Essex County
Single Point of Access (SPOA) Committee

UNIVERSAL REFERRAL FORM
FOR CARE MANAGEMENT AND SUPPORTED HOUSING

Name of Individual: _____ DOB: _____

Current Address: _____

I agree to be considered for adult case management and/or housing services. I have been informed as to the nature of these services and understand that participation in any of these programs is voluntary.

I understand that with my agreement, acceptance into one of the care management and/or supported housing programs is decided by Essex County's Single Point of Access Committee. I understand that this committee is comprised of representatives from community agencies. Community agencies represented include, but are not limited to: Adirondack Health Institute, Essex County Mental Health, Mental Health Association in Essex County, Inc., Essex County Department of Social Services, Families First, ACCESS-VR, Mobile Integration Team, Sunmount DDSO, Mountain Lake Services, ACAP, Essex County Probation, Essex County Community Services, UVMHN- CVPH, HAPEC, St. Joseph's, The Colby Center, Glens Falls Hospital, Alliance for Positive Health, Citizen Advocates, Behavioral Health Services North, Fort Hudson.

I understand that the members of this committee are bound to maintain the highest standards of confidentiality defined by law and are not to disclose information that identifies me personally, outside of the SPOA Committee process. I understand that it is the role of the committee to oversee the use of adult case management/housing services in Essex County and to decide which level of service, depending upon availability and program eligibility requirements, is most appropriate for each individual based on their needs and desires. In making its decision, the committee will use and possibly discuss all information provided by the individual agency representatives regarding my circumstances. I understand that I may request that an agency, which possesses my protected health information, exclude or hold private specific information from SPOA Committee consideration.

By signing this authorization, I give my permission for members of the Single Point of Access Committee to share information necessary to describe my situation, and to determine the most appropriate service or services based on my needs and desires. I understand that upon my written request, I may withdraw my permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future applications for these services. Unless my permission is withdrawn I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Withdrawal of Request/Authorization

I voluntarily withdraw my request for case management and housing services and in doing so withdraw my authorization for the Single Point of Access Committee to continue to share information regarding my circumstances. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Individual's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Essex County
Single Point of Access (SPOA) Committee

Care Management ☐		**Supported Housing ☐**	
Individual Being Referred			
Name:	**Sex:**	**DOB:**	**Age:**
Address:			**County:**
Phone:	**Social Security #:**	**Marital Status:**	
Religion:	**Legal Status:**	**Veteran: ☐Y ☐N**	
Current Living Arrangement:			
Health Insurance			
Medicare:	**Medicaid:**	**Private:**	
Financial Information/sources of income (If applied and not yet receiving a potential source of income, please describe & give date of application)			
Monthly Income:		**Employer:**	
SSI:	**SSD:**	**PA:**	**VA:**
Alimony:	**Child Support:**	**Retirement:**	**Other:**
Existing Rep. Payee? ☐Y ☐N (Name, phone #)			
Emergency Contact			
Name:	**Relationship:**	**Phone:**	
Address:			
Referred By			
Name:	**Title:**	**Agency:**	
Address:		**Phone:**	
		Fax:	
Psychiatric Data			
Diagnosis:			

Essex County
Single Point of Access (SPOA) Committee

Current Mental Health Services **(Include Name and Phone Number of Clinic, Primary Therapist, Psychiatrist And/or Relevant Providers)**
Other Agencies Involved With This Individual
Psychiatric Hospitalizations

Currently Hospitalized: ☐ Y ☐ N	**Admission Date:**	**Anticipated/Actual Discharge Date:**
Where will the individual be referred upon discharge, if not already linked to outpatient mental health services?		

Past Psychiatric Hospitalizations (Dates, Locations, Reasons)		
Date	**Location**	**Reason**

Current Medications (Dosage and Frequency) (Psychiatric and Medical)		
Medication Name	**Dosage**	**Frequency**

Risk Factors	**Yes**	**No**	**Comments**
Drug/Alcohol Abuse/Use	☐	☐	
Non-Compliance With Treatment	☐	☐	
AOT Referred	☐	☐	
Mild or Moderate Stress Creates Exacerbation of Symptoms	☐	☐	
Difficulty Coping with Major or Multiple Medical Problems	☐	☐	
Suicide Attempts	☐	☐	
Self-Injurious Behavior	☐	☐	
Trauma	☐	☐	
Sexual Misconduct	☐	☐	
Sexual Offender	☐	☐	Level:
Transportation needs	☐	☐	

Essex County
Single Point of Access (SPOA) Committee

Risk Factors (cont)	Yes	No	Comments
Problems with Self Direction/Concentration	☐	☐	
Difficulty With Self Care	☐	☐	
Difficulty with ADL's	☐	☐	
Lack of Support System	☐	☐	
Frequent Crisis Contacts	☐	☐	
Parent/Child Problems	☐	☐	
Chronic Vocational/Economic Problems	☐	☐	
Property Damage	☐	☐	
History of Violence	☐	☐	
Temper Outbursts	☐	☐	
Incarceration	☐	☐	
Chronic Housing Problems** Describe	☐	☐	
Chronic Legal Problems	☐	☐	

Criminal History		
Offense	**Outcome**	**Date**

Safety Concerns
Safety concerns are addressed to assure that case managers can safely go into the home

Safety issues around this person or others in the household? ☐ Y ☐ N (Explain)

Firearms, swords, weapons in the home? ☐ Y ☐ N (Explain)

Animals in the home (dogs that are dangerous?) ☐ Y ☐ N (Explain)

Medical Information (Housing Only)	Yes	No	Comments
Physical Exam (Within 1 year)	☐	☐	

Medical Information	Yes	No	Comments
Cardiac/COPD Problems	☐	☐	
Diabetes	☐	☐	
Seizure Disorder (Indicate Date of Last Seizure)	☐	☐	
Allergies	☐	☐	
Special Diet	☐	☐	
Limited Ambulation	☐	☐	Able to do stairs?
Any Restriction of Activities	☐	☐	

Essex County
Single Point of Access (SPOA) Committee

Statement of Need **(Describe what the person sees as his/her concrete case management needs in terms of advocacy, linkage, monitoring, or state the reason(s) individual needs requested level of housing.)**

Signature of Individual Making the Referral: _____ Date: _____

Signature of Individual Being Referred: _____ Date: _____

SEND REFERRAL FORM TO: Essex County Mental Health, Adult SPOA Coordinator: FAX# (518) 873-3777 (OR) PO Box 8, 7513 Court St., Elizabethtown, NY 12932 Phone: (518) 873-3670

ATTACHMENTS NEEDED:

☐ Current SPMI Form