OTSEGO COUNTY COMMUNITY SERVICES

SINGLE POINT OF ACCESS

140 CT. HWY 33W, SUITE 1, COOPERSTOWN, NEW YORK 13326
PHONE: (607) 547-1621 · FAX: (607) 547-1618

ADULT UNIVERSAL REFERRAL FORM

URF Application Must Include the Following:

- ☐ The Universal Referral Form (URF). Please answer all questions. Type answers when possible or write legibly. Indicate if information is Unknown (U/K) or Not Applicable (N/A).
- ☐ A Comprehensive Psychosocial Summary completed or updated within the last 6 months.
- ☐ A Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner and completed or updated within the last 6 months.
- ☐ SPOA Release Form and Community Support Services Determination Form.
- ☐ Do not include any HIV or HIV related information (diagnosis/medications) in this application.

Service Being Requested:
- O Community Residence Program
- O Treatment Apartment Program
- O Supported Housing Program
- O Mountain View Recovery Program
- O Vocational and/or Educational Services
- O Assisted Outpatient Treatment

NOTICE REGARDING DISCLOSURE OF CONFIDENTIAL INFORMATION

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as other wise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

Section A: Demographics

1. Name: First _____ Last _____

2. DOB: _____ 3. Sex M / F

4. Medicaid # (if applicable): _____ Seq #: _____

5. Primary Language

O American Sign Language	O Hindi	O Spanish
O Cantonese	O Indic	O Urdu
O Chinese	O Italian	O Vietnamese
O Creole	O Japanese	O Yiddish
O English	O Mandarin	O No Language
O French	O Polish	O Unknown
O German	O Portuguese	O Other (specify):
O Greek	O Russian	_____

6. English Proficiency: O Does not speak English O Poor O Fair O Good O Excellent

7. Social Security Number: _____
If not provided, indicate reason: O Applicant declines to provide O Does not have SSN

8. Applicant Address (If applicant is homeless, not the shelter/drop in center or place where he/she may be contacted. If applicant is hospitalized and being discharged to a different address, or if the applicant is homeless and moving into housing, please indicate new address/contact information.):

Address: _____

_____

_____

_____

Telephone # _____ Cell # _____

9. Applicant's Race/Ethnicity (Check all that apply):

O White, European American	O Vietnamese	O Latino/Latina
O Black, African American	O Other Asian	O Korean
O American Indian or Alaskan Native	O Native Hawaiian	O Unknown
O Asian Indian	O Guamanion/Chamorro	O Other Pacific Islander
O Chinese	O Samoan	O Other (specify):
O Filipino	O Japanese	_____

10. Religious Preference: _____

11. Military History: O Yes O No

Section B: Family Contacts

1. Marital Status (Check one):

O Single, never married	O Currently married	O Widowed
O Cohabiting with significant other or domestic partner	O Divorced/Separated	O Unknown
		O Other _____

2. Family/Friend/Emergency contacts(s) (Include name, address, telephone number and relationship):

Name: _____ Relationship: _____

Address: _____

Telephone #: _____ Cell #: _____

Name: _____ Relationship: _____

Address: _____

Telephone #: _____ Cell #: _____

3. List everyone who lives with applicant and their relationship:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section C: AOT

AOT: O Yes O No

If Yes: Effective Date: _____ Expiration Date: _____

AOT Contact Person: _____ Phone #: _____

Section D: Characteristics

1. Current Living Situations (Check one):
   - O Private residence, alone
   - O Private residence with spouse or domestic partner
   - O Private residence with parent, child, other family
   - O Private residence with others
   - O MH Supported Housing
   - O Community Residence Program
   - O Treatment Apartment Program
   - O Inpatient state psychiatric hospital
   - O Inpatient, general hospital or private psychiatric
   - O DOH adult home
   - O Drug or alcohol abuse residence or inpatient setting
   - O Correctional facility
   - O Homeless, undomiciled
   - O Shelter or emergency housing
   - O Unknown
   - O Other (specify): _____

2. Has the applicant ever been homeless: O Yes O No

3. If applicant is currently homeless, where did applicant reside prior to current episode of homelessness? (Indicate name of facility if applicable):
   - O Own apartment/house
   - O Single room occupancy
   - O With family
   - O Community residence
   - O With friends
   - O Jail/prison facility
   - O Adult home
   - O Inpatient psychiatric
   - O Unknown
   - O Other (specify): _____

   Facility Name: _____ Address: _____

   Length of occupancy: _____

   Reason for leaving: _____

4. Has an application for HUD housing been submitted for this applicant?
   O Yes O No O Not applicable O Unknown

5. Current Employment Status (Check one):
   - O No employment of any kind
   - O Competitive employment
   - O Supported employment
   - O Other: _____
   - O Unknown

6a. Highest level of education completed: _____

6b. Any special degrees/certificates: _____

7a. Income or benefits currently receiving (Check all that apply):

O Wages, salary or self-employed
O Supplemental Security Income (SSI)
O Social Security Disability Income (SSD)
O Social Security Retirement, Survivor's Dependent's (SSA)
O Veteran benefits
O Worker's Compensation or Disability Insurance
O Medicaid
O Medicaid pending
O Medicare
O Public assistance cash program, TANF, Safety, temporary disability
O Private insurance, employer coverage, no-fault, or third party insurance
O None
O Ineligible (Reason): _____
O Other: _____

7b. For any current benefits checked in Question 7a, indicate the type and amount per month:

Type of benefit	Amt. per mo.	Type of benefit	Amt. per mo.
1. _____		3. _____	
2. _____		4. _____	

7c. Describe any special payee arrangements and the name and address of Representative Payee:

_____

_____

_____

_____

8. Current Criminal Justice Status (Check all that apply):

O Applicant is not under Criminal Justice Supervision
O CPL 330.20 order of conditions and order of release
O In NYS Dept. of Correctional Services (State Prison)
O On bail, released on own recognizance (ROR), conditional discharge, or other alternative to incarceration
O Under probation supervision (PO/Contact) _____
O Under parole supervision (PO/Contact) _____
O Under arrest in jail, lockup or court detention
O Released from jail or prison within the last 30 days
O Unknown
O Other (specify) _____

Section E: Clinical

1. Clinical Disorders and other conditions that may be focus of clinical attention. *General Medical Disorders, as well as any Chronic Disorders. If none, please indicate with N/A.*

Diagnosis (if none, please indicate)	ICD 10 Code

2. Psychosocial and Environmental Problems (Check all that apply):

O Problems with primary support group
O Problems related to the social environment
O Educational/Occupational problems
O Insurance or Benefit problems
O Housing problems
O Economic problems
O Problems with access to health care facilities/referrals
O Problems related to legal system/crime
O Unknown
O Other _____

3. Current Psychotropic Medications. If none prescribed, please check here O.

Name	Dosage	Schedule	Reason Taken

4. Current Medications for Physical Illness. If none prescribed, please check here O.

Name	Dosage	Schedule	Reason Taken

5. Applicant Adherence to Medication Regimen (Check one):
   - O Takes medication as prescribed
   - O Takes medication as prescribed most of the time
   - O Sometimes takes medication as Prescribed
   - O Rarely or never takes medication as prescribed
   - O Applicant refuses medication
   - O Medication not prescribed
   - O Unknown
   - O Other (specify): _____

6. What level of support is required for compliance with medication regimen (Check one):
   O None, independent O Reminders O Supervision O Dispensing O N/A O Unknown

7. Are there any safety concerns? _____
   _____
   _____

8. Does applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support and/or a therapeutic diet?
   O Yes O No
   If yes, please describe: _____
   _____
   _____

9. Name of treating medical MD or facility: _____ Phone #:_____

10. Medical Tests: Has applicant been tested for TB in the past year? O Yes O No

11. Physical Functioning Level:
    - Y / N Fully ambulatory
    - Y / N Climbs one flight of stairs
    - Y / N Needs wheelchair accessible housing
    - Y / N Other: _____

Section F: Utilization

1. Applicant services within the last 12 months (Check all that apply):
   - O None
   - O State Psychiatric Center, Inpatient Unit
   - O General Hospital or Certified Psychiatric Hospital
   - O Mental Health Housing/Housing Support
   - O Mental Health Outpatient Clinic
   - O Alcohol/Drug Abuse Inpatient Treatment
   - O Alcohol/Drug Abuse Outpatient Treatment
   - O Emergency Mental Health
   - O Care Coordination
   - O ACT, Care Coordination or other Case Management
   - O Prison, Jail or Other Court Mental Health service
   - O Local Mental Health Practitioner
   - O Assisted Outpatient Treatment (AOT)
   - O Self Help/Peer Support Services
   - O Community Support Program Non-Residential Mental Health Program
   - O Unknown
   - O Other _____

2. Psychiatric Services utilization including current hospitalization if applicable. (Indicate the number of utilization for each. Include a "0" if none, "UK" is unknown.

   Psychiatric hospitalizations in the last 12 months: _____
   Emergency Room/Mobile Crisis Visits for Psychiatric Conditions in the last 12 months
   (Note: Only those ER/Mobile Crisis visits that did NOT result in a psychiatric admission): _____
   Psychiatric Hospitalizations in the last 24 months: _____
   Arrests in the last 12 months: _____

3. To degree known, list all psychiatric hospitalizations (including current), psychiatric emergency room visits and mobile crisis visits within the last two years. OMH Residential Treatment Facilities are considered inpatient. (This information is required to determine eligibility for service).

Hospital/ER/Mobile Crisis Admission Date Discharge Date* Source of Date

_____

_____

_____

_____

_____

**(If currently hospitalized, expected Discharge Date)*

4. Indicate any mental health or substance abuse program the applicant attends, have previously attended in the last 24 months, and/or if program is part of the discharge plan (e.g. mental health clinic, substance abuse treatment program, day treatment, vocational services program). Indicate whether program is: **C = C**urrently attending or **P = P**reviously attended.

Dates	Program Name	Contact Name	Telephone Number	C or P

5. Indicate any current Interagency Involvement.

Agency	Contact Person	Phone #

Section G: Wellbeing

Key

0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, But not in the past 3 months
3=one or more times in the past 3 months But not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
6=daily
U=unknown

1. High Risk Behavior (Indicate one response for each):

	0	1	2	3	4	5	6	U
a. How often did applicant do physical harm to self?	O	O	O	O	O	O	O	O
b. How often did applicant attempt suicide?	O	O	O	O	O	O	O	O
c. How frequently did applicant physically abuse another?	O	O	O	O	O	O	O	O
d. How frequently did applicant assault another?	O	O	O	O	O	O	O	O
e. How frequently was applicant a victim of sexual abuse?	O	O	O	O	O	O	O	O
f. How frequently was applicant a victim of physical abuse?	O	O	O	O	O	O	O	O
g. How frequently did applicant engage in arson?	O	O	O	O	O	O	O	O
h. How frequently did applicant engage in accidental fire setting?	O	O	O	O	O	O	O	O
i. How often did applicant exhibit the following symptoms?								
Homicidal attempts	O	O	O	O	O	O	O	O
Delusions	O	O	O	O	O	O	O	O
Hallucinations	O	O	O	O	O	O	O	O
Disruptive behavior	O	O	O	O	O	O	O	O
Severe thought disorder	O	O	O	O	O	O	O	O
Other (specify):	O	O	O	O	O	O	O	O

j. Please comment below on any above selections:

2. Does applicant have current or history of substance abuse: O Yes O No
If yes, complete the questions below.

	0	1	2	3	4	5	6	U
a. Alcohol	O	O	O	O	O	O	O	O
b. Cocaine	O	O	O	O	O	O	O	O
c. Amphetamines	O	O	O	O	O	O	O	O
d. Crack	O	O	O	O	O	O	O	O
e. PCP	O	O	O	O	O	O	O	O
f. Inhalants	O	O	O	O	O	O	O	O
g. Heroin/Opiates	O	O	O	O	O	O	O	O
h. Marijuana/Cannabis	O	O	O	O	O	O	O	O
i. Hallucinogens	O	O	O	O	O	O	O	O
j. Sedatives/hypnotics/anxiolytics	O	O	O	O	O	O	O	O
k. Other prescription drug abuse	O	O	O	O	O	O	O	O
l. Tobacco	O	O	O	O	O	O	O	O
m. Other (specify)	O	O	O	O	O	O	O	O

3. Co-occurring disabilities (Check all that apply):

O Drug or alcohol abuse	O Tobacco	O Bedridden
O Cognitive disorder	O Wheelchair required	O Amputee
O Mental retardation/developmental disorder	O Hearing impairment	O Incontinence
	O Speech impairment	O None
O Blindness	O Visual impairment	O Other (specify)
O Impaired ability to work	O Deaf	_____

Section H: Referral Source

Referring Agency Information:

Agency Name: _____

Program/Unit Name: _____

Primary Contact: _____

Primary Contact phone number: _____ Fax number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date: _____

INDIVIDUAL'S STATEMENT

This section is provided so the individual can provide any information relevant to the services they are requesting, including special needs and preferences.

_____

_____

_____

_____

_____

_____

_____

_____

Review the following statement with the individual being referred for services and have them sign statement.
I am aware that I am being referred to the Otsego County Single Point of Access Committee to match my clinical needs with community support programs. I have had the opportunity to review the list of services above and have participated in the completion of the SPOA application. I am aware that the SPOA Coordinator will be contacting me if further information is required and to answer any questions I have about the SPOA process. I also am aware that I may attend the SPOA meeting where my case will be reviewed.

Applicant's Signature: _____ Date: _____

OTSEGO COUNTY COMMUNITY SERVICES

SINGLE POINT OF ACCESS

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC INFORMATION

NAME: _____ DOB: _____

I, _____ (Patient/Client/Legal Representative) hereby authorize the following agencies to _X_ release information to, _X_ receive information from SPOA, Otsego County Community Services, 140 County Hwy 33W, Cooperstown, NY 13326:

____ Rehabilitation Support Services	____ Otsego County Comm. Svcs.	____ Bassett Hospital Psychiatric Dept.
____ Otsego County Mental Health	____ Opportunities for Otsego	____ Protective Services for Adults
____ Social Security	____ Dept. of Social Services	____ Catholic Charities
____ OPWDD	____ In-Home Stabilization	____ Bassett Health Home
____ Southern Tier	____ Bassett Care Management	____ Probation/PINS
____ Parole	____ Early Intervention	____ Otsego Co. Dept. of Health
____ Office for the Aging/NY Connects	____ Family Resource Network	____ MCAT
____ Excellus Managed Medicaid	____ Fidelis Managed Medicaid	____ Catskill Ctr. for Independence
____ Mobile Integration Team	____ FORDO/Turning Point	____ LGU
____ Other _____	____ Other _____	____ Other _____

EXTENT or NATURE OF INFORMATION TO BE DISCLOSED:

____ Psychiatric assessments, treatment history, medication history, current treatment plan
____ Medical History
____ Service Plans, Admission/Discharge Summaries
____ Other: _____

REASON FOR RELEASE OF INFORMATION:

____ Information is required as part of application process to determine appropriateness for services
____ To assist in assessment/service planning
____ To coordinate services
____ Follow-up post discharge
____ Other: _____

Covering the period(s) of healthcare from (date): ____/____/____ to (date) ____/____/____, I understand that only the minimum amount of health information necessary to achieve the purposes of the disclosure will be released and only for the dates authorized above. I understand that I can revoke this authorization in writing at any time, except to the extent that actions were already taken based upon the original authorization. Unless otherwise revoked, this authorization will expire in one year from signature, ____/____/____ (enter expiration date). I understand the Agency cannot condition my continued or future treatment on whether I provide authorization for the requested use of disclosure and that I can refuse to sign authorization.

As allowed by law, the Agency is entitled to receive payment for the administrative costs incurred when fulfilling a request to copy records.

I understand that information used from that disclosed as a result of this signed document may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For records that contain reference to alcohol and substance treatment, the recipient understands that re-disclosure without patient/client consent will be subject to severe penalties under 42 CFR Part 2.

Signature of Patient/Client: _____ Date: __/___/___

Print Name: _____

Signature of Legal Representative: _____ Date: __/___/___

Print Name: _____

Description of Legal Representative's Authority: _____

Signature of Witness: _____ Date: __/___/___

Print Name: _____

COMMUNITY SUPPORT SERVICES ELIGIBILITY DETERMINATION

1. Name: _____
2. Social Security Number: _____ 3. DOB: _____

4. Most recent Mental Health Diagnosis (must fit the criteria of the DSM-IV or DSM-V. Must be other than, or in addition to, a diagnosis of alcohol, drug disorders, organic brain syndromes, developmental disabilities or social conditions.
   A. Principal Diagnosis: _____ Code # _____
   B. Other Diagnosis: _____ Code # _____
   C. Other Diagnosis: _____ Code # _____

5. Client is functionally disabled due to a mental illness and without provision of community support services client's ability to remain in the community would be seriously jeopardized.
   [ ] Yes [ ] No

6. Client is functionally disabled due to a mental illness in the following areas (Check all that apply):
   [ ] Self Care [ ] Social Functioning [ ] Activities of Daily Living [ ] Economic Self-Sufficiency
   [ ] Self Direction [ ] Ability to Concentrate

7a. I certify that this client is eighteen years of age or older, functionally disabled due to a mental illness, has the required diagnosis and:
   [ ] One six-month stay in an inpatient psychiatric unit
   [ ] Two stays of any length in an inpatient psychiatric unit in the preceding two years
   [ ] Client is 620/621 eligible
   [ ] Three or more admissions to an OMH operated or licensed mental health outpatient program or a forensic unit operated by OMH within the preceding 18 months; or three or more contacts with crisis or emergency mental health services within the preceding 18 months; or a combination of the three admissions or contact within the preceding 18 months
   [ ] SSI/SSD recipient due to mental illness
   [ ] Twelve months active enrollment as a waived client
   [ ] Six months consecutive residency in a designated adult home
   [ ] Six months consecutive residency in a community residence program

Signature: _____ Title: _____
Print Name: _____ Today's Date: _____

OR

7b. Waiver requested by: _____ Title: _____
Print Name: _____ Today's Date: _____

(needs to be completed by therapist or physician)

Local Government Action: [ ] Approved [ ] Disapproved Date: _____	Signature: _____ Title: _____ Print Name: _____