*This application packet must include:*

* *The* ***Albany County Single Point of Access (SPOA) Release of Information;*** *on the Release of Information, list current service providers, the referring agency, medical providers, supportive family/advocates and former providers who are relevant to the referral being made.*
* *Additional attached information including copy of insurance card(s), most recent psychiatric assessment, psychosocial, lab test results, medication list, physical exam, treatment plan and any other documentation that can assist service linkage; additional information may be required dependent on type of service.*

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| **Date of Application:** |  | **Referent Name/Agency** |  |
|  |  | **Referent Telephone #(s)** |  |

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| **Services Applying for (*check all that apply)*** | | | |
| **Clinical Treatment** | **Care Management** | **ACT** | **Peer Support** |
| **PROS** | **CTT/Aging Out Adoles.** | **Residential** | **Other:** |

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| **Demographics** | | | |
| **Patient Name/Alias:** |  | **Patient Telephone #(s):** |  |
| **Date Of Birth:** |  |
| **Social Security # :** |  | **Emergency Contact Name:** |  |
| **Address:** |  | **Emergency Cont. Relation:** |  |
| **Emergency Contact #:** |  |

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| **Financial Information** | | | |
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| **Insurance Name(s)** |  | **Income Sources/** |  |
| **and Policy #s** |  | **Amounts:** |  |
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| **Public Assistance: Current**  **Yes** **No** | | **Application:  Yes No Date** | |

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| **Medical History** | | | | | | | | | |
| **Primary Care Provider:** | |  | | | **PCP Phone #:** |  | | **PCP Fax #:** |  |
| **Other Medical Providers:**  **(List Name/Phone /Fax)** | | |  | | | |  | | |
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| **Allergies:** |  | | | | | | | | |
| **Medical Conditions/Special Needs:** | | | |  | | | | | |

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| **Current providers/Agencies Involved with the Patient (Agency/Name/Telephone #):** | | |
|  |  | **Anticipated Discharge Date?** |
| **Primary Clinician:** |  |  |
| **Psychiatrist:** |  |  |
| **Health Home:** |  |  |
| **Residential:** |  |  |
| **Vocational:** |  |  |
| **Other:** |  |  |
| **Other:** |  |  |

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| **Behavioral Health History** | | | |
| **Alerts (List risk factors including danger to self/others, CPL Status, assaultive behaviors, arson, legal involvement, suicide history)** | | | |
|  | | | |
| **Current Psychiatric Admission** | | **Yes**  **No Admit** **Date**       **Anticipated** D**ischarge** | |
| **Psychiatric History:** |  | | |
| **Substance Use History:** |  | | |
| **DSM Diagnoses:** |  | |  |
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| **Legal history (current/past Convictions, incarcerations, cps, parole, probation, etc.; include reasons)** |
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| **Reason for applying to program(s) (include patient strengths, needs and goals; specify per services)** | | | |
| **1.** |  | **4.** |  |
| **2.** |  | **5.** |  |
| **3.** |  | **6.** |  |

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| **Please state individual’s ability to tolerate a group structure (for living and/or clinical participation).** |
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| **Does the patient have family/others, involved in your recovery?** | |
| **Yes  No If yes, who?** | |
| **I would like more information about family support services?** | **Yes  No** |
| **I would like more information about peer support services?** | **Yes  No** |

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| **Patient Comments and Goal Statements** | |
| **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 Single Point of Access (SPOA) Release of Information.** | **Yes  No** |
| **I understand the SPOA Process.** | **Yes  No** |
| **The main thing I want to work on is:** | |

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| **Other comments/concerns/information:** |

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| **Patient Signature** |  | **Date** |  |
|  |  |  |  |
| **Referent Signature** |  | **Date** |  |
|  |  |  |  |