

### Referral Form: Case Management and Residential Services

**Required:** A Mental Health Assessment – Completed by a Mental Health Professional

(As defined by § 587.4 Of the State of New York Official Compilation of Codes, Rules & Regulations)

Date of referral \_\_\_\_\_ Referring Person \_\_\_\_\_  
 Relationship \_\_\_\_\_ Agency \_\_\_\_\_  
 Referent Contact Info Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**BASIC CONTACT INFORMATION: For Individual Being Referred**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ AKA \_\_\_\_\_  
 Gender M \_\_\_ F \_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 SSN \_\_\_\_\_ Medicaid Number \_\_\_\_\_ Medicare Number \_\_\_\_\_

**Address/Living Situation**

Outpatient Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Individual is Inpatient at: St E's St Luke's Other \_\_\_\_\_  
 Or in a Temporary Residence \_\_\_\_\_ Phone \_\_\_\_\_  
 If in a Correctional Facility, Anticipated Release Date \_\_\_/\_\_\_/\_\_\_ PO (if known) \_\_\_\_\_  
 Living Status (type of housing, i.e. Apartment, 1/2-way House, Shelter) \_\_\_\_\_  
 Living Arrangements (alone or living companions) \_\_\_\_\_  
 Length of Time in this Living Arrangement  
 Less than one month  1-3 months  3-6 months  6-12 months  One year or more  Unknown

**DIAGNOSIS and code**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<p><b>IMPORTANT: <u>All</u> ASPOAA referrals <u>must</u> be accompanied by separate documentation of the Diagnosis, dated within a year of the application and signed by an MD, LMSW, LCSW, Psychologist, PA, RN, LPN, NPP, LMHC or LCAT.</b></p>	<p><b>MAIL, FAX OR EMAIL TO:</b>          Oneida County Department of Mental Health          120 Airline Street, Suite 200          Oriskany, NY 13424          ATTN: Adult ASPOA/A Coordinator          Phone: (315) 768-3663 Fax: (315) 768-3670</p>
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**For OCDMH Only**

Date Referral Rec'd \_\_\_\_\_ MHA Rec'd \_\_\_\_\_ OCDMH Review \_\_\_\_\_  
 Request for Missing Information: 1<sup>st</sup> Attempt \_\_\_\_\_ 2<sup>nd</sup> Attempt \_\_\_\_\_ 3<sup>rd</sup> Attempt \_\_\_\_\_ Date Distributed \_\_\_\_\_

M A S                      M A S                      M A S                      M A S

## REQUIRED ELIGIBILITY ~MANDATORY~

In order to be considered an adult with a serious and persistent mental illness, the following requirements must be met:

- The individual must be 18 years of age or older
  
- The individual must currently meet the criteria for a DSM-V psychiatric diagnosis, not included are alcohol and drug diagnoses, organic brain syndromes, developmental disabilities or social conditions. ICD categories and codes that do not have an equivalent in DSM-V are not included as mental illness diagnoses.

Designated Mental Health Diagnosis

Primary \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AND**

- The individual is currently enrolled in SSI/SSDI due to a designated mental illness.
- OR**
- The individual must have documentation that 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:

- Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care or complying with medical advice).
- Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
- Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
- Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings 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 errors in tasks, or require assistance in the completion of tasks).

**OR**

- Reliance on Psychiatric Treatment, Rehabilitation and Supports  
A documented history shows that the individual at some prior time met the threshold for 3 (above), but the 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 (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

**Certification:**

I certify that this individual, \_\_\_\_\_, who is eighteen years or older, is functionally disabled due to mental health needs, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the eligibility requirements.

\_\_\_\_\_  
Print Name of Referent/Person Completing This Form

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**RESIDENTIAL SERVICES**

**Catholic Charities Community Residence (CR) CR, MICA, MI/MR, Geriatric, Low Demand** Seven Community Residences for a total of 62 beds provide a **24-hour staff supervised** group setting in which counselors assist individuals with activities of daily living, medication management, and preparation for less restrictive living. Specialized Houses are located in Utica and Rome. Individuals usually share a room and are expected to transition out within approximately 2 years. (315) 724-2158 x257, 258

**Catholic Charities Pathways to Independent Living (APT)** Apartments located throughout the Utica – Rome area. Individuals are seen a minimum of once a week for assistance with household tasks, money management, and preparation for independent living. Individuals are expected to transition out within approximately 2 years. Most are double occupancy. Capacity 41. (315)724-2158 x239, 240

**The Enriched Living Center of the Utica Rescue Mission (ESRO)** OMH Licensed, 52 single room residential facility. **24-hour staff supervision 7 days a week.** Individuals must be able to meet basic hygiene needs and complete a self-preservation test in 2.5 minutes. Services include medications supervision and management, transportation to medical/vocational appointments and a Representative Payee. Cafeteria style eating but cannot accommodate special diets. Individuals are expected to transition out into the community at a pre-determined future date. The average length of stay is approximately 4 years. (315) 735-1645 x120

**Mohawk Valley Psychiatric Center: Family Care (Referrals are typically limited to those being discharged from a HPC/MVPC or the TLC, however, referrals from other agencies will be considered)** A residential service that places individuals with a serious and typically chronic mental illness with families certified to deliver residential care in their own homes. This setting provides guidance, support, and companionship in a family environment. Rooms are shared or single. Individuals must participate in day programming. (315) 738-6194

**Mohawk Valley Psychiatric Center: State Operated Community Residences (SOCR) (Referrals are typically limited to MVPC clients including those being discharged from a Hutchings PC or the TLC.)** Two Community Residences located in Whitesboro and Yorkville with 12 beds each. Most are shared rooms. Programs include **24 hour staff supervision**, and strive to engage individuals during their recovery from mental illness, in the development of skills necessary for successful reintegration into the community; Emphasis is placed on the principles of normalization in a home like residential setting. Whitesboro (315) 736-8575, Yorkville (315) 768-4710

**CARE COORDINATION SERVICES**

Programs are targeted to individuals with diagnosable mental health needs, which are severe and marked by an impairment that seriously interferes with the ability to function independently, appropriately and effectively.

**Health Home Care Management (HHCM)** Health Home Care Management is a system of care coordination. Care Managers provide a single point of contact for clients and their families for all mental, healthcare and social service needs. Clients seen a minimum of once/month or as needed. Unlimited Capacity. (315) 272-2661. Client must have Medicaid or be Medicaid eligible although services are also available for those without Medicaid. (315) 272-2661

**Intensive Case Management (ICM) Adult Services**

Services are targeted to individuals with a primary diagnosis of SMI and high service/support needs. Services include assertive outreach and support to coordinate and monitor treatment, advocacy and linkages to community based and other natural support systems. toward the goal of reducing reliance on emergency and inpatient services. Consider HHCM (see above) if there is no prior case management history. Case load size is 1:12. Clients are seen a minimum of 4 times per month. Capacity 108. (315) 738-4446

**Assertive Community Treatment Team (ACT)**

ACT is a mobile, clinical mental health treatment team which includes a psychiatrist, mental health professionals, an administrative assistant and team leader. The team’s mission is to provide short-term (1-2 years) treatment, rehabilitation, and intensive supports to people in the community to help them re-connect to traditional clinic services. Program capacity is 65 and the staff to client ratio is 1:10. (315) 738-4023

**Indicate Residential OR Case Management Services** (Case Management is included at residences) Referent is responsible for recommending appropriate level of care.

First Residential Choice \_\_\_\_\_ First Case Management Choice \_\_\_\_\_

Second Residential Choice \_\_\_\_\_ Second Case Management Choice \_\_\_\_\_

~~ Please see attached brochure for additional program details. ~~

**Services Only (SO) (OCDMH) 768-3663** These services are individuals who are self/sufficient/do not require a Case Manager, but Who wish to access the following services:  Social Recreation  Transportation

**REASON FOR REFERRAL**

[It is **Mandatory** to complete the following - Please Write Legibly]

~~ Please specify the areas in which the individual is experiencing functional limitations and explain the individual's needs. Areas of functional limitation include: Self-care, Social Functioning, Activities of Daily Living, Economic Self-Sufficiency, Self-Direction, Concentration, and Employment. ~~

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Specify How You Would Like the Program to Help the Individual

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Current Symptoms Prompting Referral

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Most Recent Use of Acute Services (Inpatient, Crisis, Emergency Dept./Date and Time)

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**CURRENT TREATMENT TEAM**

Primary Therapist	_____	Agency _____	Phone _____
Psychiatrist	_____		Phone _____
Primary Care Provider	_____		Phone _____
Case/Care Manager	_____	Agency _____	Phone _____
Addiction Services	_____	Agency _____	Phone _____
Probation/Parole Officer	_____		Phone _____
Residential	_____	Agency _____	Phone _____
Other	_____		Phone _____

**CURRENT MEDICAL CONDITIONS: (List)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LIST CURRENT MEDICATIONS (Dosage/Frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CAPABILITY TO SELF-ADMINISTER CURRENT MEDICATIONS (select one)

Independently     With Supervision     With Assistance     Unable     Refuses

LIST SIGNIFICANT ALLERGIES

\_\_\_\_\_

\_\_\_\_\_

**DEMOGRAPHICS:**

Ethnicity:  Hispanic     Non-Hispanic    Language:    Does Individual speak/understand English?

Race: (may check two)    Primary \_\_\_\_\_     Yes

Caucasian    Secondary \_\_\_\_\_     Limited

African American     Very Limited

Native American-Alaska     No

Asian     **Interpreter Needed**

Native Hawaiian/other Pacific Islander

Other \_\_\_\_\_

Religious Affiliation (Specify) \_\_\_\_\_    No Religious Affiliation \_\_\_\_\_

**FUNCTIONAL/MEDICAL/ADL PROBLEMS**

Functional Medical Problems				Cognitive Impairment
<input type="checkbox"/> Special Dietary Needs	<input type="checkbox"/> Impaired Ability to Walk			<input type="checkbox"/> Developmental Disability/LD
<input type="checkbox"/> Impaired Vision	<input type="checkbox"/> Impaired Hearing			<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Requires Special Medical Equipment	<input type="checkbox"/> Other _____			<input type="checkbox"/> Other _____

Community Survival Skills    Independent    Yes    No    Unknown

Can Bathe/Dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe individual's method of getting to appointments (walking, public transportation, etc.):
Hygiene/Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating/Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At risk of falling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At risk of wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to self-evacuate a building in 3 min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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**DANGEROUS TO SELF, OTHERS, PROPERTY**

	Most Recent Date	Explanation/Notes
<input type="checkbox"/> Sexual Assault - Victim	_____	_____
<input type="checkbox"/> Sexual Assault - Perpetrator	_____	_____
<input type="checkbox"/> Physical Assault - Victim	_____	_____
<input type="checkbox"/> Physical Assault - Perpetrator	_____	_____
<input type="checkbox"/> Substance Abuse - Alcohol	_____	_____
<input type="checkbox"/> Substance Abuse – Drugs	_____	_____
<input type="checkbox"/> Homicidal Ideation- Attempt	_____	_____
<input type="checkbox"/> Homicidal Ideation- Success	_____	_____
<input type="checkbox"/> Suicidal Ideation	_____	_____
<input type="checkbox"/> Suicidal Attempt	_____	_____
<input type="checkbox"/> Arson	_____	_____
<input type="checkbox"/> Self Injury	_____	_____
<input type="checkbox"/> Property Damage	_____	_____
<input type="checkbox"/> Frequent Crisis	_____	_____

**FINANCIAL: Benefits / Entitlements / Financial Status**

**Income Sources (Specify Source and Amount)**

<input type="checkbox"/> SSI _____	<input type="checkbox"/> Food Stamps _____	<input type="checkbox"/> Employment/Wages _____
<input type="checkbox"/> SSDI _____	<input type="checkbox"/> TANF _____	<input type="checkbox"/> Family/Spouse _____
<input type="checkbox"/> Public Assistance _____	<input type="checkbox"/> Safety Net _____	<input type="checkbox"/> None _____
<input type="checkbox"/> Pension _____	<input type="checkbox"/> Support _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Veteran's Benefits _____		

Representative Payee Information     Self     Other (If other, fill out info below)

Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Describe individual's money management skills:

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

**HEALTH INSURANCE STATUS**

Insurance Type	Policy ID#	Insurance Type	Policy ID#
<input type="checkbox"/> Medicaid Enrolled	_____	<input type="checkbox"/> Medicare	_____
<input type="checkbox"/> Medicaid Application Filed	_____	<input type="checkbox"/> Private Health Insurance	_____
<input type="checkbox"/> PMHP Enrolled	_____	<input type="checkbox"/> Not Insured	_____
<input type="checkbox"/> Veteran's Insurance	_____	<input type="checkbox"/> Other	_____

**FORENSIC HISTORY**

Does individual have a history of criminal behavior or charges pending? If so, please explain.

Current Charge \_\_\_\_\_ Incarceration Dates \_\_\_\_\_

History of Sexual Offense? Yes  No  If so, what level? \_\_\_\_\_

History of Arson? Yes  No  Dates \_\_\_\_\_

History of Violent Felony? Yes  No  Dates \_\_\_\_\_

Other Forensic History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT HISTORY**

Inpatient MH Facility	Dates	Inpatient SA Facility	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

  

Outpatient MH Facility	Dates	Outpatient SA Facility	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Substance Abuse History**

Substance	Frequency of Use	Date of Last Use	Drug of Choice	Do Not Know

**VOCATIONAL/EDUCATIONAL**

Highest Level of School Completed \_\_\_\_\_

Currently in school?  Yes  No School Name \_\_\_\_\_

Currently employed?  Yes  No Employer Name \_\_\_\_\_

Currently volunteering?  Yes  No Volunteer Site \_\_\_\_\_

Currently vocational or employment services?  Yes  No

\_\_\_\_\_

\_\_\_\_\_

