

APPLICATION FOR ADULT SERVICES

This application package is for use in referring individuals to residential, case management and psychosocial/vocational programs funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties. Service providers include Warren-Washington Association for Mental Health and Behavioral Health Services of the Glens Falls Hospital.

The objectives of the programs are to provide support to recipients of mental health services; foster the values of recovery, hope, excellence, respect and safety; assist recipients with a successful transition to independent living; enable them to improve their quality of life in the community, and reduce the number of hospitalizations they experience.

The attached application should be filled out completely. In addition, the referring agent should attach copies of:

1. **Signed consent for release of information**
2. **Psychiatric evaluation (*most recent; for Residential Programs, must be within one year*)**
3. **Current treatment plans (*most recent*)**
4. **Relevant admission and discharge summaries (*most recent*)**
5. **Physical exam with Mantoux T.B. test (*Residential Programs and South Street Center Only*)**
6. **Functional assessment survey (*Residential Programs Only*)**
7. **Signed physician authorization for restorative services (*Residential Programs Only*)**

Availability of services is limited, and there may be a delay in receiving services even after an applicant has been determined to be eligible. If the referring agent or applicant is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and the programs it represents reserve the right to make the final determination.

The New York State Office of Mental Health sets residential program fees. Funding sources such as SSI, SSDI and Public Assistance adjust the recipient's support payment to ensure that the program fee is covered in the monthly payment. In order to process this application, please have the funding in place prior to admission to the residential programs. Other financial arrangements for private pay residents must also be in place prior to admission.

Completed applications and required documentation should be forwarded to:

SPOE Coordinator
Office of Community Services
230 Maple Street
Glens Falls, NY 12801
Telephone: (518) 792-7143
Fax: (518) 792-7166

After receiving the completed application, we will contact you as soon as possible regarding the next steps in the process.

Thank you for your interest in our programs.

PROGRAMS REQUESTED (Check all that apply):

Residential Programs

- Group Homes (Genesis/Pearl Street)
- Intensive Supportive Apartments
- Supportive Apartments
- Supported Housing

Case Management

- Intensive Case Management
- Supportive Case Management
- Dual Recovery Case Management

Psychosocial Club/Vocational Rehabilitation

- East Side Center
- Project C.H.O.I.C.E.

CLIENT INFORMATION:

Name: _____ Date of Referral: _____

Address: _____ City, State, Zip: _____

Phone (H): _____ Phone (W): _____ Sex: _____ DOB: _____

Social Security: _____ Medicaid/Medicare #: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Please check all that apply:

- Functionally Disabled due to a Mental Illness
- SSI or SSDI Enrollment due to a Mental Illness
- Functionally Disabled in the Areas Indicated:
 - Self-Care Activities of Daily Living Social Functioning
 - Inability to Complete Tasks Self-Direction Economic Self-Sufficiency
- Regular and Ongoing Reliance on Psychiatric Treatment, Rehabilitation, and Supports

Referral Source: _____ Name: _____ Relationship: _____

Address: _____ Phone: _____ Fax: _____

Reason for referral at this time (please state specifically how these services will benefit the applicant): _____

PSYCHIATRIC INFORMATION:

Clinical Treatment Provider: _____ Phone: _____

Therapist: _____ Psychiatrist: _____

Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Medications (please list dosage and attach additional sheets if necessary): _____

Does the applicant take medications as prescribed? Yes No

SUICIDE/HOMICIDE RISK: Yes No Unknown

Please describe recent suicidal ideation, suicide attempts or homicidal ideation: _____

Please describe past history of suicidal ideation, suicide attempts or homicidal ideation: _____

Early warning signs of decompensation: _____

PSYCHIATRIC HOSPITALIZATION: Unmet Needs Needs Met Unknown

Currently inpatient? Yes No Admit date: _____ Anticipated D/C date: _____

Please list any previous psychiatric hospitalizations: _____

MENTAL HEALTH TREATMENT: Unmet Needs Needs Met Unknown

Please list any previous outpatient treatment, including current: _____

Brief history of illness: _____

Does the applicant have a history of violence towards self or others? Yes No If yes, please explain.

HEALTH CARE: Unmet Needs Needs Met Unknown

Primary Care Provider: _____ Phone: _____

Medical Conditions: _____

Allergies: _____

Has a health care proxy been executed: Yes No

Has an advance directive been executed: Yes No

SUBSTANCE ABUSE: Unmet Needs Needs Met Unknown

Please list past and present use and treatment: _____

Length of sobriety: _____ Substance of choice: _____

Treatment provider: _____ Clinician: _____ Phone: _____

LEGAL INVOLVEMENT: Unmet Needs Needs Met Unknown

History of arson, legal or criminal involvement? Yes No Current charges pending? Yes No

Currently on probation? Yes No Currently on parole? Yes No

Please explain: _____

Probation or Parole Officer: _____ Phone: _____

FINANCIAL MANAGEMENT: Unmet Needs Needs Met Unknown

Check if applicable: Medicaid SSI SSD PA

Application pending for: Medicaid SSI SSD PA

Medicaid #: _____ Medicare #: _____ Other Insurance: _____

Please list any financial management needs, including rep payee status and income source: _____

LIVING ARRANGEMENT: Unmet Needs Needs Met Unknown

Homeless, or at risk of homelessness? Yes No

Please list current living arrangement, including any current or pending subsidies: _____

Many programs require group living and/or group participation. Please assess applicant's ability to tolerate such a structure: _____

VOCATIONAL/EDUCATIONAL FUNCTIONING: Unmet Needs Needs Met Unknown

Please list vocational/educational goals, strengths, barriers to employment/school participation and work history:

TRANSPORTATION: Unmet Needs Needs Met Unknown

Please list current transportation needs: _____

SOCIAL SUPPORTS: Unmet Needs Needs Met Unknown

Natural supports: _____

Leisure time activities: _____

Social clubs/support groups: _____

Identified needs: _____

Is individual aware of this referral? Yes No

Is individual interested in services? Yes No

Please list client strengths and skills: _____

SERVICE NEEDS:	Yes	No	High Priority	Low Priority
Psychiatric Services:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living Arrangements:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benefits/Financial:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Services:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work/School:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/Family Relationships:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis/Safety Planning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):				

ADDITIONAL COMMENTS:

Please add any additional comments: _____

Required information:

- Consent for release of information
- Psychiatric evaluation (most recent; for Residential, within 1 year)
- Treatment plan (most recent)
- Admission/discharge summaries (most recent)
- Physical exam with T.B. (Residential, South Street Center only)
- Functional assessment survey (Residential only)
- Signed physician authorization for restorative services (Residential only)

Please send form and information to:

SPOE Coordinator
Office of Community Services
230 Maple Street
Glens Falls, NY 12801
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**FUNCTIONAL ASSESSMENT SURVEY
FOR RESIDENTIAL REFERRALS ONLY**

Information is based upon (please specify by circling):

1. Direct observation
2. Patient's own report
3. Other (please specify): _____

Please use the following for Parts I and II. Rate by circling appropriate number.

1 = no problem 2 = minor problem 3 = moderate problem 4 = severe problem

I. PSYCHIATRIC PROBLEMS

IN THE LAST YEAR HAS THIS PERSON EXHIBITED:

Some concerns (preoccupation with physical health, fear of physical illness)	1	2	3	4
Anxiety (worry, fear, heightened concern for present or future)	1	2	3	4
Emotional withdrawal (lack of spontaneous interaction, isolation, deficiency in relating to others)	1	2	3	4
Unusual thought content or conceptual disorganization (odd, Disorganized, bizarre or confused thoughts)	1	2	3	4
Tension (motor manifestation, nervousness, hyperactivity)	1	2	3	4
Mannerisms, posturing (bizarre motor behavior)	1	2	3	4
Hostility (animosity, contempt or belligerence)	1	2	3	4
Suspiciousness (mistrust, belief that others harbor malicious or discriminatory intent)	1	2	3	4
Hallucinatory behavior (perceptions without normal external stimuli)	1	2	3	4
Motor retardation (slowed, weakened movements or speech)	1	2	3	4
Blunted affect (reduced emotional tone, reduction in normal Intensity of feeling, flatness)	1	2	3	4
Excitement (heightened emotional tone, agitation, increased reactivity)	1	2	3	4
Disorientation (confusion or lack of association for person, place or time)	1	2	3	4
Uncooperativeness (resistance, guardedness, rejection of authority)	1	2	3	4

II. BEHAVIOR

WITHIN THE LAST YEAR, DID THIS PERSON:

React poorly to criticism, stress or frustration	1	2	3	4
Respect limits set by others	1	2	3	4
Threaten physical violence to others	1	2	3	4
Damage property to others	1	2	3	4
Damage own property	1	2	3	4
Require one to one supervision	1	2	3	4
Miss or arrive late for assignments	1	2	3	4
Wander or run away	1	2	3	4
Behave inappropriately in a group setting	1	2	3	4
Take or use other's property without permission	1	2	3	4
Shown antisocial sexual behavior	1	2	3	4
Threaten harm to self	1	2	3	4
Do harm to self	1	2	3	4

Please use the following for Parts III and IV. Rate by circling appropriate number.

1 = independently 2 = reminders/assistance 3 = requires 1:1 supervision 4 = can't or will not

III. DAILY LIVING SKILLS

DOES THIS PERSON:

Shop for personal necessities	1	2	3	4
Manage personal money	1	2	3	4
Use social service agencies appropriately	1	2	3	4
Use social supports/community resources	1	2	3	4
Devote proper time to tasks	1	2	3	4
Engage in individual leisure activities	1	2	3	4
Dress appropriately	1	2	3	4

FUNCTIONAL ASSESSMENT SURVEY-FOR RESIDENTIAL ONLY

Do own laundry	1	2	3	4
Take medication as prescribed	1	2	3	4
Keep clinic or other appointments	1	2	3	4
Use money correctly for purchases	1	2	3	4
Perform home maintenance/cleaning	1	2	3	4
Maintain an adequate diet	1	2	3	4
Use public transportation	1	2	3	4
Maintain adequate personal hygiene	1	2	3	4
Use telephone correctly	1	2	3	4
Smoke in a safe manner	1	2	3	4
Wake up promptly	1	2	3	4
Attend a day program	1	2	3	4
Demonstrate basic cooking skills	1	2	3	4

IV. PROBLEM SOLVING AND INTERPERSONAL SKILLS

DOES THIS PERSON:

Apologize when appropriate	1	2	3	4
Respect personal space of others	1	2	3	4
Act assertively when appropriate	1	2	3	4
Listen and understand	1	2	3	4
Resolve conflicts appropriately	1	2	3	4
Exercise good judgment	1	2	3	4
Plan in cooperation with others	1	2	3	4
Treat own minor physical problems	1	2	3	4
Obtain help for physical problems	1	2	3	4
Follow through on advice of doctor	1	2	3	4
Socialize with others	1	2	3	4
Take initiative or seek assistance with problems	1	2	3	4

ANNUAL PHYSICAL

Date of Physical: ____/____/____

Name: _____ **DOB:** ____/____/____ **Age:** ____
Last First Middle Initial Month Day Year

Height: _____ **Weight:** _____ **BP:** ____/____ **Pulse:** _____

Corrected Vision: Rt 20/ ____ Lt 20/ ____ **Pupils:** Equal ____ Unequal ____ **Hearing screen:** Pass ____ Fail ____

PHYSICAL EXAM	NORMAL	ABNORMAL (please explain, including illnesses, disease, injuries, and/or deformities)
Appearance		
Skin		
Eyes, ears, nose, throat		
Mouth: Teeth & Gums		
Hair & Scalp		
Lymph nodes		
Neck, thyroid		
Heart/pulses		
Lungs		
Abdomen (include hernia)		
Back & Spine		
Genitourinary		
Neurological/Reflexes		
Psychological		
Musculoskeletal		
Extremities		

Current Medications

Name and Dose of Medication	What Medication is Treating	Prescriber

General health: ____ Excellent ____ Good ____ Fair ____ Poor

Immunizations Up To Date? ____ Yes ____ No ____ Information unavailable at this time

Immunizations given at today's appointment? ____ Yes ____ No Please describe:

Urinalysis Results: Date of Urinalysis: ____/____/____ Sugar: _____ Albumin: _____ Specific Gravity: _____

PPD Testing: Date Placed: ____/____/____ Date Read: ____/____/____ Results: _____

Further Investigation or Treatment Recommended:

Additional Comments:

 Printed Name and Credential of Examining Provider

 Signature of Examining Provider

Address: _____
