CHEMUNG COUNTY ADULT SINGLE POINT OF ENTRY (SPOE) COMMITTEE REFERRAL PROCESS

Please review the following information carefully in an effort to prevent referral rejection and/or delay in processing:

SPOE reviews community referrals for Assertive Community Treatment (ACT), Mental Health Residential Housing Services and Health Home Care Management referrals for individuals eighteen years and older.

Care Management referrals for Medicaid eligible clients should be sent directly to Tracy Marchese via e-mail: TMarchese@hhuny.org, by fax at 585-613-7670, or mail to Community Referral Coordinator, New York Care Coordination Program, Health Homes of Upstate New York, 1099 Jay Street, Building J, Rochester, NY 14611.

Please fax all **ACT, Housing and Non-Medicaid eligible care management** requests directly to the SPOE office at 607-737-5563. All services offered through the SPOE Committee are voluntary. Please indicate the specific service you are requesting on the attached referral form.

SPOE meetings are held each Thursday at 1:00 p.m. at Children's Integrated Services (CIS), Ernie Davis Academy, 951 Hoffman Street, Elmira, NY 14905 (mailing address: P.O. Box 588, Elmira, NY 14902). Please submit complete referrals by 11:00 a.m. on Wednesday in order to be included in that week's meeting. Please contact us if you have an interest in attending the individual's presentation at the meeting. If you have any questions, please call Kellie Traugott-Knoll, SPOE Coordinator, at 737-2472. For immediate attention to a referral, please secure fax (737-5563) or e-mail ktraugott-knoll@chemungcountyny.gov

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EPC ACT is an intensive mobile mental health service option for high-risk/high-need individuals meeting SPMI criteria. ACT provides emergency/crisis coverage 24 hours per day, 7 days a week, with a low staff-to-consumer ratio and with unlimited services and supports for as long as needed on a continuous basis. ACT is the highest level of support and is offered when traditional lower levels of services have already been tried. ACT includes Care Management services.

Arbor Housing and Development Supported Living Program:

Supported Housing: (OMH Supportive Scattered Site Housing) provides long-term to permanent apartment setting for individuals meeting SPMI criteria capable of living independently in the community who are capable of taking care of their personal needs. Once enrolled in the program they are assigned a case manager with monthly contact.

RCE Beds: individuals discharged from OMH psychiatric centers, residential programs, or Article 28/31 hospital inpatient units. Individuals must possess necessary skills for independent living. Individuals are also referred for Health Home Care Management services. Once enrolled in the program they are assigned a case manager with monthly contact.

Transformation Beds: Individuals must meet SPMI criteria and be high utilizers of Medicaid, OR have been identified though PSYCKES as having 4 or more psychiatric admissions/ED visits over the past 12 months OR, individuals that are transitioning out of more intensive housing options - community residences, apartment treatment programs, shelters, etc.

Gateways Community Living Programs

Luce St. Community Residence (OMH Licensed Congregate Treatment Site): A 24-hour supervised transitional rehabilitative group home residential setting designed to teach individuals daily living skills necessary for independent living. This is a congregate care level of housing and individuals must be Medicaid eligible. **Please complete the Authorization for Rehabilitative Services for OMH Residential Programs form for a 6-month timeframe, with specific beginning and ending dates (xx/xx/xx to xx/xx/xx).**

Sunshine Supportive Apartment (OMH Apartment Treatment Programs): A transitional rehabilitative apartment setting occupied by two or three individuals receiving daily or weekly staff contact. The focus is on building skills necessary for independent living. The Sunshine Program serves Chemung and Schuyler counties. This is a congregate level and individuals must be Medicaid eligible. **Please complete the Authorization for Rehabilitative Services for OMH Residential Programs form for a 12-month timeframe, with specific beginning and ending dates (xx/xx/xx to xx/xx/xx).**

MRT Funded and/or High Needs Housing: For individuals with serious mental illnesses identified as high users of Medicaid services, high users of Medicaid in need of supported housing referred by Health Homes, residents of OMH psychiatric centers or residential programs, discharged from Article 28 or 31 hospitals, or moving from Adult Homes or Nursing Homes. **Please complete the Authorization for Rehabilitative Services for OMH Residential Programs form for a 6-month timeframe, with specific beginning and ending dates (xx/xx/xx to xx/xx/xx).**

Supported Housing: (OMH Supportive Scattered Site Housing) provides long-term to permanent apartment setting for individuals meeting SPMI criteria capable of living independently in the community who are capable of taking care of their personal needs. Once enrolled in the program they are assigned a case manager with monthly contact. **Please complete the Authorization for Rehabilitative Services for OMH Residential Programs form for a 12-month timeframe, with specific beginning and ending dates (xx/xx/xx to xx/xx/xx).**

HEALTH HOMES OF UPSTATE NEW YORK (HHUNY) – CHEMUNG COUNTY

COMMUNITY REFERRAL FOR HEALTH HOME CARE MANAGEMENT SERVICES

Health Homes of Upstate New York is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible individuals into HHUNY Health Home Care Management Services. Individuals must meet all eligibility requirements to be considered for enrollment.

HHUNY Health Home Care Management Services Eligibility:

1. Individual currently has active Medicaid; AND
2. Individual resides in Chemung County; AND
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS and the risk of developing another chronic condition or one or more serious mental illnesses; AND
4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Care Management Referral to HHUNY:

1. Complete the attached Chemung County SPOE Community Referral application form (pages 3-6), including as much detail as possible to allow HHUNY to verify eligibility for health home care management services.
2. Attach a signed "Consent to Disclosure of Health Information" form (page 5)
3. Please fax referral to 585-613-7670.

Non-Medicaid Health Home Care Management Services Eligibility:

1. Referrals for Non-Medicaid clients that meet criteria 2-4 (above) should be faxed directly to the SPOE office at 607-737-5563. Referrals will be reviewed accordingly at SPOE and assigned to a care management agency with the ability to accept Non-Medicaid referrals. Please note: this does not apply to all care management agencies.

Approved individuals will be assigned to a care management agency who will conduct outreach and attempt to engage the person in health home care management services. Health home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion or status of this application, please contact:

HHUNY Community Referral Representative at 585-613-7642 or the Chemung County SPOE office at 607-737-5582.

HHUNY also provides health home services in the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne and Yates counties. Please contact the Community Referral Representative to make a referral for services in any of these counties.

Chemung County Single Point of Entry (SPOE) Community Referral
(For use when referring to Health Home Care Management, ACT and OMH Housing)

Please write legibly and complete all sections of application entirely to ensure timely review and distribution.

PLEASE CHECK SERVICE(S) BEING REQUESTED:

□ *If applying for care management, complete pages 3-6 of referral and send directly to HHUNY*

(Non-Medicaid referrals should be faxed to SPOE office at 607-737-5563)

The following referrals should be faxed directly to Chemung County SPOE Office at 607-737-5563:

□ *If applying for ACT services, complete pages 3-8 AND attach recent clinical documentation supporting SPMI criteria*

□ *If applying for housing, complete pages 3-9 AND attach recent clinical documentation supporting SPMI criteria*

Identifying Information:

Name:		Date of Birth:	Gender:
Medicaid CIN #:	Medicaid Managed Care Organization Name:		County of Residence:
Client Address:	If the referral is for youth between the ages of 18-21, please check all that apply: □ Referred youth is currently in Foster Care □ Referred youth prefers adult care management services		
Primary Contact Number:	Secondary Contact Number & Relation to Client:	If primary phone does not belong to client, client gives permission to leave message: YES □ NO □	
Indicate any need for language/interpretation services; specify language spoken if other than English:			

Eligibility Category Information: Please check all that apply for service(s) being requested.

Health Home Care Management - Must meet A only, B only or two C to be eligible

ACT/OMH Housing – Must meet A to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness *(As determined by SPMI form, pg.8)*	
	B	HIV/AIDS & the risk of developing another chronic condition	
	C	Mental Health condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors: Please check all that apply and provide detailed explanation. Must have at least (1) risk factor.

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
	Lack of or inadequate social/family/housing support	
	Lack of or inadequate connectivity with healthcare system	
	Non-adherence to treatments or medication(s) or difficulty managing medications	
	Recent release from incarceration	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative: Please provide information that will support assignment to a care management agency, ACT Team and/or housing provider and/or state why lower levels of care have not been successful:

This application is pursuant to Assisted Outpatient Treatment (AOT) ☐ Yes ☐ No

Please check client's preferred provider(s)/service(s):

***Care Management*:** ☐ Southern Tier Care Coordination Pathways ☐ Elmira Psychiatric Center

Catholic Charities of Chemung/Schuyler County ☐ Family Services of Chemung County

***Housing*:** ☐ Arbor Development ☐ Gateways (Catholic Charities) **Other:** ☐ Assertive Community Treatment

Contact Information for Person Completing Referral:

Name:	Title:
Organization: Phone: Email:	

PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this consent form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of health care services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV-related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent form and giving it to one of the providers listed in Attachment A. Anyone who receives information while your consent is in effect may retain it. If you withdraw your consent, they are not required to return your information or remove it from their records. You are entitled to get a copy of this consent form after you sign it.

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

1. The person whose information may be used or disclosed is:

   Name: ______________________________________ Date of Birth: ___________________________________

2. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: mental health records (disclosure of psychotherapy notes is not permitted); substance abuse treatment records; HIV-related information; genetic information; information about sexually-transmitted diseases; and educational records.
3. This information may be disclosed to the persons or organizations listed in Attachment A.
4. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
5. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care and monitoring of the quality of service.
6. This permission expires on ____________ (date).
7. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship: ____________________.)

I give permission to use and disclose my records as described in this document.

____ ____________________

Signature Date

Attachment A
CONSENT TO DISCLOSE HEALTH RECORDS
(MODIFIED FOR CHEMUNG COUNTY SPOE)

Please be advised: health information may be disclosed for purposes of treatment to the people and organizations listed below:

Care Management Agencies

- Catholic Charities of Chemung and Schuyler County
- Elmira Psychiatric Center
- Family Services of Chemung County
- Southern Tier Care Coordination
- Pathways Inc.
- CASA-Trinity of Chemung County

Chemung County Single Point of Entry (SPOE) Committee membership includes:

Chemung County Office for Aging and Long Term Care

Chemung County Department of Social Services

Chemung County Department of Health

ARC of Chemung

Arbor Housing and Development

Arnot Health Services (AHS) including St. Joseph's Hospital Behavioral Science Unit (BSU), New Dawn and Arnot Medical Services (AMS)

Capabilities

Catholic Charities of Chemung and Schuyler

Elmira Psychiatric Center

Family Services of Chemung County

Southern Tier AIDS Program (STAP) /Southern Tier Care Coordination (STCC)

CASA - Trinity of Chemung County

Other Related Providers

- CIRCARE (Formerly Onondaga Case Management Services)
- Coordinated Care Services, Inc.
- Fidelis Care
- New York Care Coordination Program, Inc.
- New York State Office of Mental Health
- New York State Office of Alcohol and Substance Abuse Services
- United Healthcare

Attachment B
EXPANDED REFERRAL CONTENT
(Required for ACT and OMH Housing Referrals only)

Name ____________________ DOB ________ County of Residence _______________ Ethnicity __________

Emergency Contact_________________________ Address/Phone _____________________________________

Referral Source/Contact Information: ____

Is this person homeless: ☐ Yes ☐ No

Starting Date: ____________ Where did they sleep last night? _______________________________________

Please list all previous incidents of homelessness in the last four years and verify with dates:

____

____

Does the applicant meet the criteria for a Severe and Persistent Mental Illness? ☐ YES ☐ NO
If YES, signed form must be attached. If NO, individual does not qualify for ACT or OMH Housing.

Current Mental Health Services: ____

Therapist, Psychiatrist or Other Prescriber: ____

Current Prescribed Medications: ____

Physical/Medical Limitations: ____

Current Care Manager: ____

Current Substance Abuse Services: ____

Allergies: ____

Independent Living skills Self-Assessment: *(check if individual reports they are capable of self-management)*

☐ Cooking ☐ Maintaining residence ☐ Using public transportation ☐ Managing personal finances/expenses

☐ Grocery Shopping ☐ Maintaining/making appointments ☐ Other _____________________________

Financial/Insurance Information: (*If possible, please attach financial award letter to application)*

☐ SSI/Amount: ____________ ☐ SSD/Amount: _____________ ☐ DSS/Amount: ______________

County: ___________________

Medicaid Number: ______________________ Managed Care Organization: _____________________________

Name/address/phone# of primary physician: ____

Medicare Number: ___________________Third Party Insurance (include policy number): _______________________

Representative Payee Contact Information (if other than self): _______________________________________

Legal Status (*Please attach a copy of the applicant's current pending charges, if applicable.)*

Are there any current legal charges pending? ☐ YES ☐ NO

Has the applicant ever been charged or convicted of a sexual offense? ☐ YES ☐ NO

Is the applicant subject to a current order of protection? ☐ YES ☐ NO

Attachment C

CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) AMONG ADULTS

(Required for ACT and OMH Housing Referrals only)

Name: ____ DOB: ________________________________

Please note: Authorization must be completed by a medical/mental health provider.

Please check all criteria which pertains to the client.

To be considered an adult diagnosed 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 an **ICD 10 –** psychiatric diagnosis **other than alcohol or drug disorder (F10.xx, through F15.XX), neurological disorders (G21.XX through G47.XX), developmental disabilities (F70 through F89) or social conditions (Z55.xx through Z91.xx).**

In addition, B or C or D must be met.

__B. SSI or SSDI ENROLLMENT/ELIGIBILITY DUE TO MENTAL ILLNESS

The individual is currently enrolled, or has applied, in SSI or SSDI to a designated mental illness.

__C. EXTENDED IMPAIRMENT IN FUNCTIONING DUE TO MENTAL ILLNESS

The individual has experienced two (2) of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis.

__1. Marked difficulty in self-care (personal hygiene, diet, and clothing, avoiding injuries, securing health care or complying with medical advice).

__2. Marked restriction of activities of daily living (maintaining a residence, using transportation, day-to-day money management, accessing community services).

__3. 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 and appropriate use of leisure time).

__4. 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 settings or in structured activities that take place in home or school settings; individuals may exhibit limitation 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 completion of tasks).

__D. RELIANCE ON PSYCHIATRIC TREATMENT, REHABILITATION AND SUPPORTS

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications 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.

COMPLETED BY: ____ DATE: ____________________

Name & Title

Attachment D
Authorization for Rehabilitative Services at OMH Licensed Programs
(Required for OMH Housing Referrals Only)

Initial Authorization and Face-to-Face

Please note: Initial authorizations must be completed by a medical doctor.
No other credentials can be accepted for initial authorizations.

Client's Name: ________________________________ Medicaid Number: ___________________________________

Mental Health Diagnosis(es): ____

____

I, the undersigned licensed physician, based on my face-to-face meeting (*initial authorization ONLY*) have determined that ____________________________ (client's name) would benefit from the provision of mental health rehabilitative services defined pursuant to parts 593.4(b) and 593.6 of Title 14 NYCRR as checked below.

PLEASE CHECK ONE:

☐ Community Residence* (*6 month determination period*)

☐ Supported Housing (*12 month determination period*)

☐ Supportive Housing (Sunshine Apartments)* (*12 month determination period*)

**Please note: The Community Residence and Sunshine Apartments are only available via Catholic Charities Gateways Community Living Programs.*

This application for housing is pursuant to Assisted Outpatient Treatment (AOT) ☐ Yes ☐ No

This determination is in effect for the period* ______________________ (*month/day/year*) to ______________________ (*month/day/year*), at which time there will be an evaluation for continued stay.

**Determination period time frame should reflect the housing option checked above.*

This form should be signed/dated on or before the determination period start date.

Print Physician Name: _________________________ Physician's Signature: __________________________

Date: ___________________ License #: _________________________