GENESEE COUNTY COMMUNITY SERVICES

SPOE SPOA CCSI

5130 East Main Street Road – Suite 2
Batavia, NY 14020 – 3496
Phone: (585) 344-1421 Fax: (585) 345-3080

Lynda Battaglia, LCSW — **Community Services Director**
Michael Fleming — **SPOE/SPOA /AOT Coordinator**
Robert Riccobono, LMHC — **Clinical Services Director**

Thank you for your interest in referring to the Adult SPOA Committee of Genesee County. The Adult SPOA application must be completed **in full** before a meeting with the Committee can be scheduled. Please be sure to include the following documents (if available) so there is no delay in the processing of your referral.

_____1. SPOA Release of Information Form and Rights of Clients Form signed & dated by Client and witness

_____2. Severe & Persistent Mental Illness (SPMI) Checklist, completed by licensed professional

_____3. SPOA Acuity Scale

The following items are helpful in determining which services a Client may qualify for, but are not required as part of the SPOA referral. If they are available, it is strongly recommended they be included in the referral.

_____1. Hospital Admission/Discharge reports

_____2. Psychological & Psychiatric Evaluations/Assessments

_____3. Current treatment plan for existing services

_____4. Police/legal reports

All fields in this application must be completed before it will be accepted for SPOA review. The application can be completed and returned online, however the Release of Information and Rights of Client, signed by the consumer must be sent by mail, as original signatures are needed on these documents.

Genesee County Community Services
Adult Single Point of Entry
5130 East Main St. Rd.
Batavia, NY 14020
Ph: 585-344-1421
Fax: 585-345-3080

DATE OF REFERRAL: _____

CLIENT CONTACT INFORMATION/HOUSEHOLD COMPOSITION:

Client's First Name:	MI:	Last Name:
DOB:	Sex:	Primary Language:
Medicaid #:	SSN:	
Address:		
Email Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:

Family / Significant Other Contact:

Family Member/Significant Other Name:		Relationship:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:

Others in Household:

Name	**Relationship to Client** (Spouse, child, parent, etc.)

Briefly describe client's interactions with members of the household:

Marital Status (Select one response)

☐	Single, never married	☐	Divorced / Separated	☐	Cohabitating with significant other
☐	Currently married	☐	Widowed	☐	Unknown

Custody Status (Select one response)

☐	No children	☐	Minor children currently in the client's custody	☐	Minor children not in client's custody – no access
☐	Have children all over 18 years old	☐	Minor children not in client's custody but have access	☐	Unknown

DEMOGRAPHICS:

What is Client's Race? (Check all that apply)

☐	White/ Caucasian
☐	Black (specify if desired):
☐	American Indian or Alaskan Native (specify if desired):
☐	Asian/Pacific Islander (specify if desired):
☐	Other (please specify):

English Proficiency

☐	Excellent	☐	Good	☐	Fair	☐	Poor	☐	Does not speak English

Highest level of education completed (Select one response)

☐	No formal education	☐	High School Diploma Specify type of diploma: _____	☐	GED
☐	Business, vocational or technical training	☐	College Degree (specify):_____	☐	Unknown

AOT TREATMENT

Has the Client been assessed for Assisted Outpatient Treatment? (Check one) ☐ **Yes** ☐ **No**

If YES, which option best describes the client's situation resulting from that assessment? (Select one)

☐	Client receives services under a court-ordered treatment	Effective Date:	Expiration Date:
☐	Client receives services under a formal voluntary agreement (AOT Diversion, enhanced services?)	Effective Date:	Expiration Date:
☐	Client receives enhanced services	☐	Client did not meet AOT Criteria

If the Client has an AOT court order, what was client's living situation when the court order was issued?

☐	Private residence alone	☐	Correctional Facility
☐	Private residence with others (specify relationship):	☐	Drug or Alcohol abuse residence or inpatient setting
☐	Mental Health Residence (Describe):	☐	DOH Adult Home (Describe):
☐	State Operated Residence (Describe):	☐	Homeless (Describe):
☐	Inpatient, State Psychiatric Center	☐	Children and Youth Residential (RTF, CR, TFH, Crisis)
☐	Inpatient, general hospital or private psychiatric center	☐	Other specify:

Select the option that best describes the client's living situation prior to that living situation.

☐	Private residence alone	☐	Correctional Facility
☐	Private residence with others (specify relationship):	☐	Drug or Alcohol abuse residence or inpatient setting
☐	Mental Health Residence (Describe):	☐	DOH Adult Home (Describe):
☐	State Operated Residence (Describe):	☐	Homeless (Describe):
☐	Inpatient, State Psychiatric Center	☐	Children and Youth Residential (RTF, CR, TFH, Crisis)
☐	Inpatient, general hospital or private psychiatric center	☐	Other specify:

SERVICE UTILIZATION:

Current living situation (Select one response)

☐	Private residence alone	☐	Correctional Facility
☐	Private residence with others (specify relationship):	☐	Drug or Alcohol abuse residence or inpatient setting
☐	Mental Health Residence (Describe):	☐	DOH Adult Home (Describe):
☐	State Operated Residence (Describe):	☐	Homeless (Describe):
☐	Inpatient, State Psychiatric Center	☐	Children and Youth Residential (RTF, CR, TFH, Crisis)
☐	Inpatient, general hospital or private psychiatric center	☐	Other specify:

Complete if residence is other than a private residence or currently hospitalized

Name of Facility:		
Address:		
City:	State:	Zip:
Name of Contact:	Phone:	
Date of Admission:	Date of anticipated discharge:	

Medicaid Status:

☐	Application Pending	☐	No Application Submitted	☐	Disapproved
☐	Eligible	☐	Not Applicable	☐	Unknown
☐	Active				

Income or benefits currently receiving (select all that apply)

☐	Wages / salary or self employment	☐	Medicare
☐	Supplemental Security Income(SSI)	☐	Medicaid
☐	Social Security Disability Income (SSDI)	☐	Medicaid Pending
☐	Veteran Benefits	☐	Hospital-based Medicaid
☐	Worker's Compensation or disability insurance	☐	Medication Grant
☐	Any public assistance cash program: Family Assistance (TANF), Safety Net, Temporary Disability	☐	Private insurance, employer coverage, no fault or third party insurance
☐	Social Security retirement, survivor's or dependent's (SSA)	☐	None
☐	Railroad retirement, retirement pension (excluding SSA)	☐	Unknown
☐	Unemployment or union benefits	☐	Other benefits:

Current employment status (Select one)

☐	No employment of any kind	☐	Competitive –integrated employment run by a state or local agency	☐	Non-paid work experience/Volunteer
☐	Competitive employment with no formal supports	☐	Employment in sheltered (non-integrated) workshop run by state or local agency	☐	Unknown
☐	Competitive employment with ongoing supports	☐	Sporadic or causal employment for pay (includes odd jobs)	☐	Other Specify:

Average hours per week of employment or non-paid work experience (Select one response)

☐	1 to 10 hours	☐	21 to 30 hours	☐	None
☐	11 to 20 hours	☐	Over 30 hours	☐	Unknown

SERVICE UTILIZATION CONTINUED:

Criminal Justice Status (Select all that apply)

☐	Client is not a criminal justice consumer	☐	Under Probation Supervision	☐	On bail released on own recognizance (ROR), conditional discharge or other Alternative to Incarceration status
☐	Released from jail or prison within last 30 days	☐	Under Parole Supervision	☐	Unknown
☐	Currently Incarcerated Name of facility:_____	☐	CPL 330.20 Order of Conditions and Order of Release	☐	Other Specify:
If Current Court involvement, date of next anticipated Court appearance & in which Court?:					
Briefly describe legal involvement (number of arrests in last 12 months, Active Order of Protection, Recent Police involvement, etc.):					

Client services within last 12 months (Check all that apply)

☐	Crisis Services	☐	Outpatient MH therapy	☐	Prison / jail
☐	Assisted Outpatient Treatment (AOT)	☐	Psychiatric medication management	☐	Alcohol / Drug abuse outpatient treatment
☐	Care Management or any other form of case management	☐	MH outpatient: continuing day treatment, partial hospital, IPRT	☐	Alcohol / Drug abuse inpatient treatment
☐	Self help/peer support services	☐	Respite Bed Housing	☐	None
☐	CSP nonresidential mental health program (e.g. clubhouse, vocational services)	☐	State psychiatric center inpatient unit	☐	Unknown
☐	Mental Health housing and housing support	☐	General Hospital psychiatric unit or certified psychiatric hospital	☐	Other specify:

Enter information as of Referral date (Enter number only)

How many Psychiatric emergency room visits in the last 12 months		How many psychiatric hospital admissions in the last 12 months		How many physical health hospital admissions in the last 12 months	
Briefly describe circumstances of most recent hospital experience (MHA, Admission, Duration, etc.)					

CLINICAL

Therapist Information

Name of Organization:			
Therapist Name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

Prescriber Information

Name of Organization:			
Prescriber Name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

Diagnosis

Diagnosis: clinical disorders, other conditions that may be a focus of clinical attention, personality disorders, intellectual disabilities (if any)
(Please list all Diagnoses using code and description)

CODE	DESCRIPTION

Health & Wellness: general medical conditions (if any)
(Please give full description and medical code if known)

CODE	DESCRIPTION

Axis IV Diagnosis: psychosocial and environmental problems (Select all that apply)

☐	Problems with primary support group	☐	Occupational Problems	☐	Problems with access to health care services
☐	Problems related to the social environment	☐	Housing problems	☐	Problems related to access with legal system / crime
☐	Educational problems	☐	Economic problems	☐	Other (Specify):

Does the client currently have medication prescribed for a psychiatric condition?

☐	Yes	☐	No	☐	Unknown

Please list all medications – Both Mental Health and health related medications

Medication	Total daily dose	mg	cc	Medication	Total daily dose	mg	cc
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

CLINICAL CONTINUED:

Client adherence to medication regimen (Select one response)

☐	Takes medication exactly as prescribed	☐	Rarely or never takes medication as prescribed
☐	Takes medication as prescribed most of the time	☐	Medication not prescribed
☐	Sometimes takes medication as prescribed	☐	Unknown

SYMPTOMS:

Symptoms/Risky Behaviors

Scale: 0 – Never
1 – Not at all in the past 6 months
2 – One or more times in the past 6 months, but not in the past three 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 week
U – Unknown

	0	1	2	3	4	5	U
How frequently did this client do physical harm to self and /or suicide attempt?	☐	☐	☐	☐	☐	☐	☐
How frequently did this client physically abuse and / or assault another?	☐	☐	☐	☐	☐	☐	☐
How frequently was the client a victim of sexual or physical abuse?	☐	☐	☐	☐	☐	☐	☐
How frequently did the client engage in arson?	☐	☐	☐	☐	☐	☐	☐

Other Co-occurring disabilities, if any (Select all that apply)

☐	Drug or alcohol abuse	☐	Hearing impairment	☐	Amputee
☐	Cognitive Disorder	☐	Deaf	☐	Incontinence
☐	Intellectual or Developmental Disabilities	☐	Speech impairment	☐	Bedridden
☐	Blindness	☐	Impaired ability to walk	☐	None
☐	Visual Impairment	☐	Wheelchair required	☐	Other specify:
☐	Diabetes				

Substance Use (Select one response for each)

Scale: 0 – Never
1 – Not at all in the past 6 months
2 – One or more times in the past 6 months, but not in the past three 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 week
U – Unknown

	0	1	2	3	4	5	U		0	1	2	3	4	5	U
Alcohol	☐	☐	☐	☐	☐	☐	☐	Heroin / Opiates	☐	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐	☐	Marijuana / Cannabis	☐	☐	☐	☐	☐	☐	☐
Amphetamines	☐	☐	☐	☐	☐	☐	☐	Hallucinogens	☐	☐	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐	☐	☐	Sedatives /Hypnotics/Anxiolytics	☐	☐	☐	☐	☐	☐	☐
PCP	☐	☐	☐	☐	☐	☐	☐	Other prescription drug abuse	☐	☐	☐	☐	☐	☐	☐
Inhalants	☐	☐	☐	☐	☐	☐	☐	Other (specify)	☐	☐	☐	☐	☐	☐	☐

REFERRAL SUMMARY

Reason for referral & Current service needs

Please describe presenting issues and what may be helpful to improve the situation. Include Client's perspective and goals if applicable.

Services to be discussed at SPOA (Check all that apply)

☐	Care Management & Health Home Services	☐	Self help / peer support services	☐	Alcohol / Drug abuse treatment
☐	Housing Supports and Mental Health Housing needs.	☐	AOT – Assisted Outpatient Treatment	☐	Employment, Benefits, Basic Needs.
☐	Outpatient Mental Health treatment (therapy/medication)	☐	Mental Health program (e.g. clubhouse, vocational services)	☐	Other specify:
☐	Continuing Day Treatment (CDT)	☐	Respite Bed – emergency services	☐	Domestic Violence
☐	Anger Management	☐	Parenting Classes	☐	OPWDD Services
☐	Health & Wellness	☐	Mediation		

Referral Source

Name of Organization:		
Referring Person's Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

CURRENT SERVICE PROVIDERS

Please complete for all current services and providers

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Fax #	
Provider Email	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Fax #	
Provider Email	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Fax #	
Provider Email	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
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Provider Email	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
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Provider Email	

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Re: Name_____
Date of Birth:_____/_____/_____

RELEASE OF / REQUEST FOR CONFIDENTIAL INFORMATION

I, _____, hereby give my consent for Genesee County Community Services Single Point of Accessibility (SPOA) to obtain from and / or release to authorized agencies any information or records, including but not necessarily limited to financial, psychiatric, psychological, psychosocial, probation, parole, legal records, substance abuse material, public assistance, or admission / discharge summaries, health and medical relative to myself.

I understand that all information will be treated as confidential and that the SPOA Committee, designated by Genesee County Community Services, will review and evaluate this information for the purpose of determining my eligibility for Living Opportunities of DePaul Housing, Genesee County Mental Health Care Management and/or other programs that may benefit me. I am aware that recommendations for a different level of care may also be made.

I further consent to release the information gathered to one of the aforementioned programs, if deemed appropriate, for completion of the assessment and application process for that specific program. I understand the purpose of such disclosure of information is to expedite access to such services.

I also understand that I have the right to cancel my permission to access / release the information or withdraw from the SPOA process any time before the information is released.

This consent to release information will expire twelve months after termination of SPOA monitoring.

Print Name

Applicant Signature — Date of Authorization

Witness and Title — Date of Authorization

_____
_____

I hereby revoke my authorization for release of information.

Signature — Date Revoked

Witness and Title — Date Revoked

Date revised: 02/21

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GENESEE COUNTY COMMUNITY SERVICES
SINGLE POINT OF ACCESSIBILITY

RIGHTS OF CLIENTS – Give copy to client

The Genesee County Community Services provides, a Single Point of Accessibility, to individuals in the county who have a mental illness and are in need of housing assistance and/or case management supports.

As a consumer of the Genesee County Community Services Single Point of Accessibility you are entitled by law to the following rights:

1. Coordination of systems, services and an individualized plan of service.
2. The right to take part in the planning process.
3. A full explanation of the services to be provided.
4. Voluntary participation in services except for the following:
   a. In the case of court-ordered services;
   b. When the consent of a court-appointed conservator or committee is needed;
   c. When the consent of a parent or guardian is needed for a minor;
   d. In the case of conduct, which poses a risk of physical harm to yourself or others.
5. To object to all or any part of your service plan without fear of termination from services, unless that objection is considered clinically contraindicated or endangers the safety of yourself or others.
6. Your records will be kept confidential.
7. Opportunity to request access to your records.
8. To receive care and service in a respectful, dignified manner that is appropriate to your needs and delivered in a safe, humane and skillful manner.
9. To be treated in a way which acknowledges and respects your cultural environment.
10. To privacy that will allow effective delivery of services.
11. To freedom from abuse and mistreatment by employees.

If you have a question, complaint or objection concerning services, you may seek assistance using the following procedures:

a. If you feel your service plan is inappropriate or that the service provider treated you in an unacceptable manner, you should contact the supervisor of the program where you are receiving services. The program supervisor will make a full inquiry as to your complaints, and will attempt to resolve the situation in a timely manner so that you can resume appropriate service.
b. If you are not satisfied with the response you receive from the program supervisor, then you may contact the Program Administrator.
c. If you are still unable to resolve the problem, you may contact the:
   Coordinator of SPOA at 344-1421 x 6667
   Director of Clinical Services at 344-1421 x 6635
   Director of Community Services at 344-1421 x 6632
d. If you fail to resolve the problem through the above procedures, you may contact the:
   Western NY Field Office of Mental Health in Buffalo, NY at (716) 885-4219 for assistance.

(Consumer retains this page.)

My signature verifies that I was given a copy of **Genesee County Community Services Board Single Point of Accountability Rights of Clients** information.

The purpose of this information is to ensure me of my rights as a client throughout the time I am receiving services.

Date Client Signature

(Please return this original signature page with the referral packet.)

Date Revised: 02/21

GENESEE COUNTY COMMUNITY SERVICES
ADULT SINGLE POINT OF ACCESS
ACUITY SCALE – (Last 6 Months of Functioning)

Name:	**Date:**
DOB:	

Acuity Scale Need Dimension	0	1	2	3	4
Treatment Participation Score:	Engaged in treatment – no concerns	Recently engaged in treatment – no concerns	Engaged in treatment – some concerns	Engaged in treatment – frequent concerns	Not engaged and/or recent inpatient status
History of Hospitalizations Score:	None	One episode within last 5 years	One episode within last 2 years	History of multiple hospitalizations	Hospitalized within last 6 months
Medication Status Score:	No assistance needed	Stable with some assistance and/or support	Occasional intervention needed	Regular/recent intervention needed	Unstable at current level
Housing Score:	Stable housing	Stable housing for less than three months	Frequent housing concerns	Unstable housing situation	Homeless
Basic Needs Score:	Has not required assistance for more than six months	Has not required assistance in the last three to six months	Requires assistance to maintain basic needs	Basic needs are only minimally met	Basic needs are not met
Benefits and income stream Score:	Stable income/benefits	Just received source of income/benefits	Has applied for benefits but not received	None; Not yet applied for benefits	No intention of applying for benefits
Substance Abuse Score:	Abstinent from drugs and alcohol	None apparent for the last three months	Occasional impairment	Frequent impairment	Frequent major impairment
Risk (to self or others) Score:	None apparent	No recent or apparent risk/danger	Some minor episodes of risk/danger	Occasional risk/danger	Frequent episodes of risk/danger
Health Management Score:	No current health concerns	History of health concerns-managed	Occasional acute concerns	Recent acute concerns	Unmanaged chronic concerns
Total Score					

Additional Information:

_____

_____

FORM COMPLETED BY:_____ ***DATE:_____***

AGENCY/TITLE:_____

Date revised: 02/21

Client Name:_____

CRITERIA FOR SEVERE & PERSISTENT MENTAL ILLNESS (SPMI) Among Adults

To be considered an adult with Severe and Persistent Mental Illness, A must be met:

A. Designated mental illness diagnosis.

The individual is 18 years of age or older and currently meets the criteria for a DSM-III-R psychiatric diagnosis other than alcohol or drug disorders (291.Xx, 303.Xx – 305.Xx), organic brain syndromes (290.Xx, 293.Xx, - 294.Xx), developmental disabilities (299.Xx, 315.Xx – 319.Xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent in DSM-III-R are also not included as designated mental illness diagnosis.

- AND -

B. SSI or SSDI enrollment due to mental illness. The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

- OR -

C. Extended impairment in functioning due to mental illness.

(The individual must meet 1 or 2 below):

1. The individual has experienced at least two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:

a. Marked difficulties in self-care (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).

b. Marked restriction of activities of daily living (maintaining a residence; using transportation; day to day money management; accessing community services.

c. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).

d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work setting or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period; make frequent errors in tasks, or require assistance in the completion of tasks).

2. The individual has met criteria for ratings of 50 or less on the global assessment of functioning scale (Axis V of DSM-III-R) due to a designated mental illness over the past twelve (12) months on a continuous or intermittent basis.

- OR -

D. Reliance on psychiatric treatment, rehabilitation, and supports. A documented history shows that the individual, at some prior time, met the threshold for item C (extended impairment), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medication which may control certain primary manifestations of mental disorder (e.g. hallucinations), but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby minimize overt symptoms and signs of the underlying mental disorder.

Is the client SPMI? **YES** **NO**

Completed by:_____ Date:_____