Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Adult Mental Health Services
Westchester County Department of Community Mental Health
112 East Post Road, 2nd Floor
White Plains, NY 10601

2. Please review REQUIRED DOCUMENTATION FORM below.
   Referrals will NOT be considered complete without:
   Complete SPOA Application
   Clinical Information as specified below.

3. Upon receipt, application will be reviewed by DCMH for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 995-5245.

REQUIRED DOCUMENTATION

			Housing				
Required Documents	**ACT**	**ICM/SCM**	**CR**	**SRO**	**TX APT**	**SH**	**SPC**
Eligibility Determination	X	X	X	X	X	X	X
Referral Form	X	X	X	X	X	X	X
Psychiatric Evaluation (Including DSM VI and Current within 90 days)	X	X	X	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X	X	X	X
Physical Exam & Immunization Record			X	X	X		
Authorization for Restorative Services **(MUST BE ORIGINAL)**			X		X		
Disability Verification for HUD Shelter Plus Care Eligibility (**MUST BE HOMELESS**)							X

Eligibility Determination

In order to be eligible for services through DCMH, applicants for Housing, Case Management or ACT Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, B, C, **or** D must be met:

Yes ____ No _____ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary DSM-IV diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions (V-codes).

Please complete: DSM-IV code: _____

Yes ____ No _____ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI ***DUE TO A DESIGNATED MENTAL ILLNESS***.

Yes ____ No _____ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant must meet 1 or 2 below:

1. The individual has experienced two of the following four functional limitations *due to a designated mental illness over the past 12 months on a continuous or intermittent basis. (*Documentation in psychosocial assessment required.)

   Yes ___ No ___ **a. Marked difficulties in self care.**
   Yes ___ No ___ **b. Marked restrictions of activities of daily living.**
   Yes ___ No ___ **c. Marked difficulties in maintaining social functioning.**
   Yes ___ No ___ **d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home of school setting.**

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 12 months on a continuous or intermittent basis.

   Yes _____ Date: From _____ To: _____ Score: _____

Yes ____ No _____ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)
Yes ____ No _____ One six month stay in an inpatient psychiatric unit
Yes ____ No _____ Two stays of any length in an inpatient psychiatric unit in the preceding two years.
Yes ____ No _____ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.
Yes ____ No _____ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.
Yes ____ No _____ Six months consecutive residency in a designated Adult Home.
Yes ____ No _____ Six months consecutive residency in a Residential Care Center for Adults (RCCA)
Yes ____ No _____ Six months consecutive residency in a Residential Treatment Facility (RTF)

Applicant Information

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #:_____ Military Service: Yes ___ No ___

Address: _____ Apt. #: _____

City: ____ _____ State: _____ Zip: _____

Telephone: _____ Male __ Female __ Citizenship: Yes ____ No (if no, immigration status): _____

Ethnicity

____ White (Non-Hispanic) ____ Black (Non Hispanic)
____ Latino/Hispanic ____ Asian/Asian American
____ Native American ____ Pacific Islander
____ Other _____

Primary Language

___English ___Spanish ___Chinese ___French
___Italian ___Russian ___German ___Japanese
___Other

Custody Status of Children

____ No children
____ Children are all above 18 years of age
____ Minor children currently in client's custody
____ Number of children:_____ Gender: _____
____ Minor children not in client's custody but have access
____ Minor children not in client's custody – no access

Current Living Situation

____ Room ____ Homeless (shelter)
____ Own apt ____ Homeless (streets)
____ Supervised Living ____ Nursing Home
____ Supported Housing ____ Psychiatric Hospital
____ Lives with spouse ____ Lives with Parents
____ Correctional facility Other _____

Insurance and Financial Information: Currently Receives

Social Security	☐	Earned Income/Wages	☐
SSI/SSD	☐	Food Stamps	☐
Public Assistance	☐	VA Benefits	☐
Medicaid	☐	Representative Payee	☐
Medicare	☐	Other _____	

Referral Source

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program: _____ Relationship: _____

***Psychiatric Information*:**

	Diagnosis	**DSM IV Codes**
Axis I:	_____	_____
	_____	_____
Axis II:	_____	_____
	_____	_____

Axis III: **Current Medical Problems**

_____

Axis IV Diagnosis: psychosocial and environmental problems: Please list below

_____

Axis V: Global Assessment of Functioning (GAF Score) _____

Risk Assessment

Cruelty to Animals	☐	Suicidal Behavior	☐
Fire Setting	☐	Severe Violence	☐
Homicidal Behavior	☐	Sexual Offense	☐

Current Medications: Please List

_____

_____

***Outpatient Treatment Provider*:**

Agency: _____ **Program:** _____

Contact: _____ **Telephone:** _____

***Substance Abuse History* :Please List Drugs of Choice**

_____

Length of Time Recipient Has Been Substance Free: _____

Criminal Justice – Current Status

___ None ___ Incarcerated-Jail ___ Incarcerated-Prison ___ CPL 330.20/730
___ Probation ___ Parole ___ TASC/MHATI ___ Other:_____

P.O. Name: _____ Telephone: _____

Number of arrests/incarcerations in past year _____ **Number of lifetime arrests** _____

Reason for Arrest:_____ _____ **Date:** _____

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law? _____ **Yes** ____ **No**

Is an AOT under Kendra's Law currently being pursued? _____ **Yes** ____ **No**

Case Management Service Requested

_____ Supportive (SCM) _____ Intensive (ICM) _____ Adult Home (AHCM)

Is there a specific case management program requested? _____

Act Services Requested _____ Is there a specific ACT Team requested?_____

Residential Services Requested

_____Supervised Community Residence ____Supported Single Room Occupancy (SRO)
_____Supervised MICA Community Residence ____ Treatment Apartment Programs
_____Supervised Community Residence MI/MR
_____Supported Housing _____Individual _____Family
_____Shelter Plus Care _____Individual _____Family

Geographical Preference/Community: _____

Recipient Requests:

_____

_____

Recipient Signature: _____ **Date:** _____

Referring Party Signature: _____ **Date:** _____

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

☐ Initial (Face to Face Assessment) Authorization (must be completed by Physician only)

☐ Semi-Annual Authorization

☐ Annual Authorization

Client Name:	
Client Medicaid Number:	
Diagnosis ICD.10:	

I, the undersigned authorized licensed physician/Nurse Practitioner in Psychiatry/Physician's Assistant, have determined that the above named client would benefit from provision of community rehabilitation services as defined pursuant of 14 NYCRR Part 593.4(b).

This authorization is in effect from _____ to ___ ___ _____.
Month/Day/Year Month/Day/Year

_____
Physician/Nurse Practitioner in Psychiatry/Physician's Assistant Signature

_____
Date of Signature

_____
Provider's Name (Please Print)

_____ _____
NYS Provider Licensure # National Provider ID # (NPI)