Revised on 11/10/2021

SCHENECTADY COUNTY SINGLE POINT OF ACCESS APPLICATION FOR HOUSING AND CASE MANAGEMENT SERVICES
(Only typed Submissions will be accepted)

Referral Date:

CLIENT INFORMATION:

Name:	**Gender**:
Social Security Number:	**County of Origin**: .
Primary Address (please include City and Zip Code):	**Date of birth**: .
Client's phone number:	
Emergency contact:	**Relationship to client**:
Emergency contact's Address and Phone:	
Marital Status:	**Health Home Patient**: **AOT Client**:
Ethnic group:	**Education level**:
Current employment status:	**Custody of children**:
Current criminal justice status:	**Specify charges**:
Is client currently involved in other legal matters: Choose an item. **If yes, please specify:**	**Sex offender status**: **Notes:**

REFERENT'S INFORMATION:

Referred by:	**Agency**:
Title:	**Phone number**:
Referent's email address:	
Reason for referral (Client's needs & goals) **Be Specific:**	

CLIENT'S FINANCIAL INFORMATION:

Medicaid #:	**Medicare #**:
Private insurance information:	
Entitlements and income (check appropriate boxes and attach award/shelter letter): ☐ SSI/SSD ☐ Food Stamps ☐ Workers Compensation ☐ Public Assistance ☐ Pension: Amount: $ ☐ Other (trust fund, unemployment, etc: $ ☐ Veteran's Benefits: $	
Does this client have a Representative Payee?	**If yes, who**? (Enter contact name)

CLIENT'S NEEDS: When a need is Indicated → Complete notes section in detail

Housing / Basic Needs:	**Notes**:
• ☐ 24-hr. on site staff supervision • ☐ Daily Medication Management *(Staff provide medications to client daily)* • ☐ Home Health Aide Services • ☐ Meals provided to applicant *(Is unable to cook and needs someone to cook and provide each meal)* • ☐ No ability to self-preserve (exit home unattended in 3 minutes • ☐ Needs assistance managing money (Be specific)	
Treatment Needs / Issues: • MH OP TX in place? • Day Tx / Psychiatric Rehab? • Substance Abuse Tx Svcs? • Recent MH Hospitalization? ○ # in last 6 months:	**Notes**:

ALERTS –

☐ **Danger to self** ☐ **Danger to others** *(List Risk factors including assaultive behavior, arson, legal involvement, suicide attempts/gestures)*	Specify:
☐ **Physical abuse** • ☐ Victim ☐ Abuser	Specify:
☐ **Sexual abuse** • ☐Victim ☐Abuser	Specify:
☐ **Drug / Alcohol Abuse History**	Specify:
☐ **Medical issues**: • Specify:	
☐ **Adult history of homelessness**	Specify:

CLINICAL INFORMATION:

DSM DIAGNOSIS (Enter both diagnosis and code):
• Current Mental Health Dx:

CURRENT TREATMENT TEAM:	
Agency name:	**Agency phone**:
Psychiatrist's name:	**Psychiatrist's phone**:
Clinician's name: .	**Clinician's phone**:
Care Management Agency: **Assigned Care Manager**:	**Care Manager's phone**:
Clinical Treatment appointments: • **Telehealth**: • **In person:**	

MEDICAL:

Medications (Psychiatric & Medical): (Please send medication list with packet)					
Medication	**Dose/Schedule**	**DR/NP Prescribed**	**Medication**	**Dose/Schedule**	**DR/NP Prescribed**

Date of COVID vaccine if applicable (please send proof with application)

Medical Providers:	
Primary care physician's name:	**Physician's phone**:
Dentist: .	**Dentist phone**:
Eye Doctor:	**Eye Doctor Phone**:
Specialty Doctors:	**Specialist phone number**:
Allergies:	
What level of support does the client require to achieve medication compliance?	

HOSPITALIZATION HISTORY:

To the degree known, list all psychiatric hospitalizations:			
Hospital	**Admit Date**	**Discharge Date**	**Comments**

Please give a brief history of the client's illness:
Mental health service utilization for the past 12 months: • Number of inpatient hospitalizations: • Number of days in the hospital: • Number of psychiatric emergency room visits w/o admission:

***SUBSTANCE ABUSE HISTORY*:**

<table>
<tr><td colspan="4">Does this client have a history of drug/alcohol abuse/dependency:
• If yes, at what age did abuse begin?</td></tr>
<tr><td colspan="3">Date of last use:</td><td>Longest period of sobriety:</td></tr>
<tr><td colspan="4">Drug(s) of choice:
☐ Tobacco ☐ Alcohol ☐ Cannbinoids ☐ Opiods ☐ Stimulants ☐ Club Drugs
☐ Hallucinogens Prescription Drugs ☐ Other compound</td></tr>
<tr><td colspan="4">List treatments beginning from most recent</td></tr>
<tr><td>Level of Care</td><td>Admit Date</td><td>Discharge Date</td><td>Comments</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">(SA History be specific):</td></tr>
<tr><td colspan="4">Substance abuse service utilization for the past 12 months:
• Number of inpatient rehabs:
• Number of admissions for detoxification:
• Number of inpatient psychiatric hospitalizations where substance abuse was a prominent issue:</td></tr>
</table>

***CONSUMER STATEMENT*:**

If the consumer chooses, they may use this space to express any information relevant to the above referral. This may include immediate and long term goals, personal needs, concerns, etc. (This section may be hand written by client.)

UNIVERSAL RELEASE OF INFORMATION:

All referrals for housing services should be forwarded to the Single Point of Access Coordinator. Referrals will be shared with the SPOA Committee, which is comprised of, but not limited to, representatives from Bethesda House of Schenectady, Capital District Psychiatric Center, Schenectady Community Support Center, Mohawk Opportunities, Rehabilitation Support Services, YMCA, ACT Team, Schenectady County Adult Protective Services, Hometown Health, DePaul Housing, Schenectady Community Action Program, New Choices Housing, Capital Region Health Connections, CDPHP, Catholic Charities, Northern Rivers and Ellis Medicine. This release may be used to request information from Capital Region BOCES, Schenectady County Department of Social Services, Schenectady County Probation, Schenectady County Adult Protective Services, NYS Parole, NYS Office of Mental Health, NYS Office of Alcoholism and Substance Abuse Services, NYS Office for People with Developmental Disabilities, NYS Department of Corrections and other contract agencies through the Schenectady County Office of Community Services. All client information will be used by the SPOA committee and the referral agency to assist in determining appropriate placement. My consent to release information will be used only during the application process and while on a waiting list for these services. I understand that this consent can be revoked at any time.

IN COMPLIANCE WITH FEDERAL HIPPA REGULATIONS; ALL REFERRALS MUST BE SIGNED BY CLIENT AND ONE WITNESS.

Signature of Client Date signed by Client

Signature of Witness Date signed by Witness

FOR ALL REFERRALS: MUST INCLUDE THE FOLLOWING SUPPORTING DOCUMENTATION TO BE PROCESSED:

- ☐ Current psych assessment signed by psychiatrist or nurse practitioner
- ☐ Core history updated over the past year
- ☐ Most recent physical examinations
- ☐ Most recent TB test

Please make sure all boxes are completed. If it doesn't apply please add N/A

Handwritten referrals WILL NOT be accepted.

Please type the information on the form.