2017 Onondaga County Adult SPOA Application

Send with **Records** and signed **SPOA Permission Form to SPOA Fax: 315-435-3279**

Referral Information

Referral is for: *See OMH SMI High Priority Eligibility Criteria	☐ OMH Residential Services; Congregate or Apartment Treatment ☐ OMH Supported Housing ☐ Non Medicaid CM for SMI* Eligible ☐ Forensic Case Management ☐ ACT Team ☐ SRO ☐ To be determined ☐ Other_____		
Date of Referral:		**Applicant Gender:**	☐ **Male** ☐ **Female**
Applicant Name:		**AKA:**	
Social Security Number, last 4 digits:	**Applicant DOB:**		
Home Street Address:			
(City, State, Zip)			
Current Location:			

If inpatient, anticipated release date:_____

Alternate Contact, Address and/or Phone # for Client when in the community:	Emergency Contact Name, Address & Phone #:
May we leave a message? ☐ Yes ☐ No	

Referring person contact information: **Provider Type**: _____

Name: _____ Role_____

Agency: _____

Address: _____

Phone: _____ Fax: _____

Email Address: _____

Legal Status

Involved with: **If incarcerated, anticipated release date_____**

☐ Parole ☐ County Probation ☐ Federal Probation/history

PO name and phone: _____

Reason/charges/convictions_____Restrictions? _____

☐ CPL _____ ☐ Court Order or Diversion ☐ Town Court ☐ Treatment Court

☐Adult Protective Services ☐Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other: _____

Medicaid Status

Client Medicaid #: __ __ __ __ __ __ __ __

Managed Care Company:_____

Medicaid active? Yes_____ No_____ HARP eligible? **Yes ____ NO_____ Not known _____**

Name_____

Personal And Demographic Information

Race / Ethnicity	Primary Language	English Proficiency (If primary language is not English)
☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian ☐ American Indian or Native ☐ Other (specify) _____	☐ English ☐ Spanish ☐ American Sign Language ☐ Other (specify) _____	☐ Does Not Speak English. ☐ Poor ☐ Fair ☐ Good - Does Not Need Translator ☐ Literacy level:

Veteran Status

Veteran or served in military? ☐ Yes ☐ No Branch/ type of discharge: _____

Service Connected Disability? ☐ Yes ☐ No If Service Connected _____%

Current Marital Status	Custody Status of Children
☐ Single, never married ☐ Currently married ☐ Divorced/separated ☐ Widowed	☐ No children ☐ Minor children in clients custody, ages:_____ ☐ Have children - older than 18 years ☐ Minor children not in client's custody but have access ☐ Minor children no custody - no access

Prior Living Situations: **Section 8 Status:**

If planning to live with family/friend, please list other members of the household:

Current Educational Level	Employment/Vocational
☐ No formal education ☐ Some grade school (1-8th grade) ☐ Completed grade school ☐ Some HS (9-12th grade, but no diploma) ☐ HS diploma or GED ☐ Vocational, business training ☐ Some college, no degree ☐ College degree ☐ Master's degree ☐ Other:_____	☐ If has employment history, describe: ☐ Other vocational training, describe: Recommendations: ☐ Access-VR involvement ☐ Other:

Representative payee history?	☐ No ☐ Yes ☐ Recommended? Debts, if any: _____
Representative Payee Name:	
Agency:	
Phone:	**Address:**

Name_____

Clinical Information

	Diagnoses	CODE
DSM 5 MH		
DSM 5 SUD		
DSM 5 other		
Disability level		
Chronic health conditions		
Other health conditions		
BH Treatment type:		
Clinician:		
Psychiatrist:		
Other behavioral health supports:		

Number of ER Visits For Psychiatric Reasons in the in last 12 Months:_____
Number of Psychiatric Hospitalizations in the last 24 Months:_____

Date	Hospital	Length of Stay
_____	_____	_____
_____	_____	_____

Substance Use

Drugs of Choice:

☐ None ☐ Any IV Drug Use ☐ Alcohol ☐ Marijuana/Cannabis
☐ Crack ☐ Heroin/Opiates ☐ PCP ☐ Hallucinogens
☐ Cocaine ☐ Sedative/Hypnotic ☐ Benzodiazapines ☐ Spike, Synthetic Marijuana
☐ Prescription drugs ☐ Amphetamines ☐ Inhalant: Sniffing Glue/Other Household Product
☐ Other:_____Inpatient Rehab?_____

Physical Health/Wellness

Check off any of the following that apply:

☐ Incontinent ☐ Impaired Walking ☐ Requires Special Medical Equipment
☐ Hard of Hearing/Deaf ☐ Impaired Vision/Blind ☐ Lung Problems
☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure
☐ Chronic Pain ☐ Weight Concern ☐ Cognitive Impairment
☐ Speech Impairment ☐ Developmental Disorder ☐ Traumatic Brain Injury
☐ Learning Disability ☐ Other: _____

Financial Section: Income And Insurance Status

Income and Insurance	Now Receives	Income and Insurance	Now Receives
No Income	☐	Wages/Earned Income	☐
SSI	☐	Unemployment/Amount_____	☐
SSD	☐	Child Support Owed or Received $_____	☐
Temporary Assistance	☐	Worker's Comp	☐
Veterans benefits	☐	Social Security Retirement	☐
Medicare	☐	Pension/Amount:_____ Source _____	
Medicaid	☐	Trust Fund	☐
Food Stamps	☐	Special Needs Trust	☐
Other, Describe:_____		Private Insurance/Third Party Payer	☐

Name_____

Alerts Related To Risk To Self Or Others

	Yes	No	Date of most recent episode
History of Homelessness			
Victim of Physical/Sexual Abuse			
History of Domestic Violence in Home			
Chronic Self-Harm/Self-Mutilation			
History of Suicidal Ideation			
History of Suicide Attempts /Self Harm			
Elaborate on Other Serious Attempts			
Arson			
Physically Abusive and/or Assaultive of Another			
Sexually Assaultive Behavior			
Destruction of Property			
Current Access to Firearms			
Criminal Justice Involvement			
AOT Order			
AOT Enhanced			

Reason For Referral

Precipitating Events Leading up to Referral:

_____

_____

Current Symptoms:

_____

Desired Outcome of Care Coordination or Residential Services:

_____

_____

Strengths:

_____

_____

Please Specify Discharge Linkages:

_____

_____

Please Note Anything You Have Questions About Regarding Your Plan:

The individual requesting services agreed to submit this application □ **YES** □ **NO**

The individual requesting services agreed to review by the SPOA Team and Potential Providers. □ **YES** □ **NO**

Individual, i.e. Applicant's Signature: _____

Date: _____

Onondaga County SPOA Team

Call: 315-435-3355 x4695;

Valerie Flanagan, x4695, Jennifer Feliciano x4997, Jan Moag x4696

Name_____