



COUNTY OF DUTCHESS

DEPARTMENT OF BEHAVIORAL AND COMMUNITY HEALTH
DIVISION OF MENTAL HYGIENE

Please Note: If all documentation below is not included with the application, it cannot be processed and should not be sent in until complete

Name: _____ Date: _____

HOUSING APPLICATION CHECKLIST

AUTHORIZATIONS	√ = COMPLETE
Care Coordination Authorization:	
Complete "Information Being Disclosed From"	
Check Expiration	
Signed & Dated	
Treatment Authorization	
Check all agencies that apply	
Check Expiration	
Signed & Dated	
DOCUMENTS	DOCUMENT DATE
Eligibility Determination for Housing Services – A must be met. In addition, B, C or D must be met.	
Psychiatric Summary or Update (Must be w/in 6 months)	
Comprehensive Psycho-Social Summary	
SPMI Diagnosis	
Physical Exam (w/in 1 year)	
PPD Results (w/in 1 year)	
Verification of Income	

Comments: _____

Single Point of Access
(SPOA)
Referral Form

Please review the following instructions to request Care Management and/or Housing services:

1. Complete the **Eligibility Checklist for Housing Services**
2. Please review the REQUIRED DOCUMENTATION below. Referrals will NOT be considered without a completed application and any required clinical information as indicated below.

Incomplete Applications will be delayed until completed by the referring party

Forward completed applications and required documentation to:

SPOA Unit
Dutchess County Department of Behavioral & Community
Health 230 North Road
Poughkeepsie, NY 12601
Fax: (845) 486-2882
Email: tclifford@dutchessny.gov
cc: ddisanza@dutchessny.gov

For questions regarding the SPOA Application, please call:
Deborah DiSanza (845) 486-2768 or Tonya Clifford (845) 486-2764

REQUIRED DOCUMENTATION		
Documents	Care Management	Residential Housing
Eligibility Determination Checklist		✓
Referral Form (2 pages)	✓	✓
Psychiatric Evaluation with SPMI diagnosis <u>(Within 6 months)</u>	*	✓
Psychosocial (Must support Eligibility Determination Checklist)	*	✓
Physical Exam and Immunization Record (All housing applications require a current physical exam along with current PPD results) (Both must be within 1 year)		✓
Admission Note if currently hospitalized		✓
Copy of current benefit letter, or if employed, provide pay stubs (All must be within 2 months)		✓
Authorization(s) - Signed release(s) of information: <ul style="list-style-type: none"> • Exchange of information (Care Coordination and Residential Services) 	✓	✓
<ul style="list-style-type: none"> • Authorization for Communication Between DBCH & Treatment Providers 		✓
Applicants <u>may voluntarily choose</u> to disclose their HIV/AIDS testing information. Should they choose to do so, the NYS DOH form "Authorization for Release of Health Information and Confidential HIV- Related Information" must be included.	Voluntary Disclosure	

*** For Care Management Referrals:** Once the Referral Form and Care Coordination Authorization are faxed to DBCH, all other required documentation (i.e. psychosocial, psychiatric evaluation must be faxed directly to the agency requested - Mental Health America Care Management at (845) 471-6932 or Rehabilitation Support Services at (845) 615-9112.

Eligibility Determination for Housing Services

Name: _____ Date of Birth: _____

In order to be eligible for services through DBCH, applicants for Housing 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-V 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.

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 at least two of the criteria below:

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 _____ Marked difficulties in self-care.

Yes _____ No _____ Marked restrictions of activities of daily living.

Yes _____ No _____ Marked difficulties in maintaining social functioning

Yes _____ No _____ Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school setting.

Yes _____ No _____ D. 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 contacts 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) (OMH)



SINGLE POINT OF ACCESS FOR RESIDENTIAL OPPORTUNITIES IN DUTCHESS COUNTY

Dutchess County Department of Behavioral & Community Health coordinates a continuum of supportive residential services for adults with serious mental illness. These programs are located throughout Dutchess County

OMH CONGREGATE TREATMENT PROGRAMS/COMMUNITY RESIDENCES

(24-HOUR SUPPORT/SUPERVISION)

These residences/homes provide 24-hour on site support and supervision. Residents develop individualized plans based on the goals of psychiatric rehabilitation. Medication management, treatment adherence, daily living skills, vocational training, links to natural community supports, interpersonal development and other areas are addressed in a home-like setting based on individual goals and desires and treatment recommendations. This program is highly structured with an emphasis on movement towards an increased level of independent living.

Highview Residence – Rockland Psychiatric Center, (RPC) (Hudson River Division), Poughkeepsie – 24 beds

South Randolph – Rehabilitation Support Services, Inc (RSS), Poughkeepsie – 14 beds

Osborne Hill Residence (55 and older) – RSS, Wappinger Falls – 12 beds

Beacon Residence – Gateway Community Industries, Inc (GCI), Beacon – 12 beds

HIGHRIDGE CR-SRO – Rehabilitation Support Services, Inc. (RSS), Poughkeepsie – 50 studio apartments

OMH SUPPORTIVE TREATMENT APARTMENT PROGRAM

This is typically a shared apartment program with locations throughout the county. Most apartments are 2 bedrooms and are shared with a roommate, each having their own bedroom. However, some single apartments are available. Staff visits residents a minimum of three times per week (more if indicated) to assist with continued medication management, interpersonal relations, general daily living skills, apartment maintenance, socialization, symptom management and community integration. Staff is also available 24 hours, 7 days per week to provide mobile crisis resolution and support. Emphasis at this level is on maintaining a high-level functioning in daily living, emotional stability and movement towards more independent living.

Rehabilitation Support Services – 36 beds

Newkirk (MH/MR) – GCI, located in Ulster County, serves Dutchess – 12 beds

SUPPORTED HOUSING AND SHELTER PLUS CARE

Residential and case management services are provided to Dutchess County residents who can live independently with enhanced supports. Residents are assisted in locating apartments and securing furnishings. Residents are required to pay 30 % of their monthly income towards rent. The rent balance is subsidized by the agency. Additional resources may be available for the security deposit only. Residents are assisted with applying for Section 8 and/or other alternate rent subsidies for future independent living. Home visits occur at least 1x per month. Shelter Plus Care provides the same level of support/services for individuals who were previously homeless or at risk of homelessness. Some programs can provide housing to families/couples. There are enhanced services for single parents with children, parents with special needs living with their children and the MICA consumers.

Shelter Plus Care

Hudson River Housing – 12 beds

Rehabilitation Support Services – 16 MICA beds

Supported Housing

Gateway Community Industries – 50 beds

Hudson River Housing – 52 beds

Mental Health America – 24 including 5 transitioning youth beds (age 18-25)

PEOPLE, Inc. – 39 beds

Rehabilitation Support Services – 129 beds

Additional residential options are available throughout Dutchess County. These include private community residences, adult homes and Family Care. For further information/applications, contact Deborah DiSanza, LCSW-R, Housing Coordinator, DCDBCH at 845-486-2768.

If requesting Care Management, please choose only **one** agency

- Care Management – Mental Health of America
- Care Management – Access: Supports for Living Inc. (Internal referrals only)
- Care Management – Rehabilitation Support Services (Medicaid Only)

- Residential Housing
- Dutchess Outreach Team

1. CLIENT DEMOGRAPHIC/INFORMATION			
Name:	DOB:	SS#:	Register #:
Address:			COUNTY:
Phone #:	Best time to contact:	Email:	
Gender Identity:	US Citizen <input type="checkbox"/> Y <input type="checkbox"/> N If NO, status?		Primary Language:
Ethnicity: <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other:			
Applicant can work with: <input type="checkbox"/> Male OR <input type="checkbox"/> Female OR <input type="checkbox"/> Both		Emergency Contact Name:	Phone #:
2. REFERRAL SOURCE INFORMATION			
Name:	Title:	Agency / Program:	
Address:		Phone#:	FAX#:
Email Address:			
Relationship:	# of visits:	Date Last Seen:	
Reason for Referral (describe in detail):			
Client requests assistance in the following areas: (check all that apply)	<input type="checkbox"/> Medical <input type="checkbox"/> Vocational/Educational <input type="checkbox"/> Housing <input type="checkbox"/> Budgeting Money <input type="checkbox"/> Access to Resources <input type="checkbox"/> Other (please describe):		
3. CLINICAL INFORMATION			
<i>Care Management Eligibility Criteria: Applicant must have at least one psychiatric dx OR substance abuse dx AND at least one chronic medical condition; OR two chronic medical conditions</i>			
Diagnosis		ICD Codes	
Please describe any history of the following:	Suicidal ideation/attempts: <input type="checkbox"/> N/A		
Alcohol/substance abuse: <input type="checkbox"/> N/A (Please include drug(s) of choice and date of last use)			
Current Medications:			
4. TREATMENT PROVIDERS			
	Inpatient	Outpatient	PCP
Agency			
Primary Therapist/Phone #			
Licensed Prescriber/ Physician			
Date of Admission			

5. LEGAL INFORMATION

Current Status	<input type="checkbox"/> None <input type="checkbox"/> CPL 330.20/730 <input type="checkbox"/> TASC/MHATI <input type="checkbox"/> Probation <input type="checkbox"/> Parole	P.O. Name:
	<input type="checkbox"/> Incarcerated – Jail <input type="checkbox"/> Incarcerated – Prison <input type="checkbox"/> History of Fire Setting	Phone #:
	<input type="checkbox"/> Sex Offender If yes, level of offense: <input type="checkbox"/> Other:	Correctional Facility:

History	Has client ever been charged or convicted of a violent crime? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please describe:	
	# of arrests/incarcerations: Past Year ____ Lifetime ____	Reason(s):

6. FINANCIAL/INSURANCE INFORMATION

<input type="checkbox"/> Medicaid #:	<input type="checkbox"/> Medicare #:	<input type="checkbox"/> VA Benefits/VA #:
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> SSI	<input type="checkbox"/> SSDI
<input type="checkbox"/> Earned Income/Wages	<input type="checkbox"/> Managed Care	<input type="checkbox"/> Representative Payee Name:
		<input type="checkbox"/> Other Income/Insurance:

PROGRAM SPECIFIC INFORMATION

HOUSING

Custody Status of Minor Children	<input type="checkbox"/> No Children <input type="checkbox"/> Children above 18 y.o.	<input type="checkbox"/> Minor Children currently in client's custody - # & Gender :			
	<input type="checkbox"/> Minor Children not in client's custody, but have access		<input type="checkbox"/> Minor Children not in client's custody - no access		
Current Living Situation	<input type="checkbox"/> Room	<input type="checkbox"/> Own Apt.	<input type="checkbox"/> Lives with Spouse	<input type="checkbox"/> Lives with Parents	<input type="checkbox"/> Correctional Facility
	<input type="checkbox"/> Supervised Living		<input type="checkbox"/> Supported Housing	<input type="checkbox"/> Homeless (shelter)	<input type="checkbox"/> Homeless (streets)
	<input type="checkbox"/> Psychiatric Hospital		<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other:	
AOT Status	Current AOT Order or ESC in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is AOT being pursued? <input type="checkbox"/> Yes <input type="checkbox"/> No		
ACT TEAM	Is client open with ACT Team? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is ACT Referral being pursued? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Housing Type Requested - Please pick housing level 1, 2, OR 3

1 Community Residence 24 Hour Support/Supervision	<input type="checkbox"/> State Operated Community Residence (SOCR) - Highview			
	<input type="checkbox"/> Community Residence (CR) (not-for-profit only - RSS, GCI)			
	<input type="checkbox"/> Community Residence-Single Room Occupancy (CR-SRO) (*see special requirements) - Highridge Gardens - RSS * CR-SRO requirements: due to federal and state regulations for the program type, gross annual income cannot exceed \$18,030.00 for an individual and all income and assets must be verifiable and will be re-certified annually.			
OR				
2 Supportive Apartments Moderate Supervision	<input type="checkbox"/> Rehabilitation Support Services Supportive Apartment (Roommate)			
	<input type="checkbox"/> Newkirk (Dual Diagnosis - MH/DD) - GCI			
OR				
3 Supported Apartments Independent	<input type="checkbox"/> Individual/Couple (Moderate Supervision)		<input type="checkbox"/> Youth (age 18 - 25)	<input type="checkbox"/> MICA Focus
	<input type="checkbox"/> Shelter Plus Care (Moderate Supervision)		<input type="checkbox"/> Family - must have children (Gateway Community Industries & Hudson River Housing Only)	
	<input type="checkbox"/> Coach Project (Vocational Requirement)			

Geographical Preference/Community:

Recipient Requests:

Client Signature: _____ Date: _____ Referent Signature: _____ Date: _____

For DBCH Use Only

Date Application Received:		Comments:
Date to Care Management:		Comments:
Date to Provider(s):		Comments:



DUTCHESS COUNTY
 DEPARTMENT OF BEHAVIORAL & COMMUNITY HEALTH
 Single Point of Access (SPOA)
 230 North Road, Poughkeepsie, NY 12601
 Tel: (845) 486-2764 Fax: (845) 486-2882

**EXCHANGE OF INFORMATION AUTHORIZATION
 (Care Coordination and Residential Services)**

CLIENT NAME: _____
 DOB: _____ REGISTER#: _____

Extent or Nature of Information to be Exchanged in Single Point of Access (SPOA) Application:

- Psychiatric Evaluation/Updates
- Psychosocial Assessment (including diagnosis and mental status)
- Hospital Admission and Discharge Plan (if appropriate)
- Physical Examination and TB Test Results /chest x-ray (if needed)
- Income Verification, Discharge Summary and or Psychological Testing (if needed)
- Other: _____

Purpose or Need for Information: To facilitate a referral for residential and/or care coordination services, determine eligibility for such services, and assess appropriateness of applicant for the various programs available.

Information Being Disclosed From: (Name, Address, and Title of Person/Organization/Facility/Program)

Information Being Disclosed To: (NOTE: All referrals, including the information indicated above, are forwarded to the SPOA Coordinator who then disseminates them to any programs listed below when there is a vacancy and to obtain care management services)

- Gateway Community Industries, PO Box 5002, Kingston, NY 12402
- Hudson River Housing Inc., 313 Mill Street, Poughkeepsie, NY 12601
- PEOPLE Inc., 126 Innis Avenue, Poughkeepsie, NY 12601
- Rehabilitation Support Services Inc., 510 Haight Avenue, Suite 102, Poughkeepsie, NY 12603
- Rockland Psychiatric Center Residential Services, (Hudson River Division), 10 Ross Circle, Poughkeepsie, NY 12601
- Mental Health America of Dutchess County, 253 Mansion Street, Poughkeepsie, NY 12601
- Other Housing Provider: _____

- A written request is necessary to revoke an authorization and should be directed to the Unit Administrator/Director in the program you are or were attending.
- I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Any re-release or further disclosure of information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations is prohibited. A general authorization for the release of medical or other information is not sufficient for this purpose.
- Information disclosed pursuant to this Authorization, except information protected by federal and/or state regulations about confidentiality of drug and alcohol abuse records, mental health records and HIV (HIV requires a separate authorization), may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. Most health care providers and all health benefit plans must follow federal rules protecting the privacy of health information; however those rules do not apply to other organizations.
- My authorization is subject to revocation at any time (except to the extent that action has already been taken) and **EXPIRES:**

_____ UPON MY REVOCATION OR ONE YEAR FROM DATE OF SIGNATURE
 _____ ON THIS EVENT OR DATE: _____

I have received a copy of this authorization.

Patient Signature: _____ Date: _____

OR

Patient's representative who is empowered to act on his/her behalf by reason of: _____

Representative's Name: _____ Date: _____
 (Print Name) (Signature)



DUTCHESS COUNTY DEPARTMENT OF BEHAVIORAL & COMMUNITY HEALTH
 Single Point of Access (SPOA)
 230 North Road, Poughkeepsie, NY 12601
 Tel: (845) 486-2764 Fax: (845) 486-2882

**AUTHORIZATION FOR COMMUNICATION
 BETWEEN DBCH AND TREATMENT PROVIDERS
 FOR SINGLE POINT OF ACCESS (SPOA)**

PATIENT'S NAME:			
UNIT:	DOB:	REGISTER #:	

I hereby authorize the Dutchess County Dept of Behavioral and Community Health Housing Coordinator to exchange information with the following Agencies and Programs as part of the Single Point of Access. **Check all that apply to the SPOA application**

- | | |
|--|---|
| <input type="checkbox"/> Access: Supports for Living, 15 Fortune Road West, Middletown, NY 10941
<input type="checkbox"/> ACT Team (of RPC), Hudson River Division, 10 Ross Circle, Poughkeepsie, NY 12601
<input type="checkbox"/> Astor Services for Children and Families, 46 Lincoln Avenue, Poughkeepsie, NY 12601
<input type="checkbox"/> Benedictine Hospital, 105 Mary's Avenue, Kingston, NY 12401
<input type="checkbox"/> Children's Home of Poughkeepsie, 10 Children's Way, Poughkeepsie, NY 12601
<input type="checkbox"/> Dutchess Clinic, (RPC), 26 Oakley Street, Poughkeepsie, NY 12601
<input type="checkbox"/> Dutchess County BOCES, 900 Dutchess Turnpike, Poughkeepsie, NY 12603
<input type="checkbox"/> Dutchess County Dept. of Community and Family Services, 60 Market St, Poughkeepsie, NY 12601
<input type="checkbox"/> Family Services Behavioral Health Centers (HVMH) Site Location: _____
<input type="checkbox"/> Lexington Center for Recovery, 20 Manchester Road, Poughkeepsie, NY 12603
<input type="checkbox"/> Mental Health America of Dutchess County, 253 Mansion St, Poughkeepsie, NY 12601
<input type="checkbox"/> MidHudson Regional Hospital of Westchester Medical Center, 241 North Road, Poughkeepsie, NY 12601 | <input type="checkbox"/> NY Presbyterian Hospital Payne Whitney Westchester, 21 Bloomingdale Road, White Plains, NY 10605
<input type="checkbox"/> PEOPLE, Inc., 126 Innis Avenue, Poughkeepsie, NY 12601
<input type="checkbox"/> Phelps Memorial Hospital Center, 701 N. Broadway, Sleepy Hollow, NY 10591
<input type="checkbox"/> Putnam Hospital Center, Stoneleigh Avenue, Carmel, NY 10512
<input type="checkbox"/> Rockland Children's Psychiatric Center, 140 Old Orangeburg Road, Orangeburg, NY 10962
<input type="checkbox"/> Rockland Psychiatric Center, 140 Old Orangeburg Road, Orangeburg, NY 10962
<input type="checkbox"/> Spectrum Behavioral Health, 510 Haight Avenue, Poughkeepsie, NY 12603
<input type="checkbox"/> St. Vincent's Hospital, 275 North Street, Harrison, NY 10528
<input type="checkbox"/> Step One, 106 Vineyard Avenue, Highland, NY 12528
<input type="checkbox"/> VA Hudson Valley Health Care System, Route 9D, Castle Point, NY 12511
<input type="checkbox"/> Westchester Medical Center Behavioral Health Center, 100 Woods Road, Valhalla, NY 10595
<input type="checkbox"/> Dutchess Outreach Team (DOT)
<input type="checkbox"/> _____ |
|--|---|

The purpose of and need for the disclosure is for the Housing Coordinator to exchange information with the agencies listed above. The information to be exchanged includes: Single Point of Access Housing Application, income verification, psychiatric evaluation/update, psychosocial assessment (including diagnosis, mental status), physical exam, PPD results (chest x-ray if needed). Discharge summary and/or psychological testing if needed.

- A written request is necessary to revoke an authorization and should be directed to the Unit Administrator/Director in the program you are or were attending.
- **I understand that my alcohol and/or other drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Any re-release or further disclosure of information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations is prohibited. A general authorization for the release of medical or other information is not sufficient for this purpose.**
- **Information disclosed pursuant to this Authorization, except information protected by federal and/or state regulations about confidentiality of drug and alcohol abuse records, mental health records and HIV (HIV requires a separate authorization), may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. Most health care providers and all health benefit plans must follow federal rules protecting the privacy of health information; however, those rules do not apply to other organizations.**
- I understand that generally, DBCH may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

My authorization is subject to revocation at any time (except to the extent that action has already been taken) and **EXPIRES:**

UPON MY REVOCATION OR SIX MONTHS FOLLOWING TERMINATION OF TREATMENT OR

ON THIS EVENT OR DATE:

I have received a copy of this authorization:

Date: _____ Patient Signature: _____

OR

Patient's representative who is empowered to act on his/her behalf by reason of: _____

Date: _____ Signature: _____