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RENEE PRATO
Adult Mental Health Coordinator
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DEPARTMENTS OF MENTAL HEALTH
SOCIAL SERVICES AND YOUTH BUREAU

This is a Putnam County Adult SPOA application for Care Management and Housing.

Please scan the completed application with **ALL** required materials and email them to: **Renee.Prato@putnamcountyny.gov**
(or)
mail them to the following address:
Putnam County Department of Mental Health
110 Old Route Six, Building# 3
Carmel, NY 10512
ATTN: Renee Prato, Adult MH Coordinator

If you have any questions regarding this application, please contact:
Renee Prato
(845) 808-1500 ext. 45276

Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 3):

SPOA UNIT
Adult Mental Health Services
Putnam County Department of Mental Health
110 Old Route 6, Building 3
Carmel, NY 10512

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 PCMH for completeness. For incomplete applications the referring party will be notified.

For questions regarding the SPOA Application, please call (845) 808-1500 ext. 45276.

REQUIRED DOCUMENTATION

Required Documents	Care Management	Housing		
		CR	TX APT	SH
Eligibility Determination **(page 3 of application)**	X	X	X	X
Referral Form	X	X	X	X
Psychiatric Evaluation with ICD-10 Diagnoses **(within 6 months)**	X	X	X	X
Psychosocial (Must support Eligibility Determination)	X	X	X	X
Physical Exam & Immunization Record **(within 1 year)**		X	X	X
Authorization for Restorative Services		X	X	

Eligibility Determination:

In order to be eligible for services through PCMH, applicants for Housing or Care Management 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 DSMV diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except for those with predominately psychiatric features, or social conditions (V-codes).

Please complete: DSM-V 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 in maintaining social functioning.
   - ☐ 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 or 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-V) due to a designated mental illness over the past 12 months on a continuous or intermittent basis.
   ☐Yes

   Date: From_____ to _____

   Score: _____

☐Yes ☐No

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 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 Number: _____

Medicaid Number: _____

Military Service: ☐Yes ☐No

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Gender: ☐Male ☐ Female ☐Other_____

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 ☐Italian ☐Chinese
☐Spanish ☐Russian ☐German
☐French ☐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
☐Own apt
☐Supervised Living
☐Supported Housing
☐Lives with spouse
☐Homeless (shelter)
☐Homeless (streets)
☐Nursing Home
☐Psychiatric Hospital
☐Lives with Parents
☐Correctional facility
☐Other: _____

Insurance and Financial Information That Applicant Currently Receives:

☐Social Security ☐Medicaid ☐Food Stamps (SNAP) ☐Representative Payee
☐SSI/SSD ☐Medicare ☐VA Benefits ☐Other: _____
☐Public Assistance ☐Earned income

Referral Source:

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program: _____ Relationship: _____

Psychiatric Information: Please List All Diagnoses **ICD 10 (F Code)**

_____ _____
_____ _____
_____ _____
_____ _____

Current Medical Problems: Please List All

_____
_____
_____

Risk Assessment

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

Current Medications: Please List All

_____

_____

_____

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
☐Probation- P.O. Name: _____ Telephone: _____
☐Parole
☐Other: _____

Number of arrests/Incarcerations in past year: _____ Number of lifetime arrests: _____

Reason For Arrest: _____ Date: _____

Assisted Outpatient Treatment (Please check all applicable)

☐Does the person have a court ordered AOT under Kendra's Law?
☐Is an AOT under Kendra's Law currently being pursued?

Type of Service Requested

☐Care Management Services Requested
☐Residential Services Requested in Putnam County

Type of Housing Requested

☐Community Residence
☐Apartment Treatment Program
☐Supported Housing

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/Date/Year Month/Date/Year

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

_____
Date of Signature

_____
Provider's Name (Please Print) *DEA #*

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