CASE MANAGEMENT SERVICES**

**(Only typed Submissions will be accepted)**

 **Referral Date:** Click here to enter a date.

***CLIENT INFORMATION*:**

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| --- | --- |
| **Name**: Click here to enter text. | **Gender**: Choose an item. |
| **Social Security Number**: Click here to enter text. | **County of Origin**: Click here to enter text. |
| **Primary Address** (please include City and Zip Code): Click here to enter text. | **Date of birth**: Click here to enter text. |
| **Client’s phone number**: Click here to enter text. |
| **Emergency contact**: Click here to enter text. | **Relationship to client**: Click here to enter text. |
| **Emergency contact’s Address and Phone**: Click here to enter text. |
| **Marital Status**: Choose an item. | **Health Home Patient**: Choose an item. **AOT Client**: Choose an item. |
| **Ethnic group**: Choose an item. | **Education level**: Choose an item. |
| **Current employment status**: Choose an item. | **Custody of children**: Choose an item. |
| **Current criminal justice status**: Choose an item. | **Specify charges**: Click here to enter text. |
| **Is client currently involved in other legal matters**: Choose an item. **If yes, please specify:** Click here to enter text. | **Sex offender status**: Choose an item. **Notes:** Click here to enter text. |

***REFERENT’S INFORMATION*:**

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| --- | --- |
| **Referred by**: Click here to enter text. | **Agency**: Click here to enter text. |
| **Title**: Click here to enter text. | **Phone number**: Click here to enter text. |
| **Referent’s email address**: Click here to enter text. |
| **Reason for referral** (Client’s needs & goals) **Be Specific:** Click here to enter text. |

***CLIENT’S FINANCIAL INFORMATION*:**

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| **Medicaid #**: Click here to enter text. **Medicare #**: Click here to enter text. |  |
| **Private insurance information**: Click here to enter text. |
| **Entitlements and income (check appropriate boxes and attach award/shelter letter)**:[ ]  SSI/SSD [ ]  Food Stamps [ ]  Workers Compensation [ ]  Public Assistance [ ]  Pension: Amount: $Click here to enter text. [ ]  Other (trust fund, unemployment, etc: $Click here to enter text.[ ]  Veteran’s Benefits: Click here to enter text. |
| **Does this client have a Representative Payee**? Choose an item. | **If yes, who**? (Enter contact name) Click here to enter text. |

***CLIENT’S NEEDS*:** When a need is Indicated → Complete notes section in detail

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| **Housing / Basic Needs:** * [ ]  24-hr. on site staff supervision
* [ ]  Daily Medication Management *(Staff provide medications to client daily)*
* [ ]  Home Health Aide Services
* [ ]  Meals provided to applicant

*( Is unable to cook and needs someone to cook and provide each meal)** [ ]  No ability to self-preserve (exit home unattended in 3 minutes
* [ ]  Needs assistance managing money ( Be specific)
 | **Notes:** Click here to enter text. |
| **Treatment Needs / Issues:** * MH OP TX in place? Choose an item.
* Day Tx / Psychiatric Rehab? Choose an item.
* Substance Abuse Tx Svcs? Choose an item.
* Recent MH Hospitalization?
	+ # in last 6 months:Click here to enter text.

  | **Notes:** Click here to enter text. |

***ALERTS* –**

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| [ ]  **Danger to self**  [ ]  **Danger to others** *(List Risk factors including assaultive behavior, arson, legal involvement, suicide attempts/gestures)* | Specify: Click here to enter text. |
| [ ]  **Physical abuse*** [ ]  Victim [ ]  Abuser
 | Specify: Click here to enter text. |
| [ ]  **Sexual abuse*** [ ] Victim [ ] Abuser
 | Specify: Click here to enter text. |
| [ ]  **Drug / Alcohol Abuse History** | Specify: Click here to enter text. |
| [ ]  **Medical issues**: Choose an item.* Specify: Click here to enter text.
 |
| [ ]  **Adult history of homelessness** | Specify: Click here to enter text. |

***CLINICAL INFORMATION*:**

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| **DSM DIAGNOSIS (Enter both diagnosis and code):*** Current Mental Health Dx: Click here to enter text.
 |
| **CURRENT TREATMENT TEAM:** |
| **Agency name**: Click here to enter text. | **Agency phone**: Click here to enter text. |
| **Psychiatrist’s name**: Click here to enter text. | **Psychiatrist’s phone**: Click here to enter text. |
| **Clinician’s name**: Click here to enter text. | **Clinician’s phone**: Click here to enter text. |
| **Care Management Agency:** Click here to enter text. **Assigned Care Manager**: Click here to enter text. | **Care Manager’s phone**: Click here to enter text. |
| **Clinical Treatment appointments:** * **Telehealth**: Click here to enter text.
* **In person:** Click here to enter text.
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***MEDICAL*:**

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| **Medications (Psychiatric & Medical): ( Please send medication list with packet)** |
| **Medication** | **Dose/Schedule** | **DR/NP Prescribed** | **Medication** | **Dose/Schedule** | **DR/NP Prescribed** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Date of COVID vaccine if applicable**(please send proof with application) |  |  |  |  |
| **Medical Providers:** |
| **Primary care physician’s name**: Click here to enter text. | **Physician’s phone**: Click here to enter text. |
| **Dentist**: Click here to enter text. | **Dentist phone**: Click here to enter text. |
| **Eye Doctor**: Click here to enter text. | **Eye Doctor Phone**: Click here to enter text. |
| **Specialty Doctors**: Click here to enter text. | **Specialist phone number**: Click here to enter text. |
| **Allergies**: Click here to enter text.  |
| **What level of support does the client require to achieve medication compliance?** Click here to enter text. |

***HOSPITALIZATION HISTORY*:**

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| **To the degree known, list all psychiatric hospitalizations:** |
| **Hospital** | **Admit Date** | **Discharge Date** | **Comments** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  |  |  | [ ]  Continued on separate Sheet |
| **Please give a brief history of the client’s illness**: Click here to enter text. |
| **Mental health service utilization for the past 12 months**:* Number of inpatient hospitalizations: Click here to enter text.
* Number of days in the hospital: Click here to enter text.
* Number of psychiatric emergency room visits w/o admission: Click here to enter text.
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***SUBSTANCE ABUSE HISTORY*:**

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| **Does this client have a history of drug/alcohol abuse/dependency**: Choose an item.* If yes, at what age did abuse begin? Click here to enter text.
 |
| **Date of last use**: Click here to enter text. | **Longest period of sobriety**: Click here to enter text. |
| **Drug(s) of choice**:[ ]  Tobacco [ ]  Alcohol [ ]  Cannbinoids [ ]  Opiods [ ]  Stimulants [ ]  Club Drugs [ ]  Hallucinogens [ ]  Prescription Drugs [ ]  Other compounds: Click here to enter text. |
| **List treatments beginning from most recent** |
| **Level of Care** | **Admit Date** | **Discharge Date** | **Comments** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| (**SA History be specific**):  |
| **Substance abuse service utilization for the past 12 months**:* Number of inpatient rehabs: Click here to enter text.
* Number of admissions for detoxification: Click here to enter text.
* **Number of inpatient psychiatric hospitalizations where substance abuse was a prominent issue**: Click here to enter text.
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***CONSUMER STATEMENT*:**

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| **If the consumer chooses, they may use this space to express any information relevant to the above referral. This may include immediate and long term goals, personal needs, concerns, etc. (This section may be hand written by client.)** |
| Click here to enter text. |
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**UNIVERSAL RELEASE OF INFORMATION:**

All referrals for housing services should be forwarded to the Single Point of Access Coordinator. Referrals will be shared with the SPOA Committee, which is comprised of, but not limited to, representatives from Bethesda House of Schenectady, Capital District Psychiatric Center, Schenectady Community Support Center, Mohawk Opportunities, Rehabilitation Support Services, YMCA, ACT Team, Schenectady County Adult Protective Services, Hometown Health, DePaul Housing, Schenectady Community Action Program, New Choices Housing, Capital Region Health Connections, CDPHP, Catholic Charities, Northern Rivers and Ellis Medicine. This release may be used to request information from Capital Region BOCES, Schenectady County Department of Social Services, Schenectady County Probation, Schenectady County Adult Protective Services, NYS Parole, NYS Office of Mental Health, NYS Office of Alcoholism and Substance Abuse Services, NYS Office for People with Developmental Disabilities, NYS Department of Corrections and other contract agencies through the Schenectady County Office of Community Services. All client information will be used by the SPOA committee and the referral agency to assist in determining appropriate placement. My consent to release information will be used only during the application process and while on a waiting list for these services. I understand that this consent can be revoked at any time.

**IN COMPLIANCE WITH FEDERAL HIPPA REGULATIONS; ALL REFERRALS MUST BE SIGNED BY CLIENT AND ONE WITNESS.**

Signature of Client Date signed by Client

Signature of Witness Date signed by Witness

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| **FOR ALL REFERRALS: MUST INCLUDE THE FOLLOWING SUPPORTING DOCUMENTATION TO BE PROCESSED:*** [ ]  Current psych assessment signed by psychiatrist or nurse practitioner
* [ ]  Core history updated over the past year
* [ ]  Most recent physical examinations
* [ ]  Most recent TB test
 |

***Please make sure all boxes are completed. If it doesn’t apply please add N/A***

***Handwritten referrals WILL NOT be accepted.***

***Please type the information on the form.***

Please fax to Michelle Cejka at 518-386-2212.