County of Oswego

OMH Permanent Supported Housing application

NAME: _____ DOB: _____

Before completing this referral, please ensure (and mark) the following:

☐This individual is 18+ years old

☐This individual has a primary DSM-5 diagnosis of a severe mental illness other than alcohol/substance use disorders, developmental disabilities, dementias, or mental disorders due to a general medical condition.

Diagnosis Codes: _____

Before submitting this referral, please ensure (and mark) the following:

☐ Completed OMH Permanent Supported Housing application (pages 1 — 5) **AND**

☐ Signed Oswego County Referral Process Consent Form (page 7) **AND**

☐ Signed Authorization for Releases of Information to obtain additional information from current or most recent MH Clinical provider **AND**

☐ Completed Eligibility Form signed by NYS licensed provider (page 6) **AND**

☐ Current (within 1 year of application) Psychosocial and/or Psychiatric Assessment

Submit Referral by email for:

☐ **DePaul Lock 7**:Lock7@Depaul.org (by mail: Lock 7 Apartments, 220 E. First Street, Oswego, NY 13126)

☐ **Selkirk Landing**: rreynolds@oco.org (by mail: Attn: Selkirk Landing, 239 Oneida St., Fulton, NY 13069)

☐ **First Available Permanent Housing**: Submit application to both above

Please call with any questions:
Oswego County SPOA: Nathan Barron (315) 963-5361
Lock 7 apartments: Gabrielle DeSilvia (315) 916-4566
DePaul: Carolyn Dzielski (585) 777-3503
OCO: Reva Reynolds (315) 216-4521

County of Oswego

OMH Permanent Supported Housing application

Referral Information			
Referral is for:	☐ Selkirk Landing ☐ Lock 7 Apartments ☐ Any Available		
Date of referral:		**Applicant Gender:**	
Applicant Name:		**AKA:**	
Social Security Number: **Home Street Address:**	**Applicant DOB:**		
(City, State, Zip)			
Current Location:		**Applicant's Phone Number:**	
If inpatient, anticipated release date:			
Alternate Contact, Address and/or Phone # for Client when in the community: **May we leave a message?** ☐Yes ☐No	Emergency Contact Name, Address & Phone #:		
Referring person contact information:	**Provider Type:**		
Name:	**Role**		
Agency:			
Address:			
Phone:	**Fax:**		
Email Address:			
Does this individual have a care manager or other supports (such as Adult protective, Housing worker, HHCM, etc.): ☐Yes ☐No			
If yes, please provide name, agency, and contact info:			

Legal Status

Involved with: **If incarcerated, facility name and anticipated release Date:**

☐ Parole ☐ County Probation ☐ Federal Probation/history

PO name and phone:

Reason/charges/convictions: Restrictions?

Current involvement with:

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

☐ Adult Protective Services ☐ Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other:

Prior Living Situation: Section 8 Status:

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

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) Translator	☐ Does Not Speak English. ☐ Poor ☐ Fair ☐ Good - Does Not Need
	Literacy level: O Below Basic O Basic O Intermediate O Proficient	

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	☐ No children ☐ Minor children in client's custody, ages:
☐ Divorced/separated ☐ Widowed	☐ Have children - older than 18 years ☐ Minor children not in client's custody but have access ☐ Minor children no custody - no access

Current Educational Level	Income Sources (with amounts)
☐ No formal education ☐ Some grade school (1-8th grade) ☐ Completed grade school ☐ Some 1-IS (9-12th grade, but no diploma) ☐ HS diploma or GED ☐ Vocational, business training ☐ Some college, no degree ☐ College degree ☐ Master's degree ☐ Other:	☐ SSI _____ ☐ SSDI _____ ☐ Temporary Assistance _____ ☐ Food Stamps (SNAP) _____ ☐ TANF _____ ☐ Veteran's Benefits _____ ☐ Employment/Wages _____ ☐ Family/Spouse _____ ☐ Child Support _____ ☐ Pension _____ ☐ None _____ ☐ Other Income _____

Representative payee	Current Payee: O No O Yes O Recommended? Debts, if any:
Representative Payee Name:	
Agency:	
Phone:	Address:

Medicaid Status

Client Medicaid (CIN) #:

Managed Care Company:

Medicaid active?	Yes	No	HARP eligible?	Yes	NO	Not known
Medicare	Yes	No				

Current Community Survival Skills:

Can the referred individual:	Not at All		With Support		Independently
Evacuate a building within 3 minutes	☐	☐	☐	☐	☐
Bathe/ dress	☐	☐	☐	☐	☐
Hygiene Grooming	☐	☐	☐	☐	☐
Eating/ cooking	☐	☐	☐	☐	☐
Risk of falling (low to high)	☐	☐	☐	☐	☐
Risk of wandering(low to high)	☐	☐	☐	☐	☐
Coordinate their own transportation	☐	☐	☐	☐	☐

Substance Use

Drugs of Choice:

☐ None	☐ Any IV Drug Use	☐ Alcohol	☐ Marijuana/Cannabis
☐ Crack	☐ Heroin/Opiates	☐ PCP	☐ Hallucinogens
☐ Cocaine	☐ Sedative/Hypnotic	☐ Benzodiazepines	☐ Spike, Synthetic Marijuana
☐ Prescription drugs	☐ Amphetamines	☐ Inhalant: Sniffing Glue/Other Household Product	
☐ Other:		**Date of last Use:** _____	

History of Inpatient/outpatient (SUD) Treatment: Yes/ No When: Where:

Clinical Information

	Diagnoses	CODE
DSM 5 MH		
DSM 5 SUD		
DSM 5 other		
Disability level		
Chronic health conditions		
Other health conditions		
Developmental disorder /cognitive impairment		
Learning Disability		
Clinician:	(Name & Number)	
Psychiatrist:	(Name)	
Other behavioral health supports:		

Hospitalizations

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

Number of Psychiatric Hospitalizations in the last 24 Months:
Length of Stay: _____

Date(s) Hospital

Physical Health/Wellness

Check off any of the following that apply:

- ❑ Asthma
- ❑ Breathing or Lung Problems
- ❑ Traumatic Brain Injury
- ❑ Incontinent
- ❑ Hearing impairment
- ❑ Impaired Vision/Blind
- ❑ Impaired Walking
- ❑ Diabetes
- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Chronic Pain
- ❑ Weight Concern
- ❑ Speech Impairment
- ❑ Requires Special Medical Equipment
- ❑ Other:

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

Reason For Referral

(Please include all relevant information such as reason for referral, current symptoms, desired outcome, etc. If there is a significant change from a previous referral, please state it here.)

The individual requesting services agreed to the submission of this application ☐YES ☐NO

Applicant's Signature: _____

Name (printed) _____

Date: _____

APPLICANT'S NAME:_____ DATE OF BIRTH_____

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SERIOUS MENTAL ILLNESS AMONG ADULTS

TO BE CONSIDERED AN ADULT DIAGNOSED WITH SERIOUS MENTAL ILLNESS, **CRITERIA A MUST BE MET. IN ADDITION, CRITERIA B OR C OR D MUST BE MET.** PLEASE CIRCLE LETTER OR NUMBER OF ALL THAT CURRENTLY APPLY. *A LICENSED PROFESSIONAL QUALIFIED TO DIAGNOSE AND TREAT MENTAL ILLNESS MUST VERIFY THAT THESE CRITERIA ARE MET.*

A. Designated Mental Illness Diagnosis _____ _____
Description Code

The individual is 18 years of age or older and currently meets the criteria for At least one DSM 5 psychiatric diagnoses as listed below: Psychotic Disorders (F21-F23, F20.81, F20.9, F25.0-F25.1, F06.0-F06.2, F28-F29), bipolar disorders (F31.11-F31.12, F31.14, F31.2, F31.73-F31.74, F31.9, F31.0, F31.31-F31.32, F31.4-F31.5, F31.75-F31.76, F31.81, F34.0, F06.33-F06.34, F31.89), obsessive-compulsive disorder (F42), depression disorders (F34.8, F32.0-F32.5, F32.9, F33.0-F33.2, F233.3, F33.41-F33.42, F33.9, F34.1, N94.3M F06.31-F06.32, F06.34, F32.9-F32.9, F34, F32.08), anxiety disorders (F41.9, F41.0-F41.1, F44.81, F40.0, F43.10, personality disorders (F60.0-F60.1, F60.3-F60.6, F60.9, F60.81, F21). Alcohol and/or Substance diagnosis, organic brain syndromes, development disabilities or social conditions **are not** qualifying diagnosis for serious mental illness.

AND

B. SSI or SSDI Enrollment due to Mental Illness
The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

OR

C. Extended Impairment in Functioning due to Mental Illness

1. The individual has experienced one or more of the following four functional limitations as a result of their qualifying diagnosis:

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

OR

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports

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 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 which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

DATE _____ CLINICIAN NAME (PRINT)_____

CLINICIAN SIGNATURE_____ TITLE_____

Oswego County
REFERRAL PROCESS
CONSENT FOR RELEASE OF INFORMATION

I consent to use and disclosure of protected health information about me for arranging services, treatment, payment, and health care operations as described below. This means that information about my health will be used by the staff of Oswego County Division of Mental Hygiene or disclosed to other people or organizations whenever needed to:

- Provide services to me or arrange for services by another health care or mental health service provider.
- Refer me to a Medicaid Health Home for access to Comprehensive Care Management Services
- Arrange for payment for services to me.
- Operate the business of Oswego County Single Point of Access Referral Process
- Enable Oswego County Division of Mental Hygiene to review the quality and appropriateness of care I receive from mental health organizations that provide services to Me.

I understand that information I choose to disclose pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed. I agree to use and disclosure of my health information as described in this consent.

_____ _____

Signature Date

_____

Print Name

I am the parent/guardian of the person whose records will be used or disclosed. I agree to the use and disclosure of the health information of (Child's Name)
_____ as described in this consent.

_____ _____

Signature Date

_____

Print Name

DePaul Community Services

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

A staff member from DePaul must complete this form prior to presenting it to you for signature. DO NOT SIGN A BLANK FORM. Please review the information below carefully and make sure you agree with the information prior to signing.

NAME: _____ DOB: _____

I hereby give permission to: _____

☐ receive information from: OR ☐ release information to:

PERSON/ORGANIZATION: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

INFORMATION:

_____Academic Performance/Vocational
_____Financial
_____Discharge Summaries
_____Intake/Screening Assessment
_____Medical History, Physical Findings, Lab reports
_____Medication Record
_____Psychiatric Evaluation/Status
_____Progress Notes
_____Medication Orders
_____Other (please specify)

_____Psych/Social Assessment
_____Residential Functioning
_____Treatment Plan (Mental Health)
_____Treatment Plan (Addiction)
_____Legal
_____Insurance
_____Psychological Evaluation
_____Dates in Program
_____Physician's Orders

_____

_____

THIS INFORMATION IS NEEDED FOR:

_____Psychiatric Treatment Services
_____Medical Treatment Services
_____Financial Linkage
_____Housing Support Services
_____Vocational Linkage/Coordination

_____Family/Significant Other Communication
_____Adult Day Care Coordination
_____At the request of the individual
_____Other (please specify) _____

I hereby authorize the release of the above Protected Health Information from my record. I understand that the information to be released from my record is confidential and protected from disclosure by Federal and State Confidentiality Rules. *

My authorization to release information to the person/organization/facility/program identified above, ***WILL EXPIRE ON ___/___/_____ OR WHEN I AM NO LONGER RECEIVING SERVICES*** from such person/organization/facility/program, unless otherwise specified. I understand if I sign this authorization, I will have the right to revoke it at any time, except to the extent the program has already taken action based upon my authorization. I also have a right to receive a copy of this form after I have signed it.

_____ _____ _____ _____

Signature of Individual Date Printed Name of Individual

_____ _____ _____ _____

Signature of Witness Date Printed Name of Witness

PLEASE NOTE: HIV/AIDS related information cannot be released under this form. A specific form exists for the release of HIV/AIDS information.

FOR CANCELLATION OF AUTHORIZATION

☐ ***I hereby revoke my permission as stated above to release protected health information from my record to the person or organization whose name and address as listed above.***

_____ _____ _____ _____

Signature of Individual Date Printed Name of Individual

_____ _____ _____ _____

Signature of Witness Date Printed Name of Witness

*With the exception of Substance Abuse Information, information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule for Substance Abuse Programs – information disclosed is protected by Federal Law and the recipient cannot make any further disclosure unless permitted by regulations.

12-5-17

Oswego County Opportunities, Inc.
Helping People. Supporting Communities. Changing Lives

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

OCO, Inc. HOPE Housing Program

I, _____ _____ hereby authorize:
(Resident Printed Name) (DOB)

Oswego County Opportunities, Inc. HOPE Housing Program

To communicate with and exchange information with:

_____
(Person and/or Agency Information is Being Released To)

_____
(Address/ Phone Number)

On an ongoing basis for the purpose of coordinating services. Information to be exchanged will be limited to medical, dental, psychological, financial, social and vocational information/

I understand that my records are protected under Federal Regulations governing Confidentiality and the Health Insurance Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

The duration of this authorization is 12 months. This authorization will expire 30 days after discharge, should I discharge from the OCO HOPE Housing Program during that time.

I understand that I may revoke this authorization at any time by notifying the program in writing, *except to the extent that an action has been taken in reliance on my consent.*

Specific Limitation(s) If Any:

_____

_____

_____ _____
Residents Signature Date

_____ _____
Witness Signature Date

Residential Services Department
239 Oneida Street | Fulton, NY 13069 | ph: 315-598-4710
| fax: 315-598-4788
Developmental Disabilities Services / Mental Health Services
Chemical Dependence Services / Backstreet Apartments