

**Westchester County Department of Community Mental Health  
Single Point of Access Application  
Case Management, ACT and Residential Services**

Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)
2. **Two copies** of the completed Single Point of Access Application and supporting documents should be mailed to:

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

**THIS MATERIAL CANNOT BE FAXED**

3. Please review REQUIRED DOCUMENTATION FORM below. Referrals will NOT be considered complete without:  
**Complete** SPOA Application  
Consumer Signature  
**Clinical Information** as specified below.
4. Upon receipt, application will be reviewed by DCMH for completeness. Incomplete Applications will be returned to the referring party.
5. Referring parties will be notified by fax of agency assignments or committee recommendations.

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

**REQUIRED DOCUMENTATION**

Required Documents	Housing						
	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 <b>(MUST BE ORIGINAL)</b>			X		X		

**DO NOT SEND:**

- **Progress Notes**
- **Outdated Psychiatric/Psychosocial Assessments (older than 90 days)**
- **Illegible (Handwritten) Assessments**

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**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 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-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)

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**Applicant Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Tel. No.: ( ) \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female  
 Citizenship: \_\_\_\_\_ Yes \_\_\_\_\_ No (If no, immigration status): \_\_\_\_\_ Email : \_\_\_\_\_

**Ethnicity**

\_\_\_\_\_ White (Non-Hispanic) \_\_\_\_\_ Black (Non Hispanic)  
 \_\_\_\_\_ Latino/Hispanic \_\_\_\_\_ Asian/Asian American  
 \_\_\_\_\_ Native American \_\_\_\_\_ Pacific Islander  
 \_\_\_\_\_ Other \_\_\_\_\_

**Marital Status**

\_\_\_\_\_ Single never married \_\_\_\_\_ Married  
 \_\_\_\_\_ Divorced/Separated \_\_\_\_\_ Widowed  
 \_\_\_\_\_ Lives with significant other \_\_\_\_\_

**Primary Language**

\_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Chinese \_\_\_\_\_ French  
 \_\_\_\_\_ Italian \_\_\_\_\_ Russian \_\_\_\_\_ German \_\_\_\_\_ Japanese  
 \_\_\_\_\_ Hindi \_\_\_\_\_ Urdu \_\_\_\_\_ Vietnamese \_\_\_\_\_ Creole  
 \_\_\_\_\_ Greek \_\_\_\_\_ Other \_\_\_\_\_ American Sign Lang.

**English Proficiency**

\_\_\_\_\_ Does not speak English \_\_\_\_\_ Poor  
 \_\_\_\_\_ Fair \_\_\_\_\_ Good

**Educational Level**

\_\_\_\_\_ Some Grade Schl \_\_\_\_\_ Grade School \_\_\_\_\_ Some HS  
 \_\_\_\_\_ HS Diploma/GED \_\_\_\_\_ Voc Training \_\_\_\_\_ Some College  
 \_\_\_\_\_ College Degree \_\_\_\_\_ Master's Degree \_\_\_\_\_ Ungraded  
 \_\_\_\_\_ No Formal Ed. \_\_\_\_\_ Other \_\_\_\_\_

**Employment Status**

\_\_\_\_\_ Full Time \_\_\_\_\_ Part Time  
 \_\_\_\_\_ Not Employed \_\_\_\_\_ 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 \_\_\_\_\_

**Referral Source**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Agency: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Program: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

**Person to Notify in Emergency**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Relationship: \_\_\_\_\_

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**Criminal Justice**

**Current Status**

None       Incarcerated-Jail       Incarcerated-Prison       CPL 330.20/730  
 Probation       Parole       TASC/MHATI       Other: \_\_\_\_\_

P.O. Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Reason for Arrest: \_\_\_\_\_ Date: \_\_\_\_\_

Number of arrests in the past year: \_\_\_\_\_ Number of incarcerations in the past year: \_\_\_\_\_

Number of lifetime arrests: \_\_\_\_\_

**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

**Insurance and Financial Information:**

<b>Benefits or Insurance</b>	<b>Currently Receives</b>	<b>Benefits or Insurance</b>	<b>Currently Receives</b>
Social Security	<input type="checkbox"/>	Earned Income/Wages	<input type="checkbox"/>
SSI/SSD	<input type="checkbox"/>	Worker's Comp	<input type="checkbox"/>
Public Assistance	<input type="checkbox"/>	Unemployment	<input type="checkbox"/>
VA Benefits	<input type="checkbox"/>	Private Insurance	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	Trust Fund	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	Medication Grant	<input type="checkbox"/>
Food Stamps	<input type="checkbox"/>	Other	<input type="checkbox"/>
Pension	<input type="checkbox"/>	Representative Payee	<input type="checkbox"/>

**Psychiatric Information:**

	<b><u>Diagnosis</u></b>	<b><u>DSM IV Codes</u></b>
<b>Axis I:</b>	_____	_____
	_____	_____
<b>Axis II:</b>	_____	_____
	_____	_____

**Axis III: Current Medical Problems (select all that apply)**  
*(Agencies may require Physical Exam as related to all that apply.)*

- |  |   |
|--|---|
| <input type="checkbox"/> None                            | <input type="checkbox"/> Hyperlipidemia (high cholesterol)  |
| <input type="checkbox"/> Arthritis/joint disorder        | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Neurological                       |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Obesity                            |
| <input type="checkbox"/> Coronary artery disease         | <input type="checkbox"/> Osteoporosis                       |
| <input type="checkbox"/> Dementia/Organic Brain Disorder | <input type="checkbox"/> Renal/Renal Dialysis               |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Sexually Transmitted Disease       |
| <input type="checkbox"/> Female Reproductive problem     | <input type="checkbox"/> Sleep Disorder                     |
| <input type="checkbox"/> Genital/Urinary Disorder        | <input type="checkbox"/> TB                                 |
| <input type="checkbox"/> Head Injury                     | <input type="checkbox"/> Ulcer/Gastrointestinal Disorder    |
| <input type="checkbox"/> Hepatitis/Cirrhosis             | <input type="checkbox"/> Other (specify)                    |
| <input type="checkbox"/> HIV/AIDS                        | <input type="checkbox"/> Unknown                            |

Current Health Care Provider(s): \_\_\_\_\_ Phone: \_\_\_\_\_

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

- |   |   |
|---|---|
| <input type="checkbox"/> Problems with primary support group        | <input type="checkbox"/> Economic problems                              |
| <input type="checkbox"/> Problems related to the social environment | <input type="checkbox"/> Problems with access to health care services   |
| <input type="checkbox"/> Educational problems                       | <input type="checkbox"/> Problems related to access to the legal system |
| <input type="checkbox"/> Occupational problems                      | <input type="checkbox"/> Other (specify) _____                          |
| <input type="checkbox"/> Housing problems                           | <input type="checkbox"/> Other psychosocial and environmental problems  |

**Axis V:** Global Assessment of Functioning (GAF Score) \_\_\_\_\_

Current Medications:

Name	Dosage	Schedule	Reason

Outpatient Treatment Provider:

**Agency:** \_\_\_\_\_ **Program:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**To the degree known, list all psychiatric hospitalizations during the past three years:**

Hospital/ER	Admission Date	Discharge Date	Source of Information

**Number of psych hospitalizations in the past year:** \_\_\_\_\_

**Is the person currently hospitalized?**    \_\_\_ Yes    \_\_\_ No    **Date of Admission:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_

Behavioral Characteristic	Current	History	Behavioral Characteristic	Current	History
Childhood violence			Hallucinations		
Cognitive Impairment			Homicidal Ideas/Attempts		
Criminal History			Severe Depression		
Cruelty to Animals			Severe Thought Disorder		
Delusions			Severe Violence Against Others		
Destruction of Property			Significant difficulty in Treatment		
Disruptive Behaviors			Compliance		
Fire Setting			Suicidal Behavior		

*Any Characteristic checked must be documented in Psychosocial and/or Psychiatric Summary.*

**Substance Abuse History**

**Drugs of Choice**

<input type="checkbox"/> None	<input type="checkbox"/> Any IV Drug Use	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Crack	<input type="checkbox"/> Heroin/Opiates	<input type="checkbox"/> Hallucinogens
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> PCP	<input type="checkbox"/> Sedative/hypnotics	<input type="checkbox"/> Benzodiazapines
<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Inhalants	<input type="checkbox"/> Other _____	

**Alcohol/Substance Abuse Treatment Program within the Past 3 Years:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

**Length of Time Recipient Has Been Substance Free:** \_\_\_\_\_

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**Case Management Service Requested**

\_\_\_\_\_ Supportive (SCM)                      \_\_\_\_\_ Intensive (ICM)                      \_\_\_\_\_ Adult Home (AHCM)

Is there a specific case management program requested? \_\_\_\_\_

**Please check all areas needing the assistance of a Case Manager:**

Money Management _____	Program Participation _____	Community Linkage _____
Nutrition _____	Use of Leisure Time _____	Travel Training _____
Socialization/Relationship _____	Use of Health Services _____	Educational _____
Securing/Maintaining Benefits _____	Personal Hygiene _____	Vocational _____
Other: _____	Housing _____	

**Act Services Requested**

Is there a specific ACT Team requested? \_\_\_\_\_

**Residential Services Requested**

\_\_\_\_\_ Supervised Community Residence  
 \_\_\_\_\_ Supervised MICA Community Residence  
 \_\_\_\_\_ Supervised Community Residence MI/MR  
 \_\_\_\_\_ Supported Single Room Occupancy (SRO)  
 \_\_\_\_\_ Treatment Apartment Programs  
 \_\_\_\_\_ Supported Housing                      \_\_\_\_\_ Individual                      \_\_\_\_\_ Family  
 \_\_\_\_\_ Shelter Plus Care                      \_\_\_\_\_ Individual                      \_\_\_\_\_ Family

Is there a specific agency requested? \_\_\_\_\_

Geographical Preference/Community: \_\_\_\_\_

If on inpatient status at the time of referral, state discharge plan while awaiting housing?

- Shelter
- Return to own apartment
- Return to live with family, significant other
- Other \_\_\_\_\_

Contact Upon Discharge: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Recipient Requests:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If application is completed Online, please give date plan was reviewed with recipient. \_\_\_\_\_

Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>DCMH Use Only</b>	
Medicaid Check _____	
Clinical Documents _____	

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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION**

**Confidential HIV (Human Immunodeficiency Virus) related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.**

**Under New York State Law, except for certain people, confidential HIV-related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV-related information without a release form by calling the HIV Confidentiality Law Hotline at 1-800-962-5065.**

If you sign this form, HIV-related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form to obtain housing and you can change your mind at any time. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 961-8624. This agency is responsible for protecting your rights

Name and address of facility/agency/provider obtaining release:  
Name of person whose HIV-related information will be released:  
Names and address of person(s) who will be given HIV-related information:  Westchester County Department of Community Mental Health's System of Services
Reason for release of HIV-related information:  Coordination of Services
Time during which release is authorized:  Six months from date that release is signed.

I authorize the disclosure of HIV-related information to the people/agencies listed on this form, and for the reason(s) listed on the form. My questions about this form have been answered. I know that I do not have to allow release of HIV-related information and that I can change my mind at any time.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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**AUTHORIZATION FOR RESTORATIVE SERVICES  
OF COMMUNITY RESIDENCES**

- Initial Authorization
- Semi-Annual Authorization
- Annual Authorization

CLIENT'S NAME: \_\_\_\_\_

CLIENT'S MEDICAID NUMBER: \_\_\_\_\_

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that \_\_\_\_\_  
(client's name)  
would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR.

\_\_\_\_\_  
Mo/Day/Yr

\_\_\_\_\_  
Signature & Licensure #

\_\_\_\_\_  
Print Name