George Latimer
County Executive

Department of Community Mental Health

Michael Orth, MSW
Commissioner

SPOA UNIT
Adult Mental Health Services
Westchester County Department of Community Mental Health
112 East Post Road, 2nd Floor
White Plains, NY 10601
Fax – 914-813-4364

1. Please review REQUIRED DOCUMENTATION FORM below. Referrals will not be considered complete without:

   Complete SPOA Application (do not write "see attached")
   Clinical Information as specified below. Do not send progress notes or treatment plans in lieu of psychosocial and psychiatric evaluation.

2. Upon receipt, applications will be reviewed by DCMH for eligibility and completeness. Due to volume, we cannot return ineligible or incomplete applications. Please contact our office to follow up on your submissions.

3. Please note that family housing is not available outside of the Rental Assistance Program, which is only for homeless families.

4. For questions regarding the SPOA application, status inquiries, or eligibility, please call (914) 995-5078.

REQUIRED DOCUMENTATION

			Housing				
Required Documents	**ACT**	**CM**	**CR**	**SRO**	**ATP**	**SH**	**RAP**
Referral Form	X	X	X	X	X	X	X
Psychiatric Evaluation (Including DSM V 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			X		X		
Disability Verification for HUD Rental Assistance Program Eligibility (**MUST BE HOMELESS**)							X

Applicant Information

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #:_____ Gender _____

Address: _____ Apt. #: _____

City: ____ _____ State: _____ Zip: _____

Telephone: _____ 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

Employment Status: Full Time _____ Part Time _____ None_____ Highest Education Level:_____

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
____ Own apt
____ Supervised Living
____ Supported Housing
____ Lives with spouse
____ Correctional facility
____ Homeless (shelter)
____ Homeless (streets)
____ Nursing Home
_____Psychiatric Hospital
____ Lives with Parents
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 V Codes**

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

_____ Care Management _____ Peer _____ Mobile Outreach Team/Transitional Outreach Program

Is there a specific program requested? _____

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

Residential Services Requested

_____Supervised Community Residence ____Supported Single Room Occupancy (SRO)
_____Supervised ID/DD Community Residence ____ Apartment Treatment Programs
_____Supervised Co-Occurring Community Residence
_____Supported Housing
_____Rental Assistance Program _____Individual _____Family

Geographical Preference/Community: _____

Recipient Requests:

Recipient Signature: _____ **Date:** _____

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

Community Oriented Recovery and Empowerment (CORE) Services

The services below can be requested for individuals who are Health and Recovery Plan (HARP) enrolled. Please contact the individual's Managed Care Organization to determine if he or she is HARP enrolled. Requests are not a guarantee of receipt of services. The Single Point of Access and provider agencies will review all individuals referred for appropriateness.

- Community Psychiatric Support and Treatment (CPST) – This service includes mobile therapy and treatment services. This cannot be used as an outpatient treatment provider. Agencies providing this service include:
  ____ HDSW
  ____ MHA
  ____ The Guidance Center
  ____ No Preference

- Psychosocial Rehabilitation (PSR) – This service provides skill building to support living, working, learning, and socializing. Agencies providing this service include:
  ____ Search for Change
  ____ CLUSTER
  ____ HDSW
  ____ MHA
  ____ The Guidance Center
  ____ No Preference

- Empowerment Services – Peer Support – This service provides support from individuals with lived experience. Agencies providing this service include:
  ____ CHOICE
  ____ HDSW
  ____ MHA
  ____ The Guidance Center
  ____ No Preference

- Family Support and Training (FST) – This service provides education and training for an individual's family of choice. Agencies providing this service include:
  ____ The Guidance Center
  ____ HDSW
  ____ MHA
  ____ Search for Change
  ____ No Preference

Authorization for Restorative Services
Licensed Housing Programs

☐ **Initial (Face to Face) Authorization (must be completed by a Physician)**

☐ **Semi-Annual Authorization**

☐ **Annual Authorization**

☐ **Change in Provider**

Client Name: _____

Client Medicaid Number:_____

Diagnosis with Code: _____

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

This authorization is in effect from _____ to _____.

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

_____
Date of Signature

_____
Provider's Name (Please Print)

_____
NYS Provider Licensure #

_____
National Provider ID# (NPI)

DISABILITY VERIFICATION FOR HUD RENTAL ASSISTANCE ELIGIBILITY (INDIVIDUAL MUST BE EXPERIENCING HOMELESSNESS AT THE TIME OF APPLICATION)

Please note: this form MUST be filled out and signed by a licensed professional in order for the applicant to be considered for additional housing opportunities through the Westchester County Continuum of Care (CoC) Partnership to End Homelessness.

CLIENT'S NAME: _____

Date of Birth: _____

I, the undersigned licensed professional, based on my review of the assessments made available to me, have determined that the individual named above meets criteria for the primary diagnosis of

_____

and that this disability is expected to be long-continuing and of indefinite duration, and substantially impedes his/her ability to live independently.
This disability could be improved by the provision of more suitable housing conditions.

_____	_____	_____
Mo/Day/Yr	Signature & Licensure #	Print Name