Onondaga County Adult SPOA Application

Onondaga County Civic Center, 8th Floor
421 Montgomery Street
Syracuse, New York, 13210
Telephone: (315) 435-7711 x4696 Email: AdultSPOA@ongov.net

Services Requested

Desired Outcome:
☐OMH Residential; Congregate or Apartment Tx ☐OMH Supportive Housing
☐ Non-Medicaid Case Management for SMI Eligible ☐Assertive Community Tx (ACT team)
☐ CR-Single Room Occupancy (CR-SRO) ☐Forensic Assertive Community TX (FACT)
☐ Forensic Case Management ☐TBD

Client Information

Name:	Gender:	DOB:	Last 4 SSN:
Preferred Name:	Primary Language:	Income source/ Amount:	

Translation Needed: ◯Yes ◯No

Current Address where residing:

Mailing Address if different from above:

Phone #:	May we leave a message on this phone? ◯Yes ◯No
Medicaid #:	If inpatient, anticipated release date:

Eligibility Information

Diagnoses: Primary ICD.10 Diagnosis Listed First (Attach Supporting Docs)	ICD 10 Codes
1.	
2.	
3.	
4.	

To be considered an adult with a Severe Mental Illness **A** must be met. In Addition, **B**, **C** or **D** must be met.

A. Designated Mental Illness Diagnosis ◯Yes ◯No

The individual is 18 years of age or older and currently meets the criteria for a psychiatric diagnosis according to the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) other than alcohol or drug disorders, organic brain syndrome, developmental disabilities, or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.

AND

B. SSI or SSD due to Mental Illness ◯Yes ◯No

The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

OR

C. Impairment in Functioning due to Mental Illness.

The individual has experienced two of the following four functional limitations due to a designated illness over the past 12 months on a continuous or intermittent basis.

◯ Yes	◯ No	Marked difficulty in self-care (i.e. personal hygiene, diet, medical care, etc.)
◯ Yes	◯ No	Marked restriction 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.

OR

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports ◯ Yes ◯ No

A documented history shows that the individual, at some prior time, met the threshold for C (above) but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control 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, which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of underlying mental disorders.

HIGH RISK/ PRIORITY RATING

Scale: Select one response for each. Provide narrative through a psychosocial or core history for responses of 3, 4 or 5.

0 – Never
1 – Not at all in the last 6 months
2 – One or more times in the past 6 months
3 – One or more times in the past 3 months
4 – One or more times in the past month
5 – One or more times in the past week
U - Unknown

For internal use only
Score: Click here to enter text.
Priority: Click here to enter text.
Initials: Click here to enter text.

	0	1	2	3	4	5	U	Score
Homeless	◯	◯	◯	◯	◯	◯	◯	
Imminent Risk of Homelessness	◯	◯	◯	◯	◯	◯	◯	
ER Visit (Medical)	◯	◯	◯	◯	◯	◯	◯	
ER Visit (Psychiatric)	◯	◯	◯	◯	◯	◯	◯	
ETOH/Substance Use	◯	◯	◯	◯	◯	◯	◯	
Suicidal ideation, plan or intent	◯	◯	◯	◯	◯	◯	◯	
Attempt homicide	◯	◯	◯	◯	◯	◯	◯	
Mental Illness that is impeding daily function	◯	◯	◯	◯	◯	◯	◯	
Assaultive Behavior	◯	◯	◯	◯	◯	◯	◯	
Arrested	◯	◯	◯	◯	◯	◯	◯	
Incarcerated	◯	◯	◯	◯	◯	◯	◯	

If yes to any of the following, please attach narrative psychosocial history.

Has the individual ever been suspected of sexual abuse to a child and/or adult? ◯Yes ◯No

Has the individual ever physically abused and/ or assaulted a child and/or adult? ◯Yes ◯No

Has the individual ever engaged in fire setting? ◯Yes ◯No

Has the individual ever been a victim of physical or sexual abuse? ◯Yes ◯No

Sex Offender Status? ◯Unknown ◯Level I ◯Level II ◯Level III ◯N/A

Psychiatric Hospitalization and/or Inpatient Rehabilitation Stays

Facility Name/Location	Admission/Discharge Dates		Reason for admission

Significant Other / Emergency Contact

Name:	Relationship:	Address:	Phone:

Referral Information

Substance Use: ◯Current use ◯In the last 6 months ◯6 months or more since last use

List substance(s) used:

Physical/Medical Concerns:

Reason for Referral: (Why does this individual require the level of service? Identified barriers? Strengths?)

Collateral Services/Providers		
Please list any service providers the individual is currently engaged with.		
Name:	Name:	Name:
Role:	Role:	Role:
Agency:	Agency:	Agency:
Email:	Email:	Email:
Phone:	Phone:	Phone:
Name:	Name:	Name:
Role:	Role:	Role:
Agency:	Agency:	Agency:
Email:	Email:	Email:
Phone:	Phone:	Phone:

Referral Source	
Name/Title of referral Source:	Signature:
Agency:	Date:
Address:	
Phone:	
Email Address:	
I understand that by signing this referral packet, I am voluntarily requesting access to mental health support services.	
Signature of applicant (Digital Signature or Ink Signature Please)	Date:

This referral will not be processed without the following items attached and <u>all</u> of the referral completed:

☐ Current psychosocial History
☐ Current Psychiatric Assessment
☐ Signed SPOA Release of Information