

Last Name:

## Community Referral Application Serving: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida and St. Lawrence Counties

Male

## Oneida County Department of Mental Health Application for Care Management

Date of Birth:

## **Identifying Information**

First Name:

				□ Female
Address:			Particular CININ	
			Medicaid CIN#:  Medicaid Managed Care Organization Name:	
			County of Residence:	
			Phone:	
			-	
Cell Ph	one:			
Indicat	e an	y current health care providers (clinic	c, therapist, psychiatrist):	
		16.1	•	
		y need for language/interpretation so	ervices;	
		guage spoken if other than English:		•••
i partic	ipati	ed in the completion of this form and	agree to participate in servic	es:
Individual (Print Name)			 Signature	Date
	•	•	· ·	
Witness (Print Name)			Signature	Date
		_		
Eligib	ility	Category Information – Must	meet Category A to be	eligible for mental
healtl	n ca	re management services thro	ugh ASPOAA. Check any	others that apply:
Check		Category	Specify Diagnosis; Prov	vide Available Detail
	Α	Serious Mental Illness		
	•	HIV/AIDS and the risk of developing		
	В	another chronic condition		
	С	Mental Health Condition		
	С	Substance Abuse Disorder		
	С	Asthma		
	С	Diabetes		
	С	Heart Disease		
<u>-</u>				
	С	BMI > 25		

Risk Factors – Check All That Apply 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 connectivity with healthcare system. Non-adherence to treatments or medication(s) or difficulty managing medications. Recent release from incarceration. Recent release from psychiatric hospitalization. (List hospitals and dates within last 2 years) Deficits in activities of daily living such as dressing, eating, etc. Learning or cognition issues. History of violent behavior. **Narrative** Please specify the individual's needs and how you would like the program to help them. Supporting documentation of Mental Health Diagnosis <u>must be attached</u>. **Contact Information for Person Completing Referral** Name: Title:

**Email:** 

## MAIL, FAX OR EMAIL TO:

Rachel Gacek-DeMetro - ASPOAA Coordinator 800 Park Avenue, 9th Floor Utica, NY 13501 rgacek-demetro@ocgov.net

FAX: 315-768-3670 PHONE: 315-768-3660

IMPORTANT: <u>All</u> Health Home Care Management referrals <u>must</u> be accompanied by separate documentation of Serious Mental Illness, dated within a year of the application and signed by an MD, LMSW, LCSW, Psychologist, PA, RN, LPN, NPP, LMHC, LMFT or LCAT.

Organization:

Phone: