Catholic Charities of Cortland County
OMH Supported Housing Referral

The Supported Housing Program provides on-going rental subsidies to individuals who qualify due to a serious and persistent mental illness (SPMI) documented by a qualified professional and who meet income guidelines. Individuals meet with the Program Coordinator monthly to discuss their progress and any housing issues.

Referral Source _____ Phone _____ Date _____

Contact Name _____

CLIENT INFORMATION

Name _____ Date of Birth _____ Soc. Sec. # _____

Address _____ Phone _____

Male _____ Female _____

Emergency Contact_____ Relationship _____

Address _____Phone _____

Has the applicant been referred to us before? Yes _____ No _____
If yes, explain. When, for what services and circumstances:_____

_____

_____

Current Living Situation: _____

Client is seriously and persistently mentally ill ☐ Yes ☐ No
***SPMI Form must accompany referral**

FINANCIAL STATUS

Client Receives: ☐ SSI ☐ SSD ☐ SSI/SSD Pending ☐ VA Benefit ☐ Wages
☐ PA - If yes, County of origin _____
Caseworker _____Caseworker Phone _____
☐ Other – Explain _____
☐ Medicaid # _____ ☐ Medicare ☐ Private Ins.: _____
☐ Current Representative Payee _____
☐ Applicant needs Representative Payee services
☐ Has the client ever been sanctioned by DSS? If yes, please explain:

_____

Current Financial Obligations
List all appropriate bills and amounts
Rent/Housing _____ Heat _____ Electricity _____

MEDICAL STATUS
Does applicant have any medical conditions that we should be aware of? (i.e. seizures, allergies, special diet, visual impairment, limited impairment, chronic illness, etc.)
☐ Yes ☐ No If yes, explain _____

_____

Applicant's Doctor(s) Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

Is applicant capable of self- preservation in case of emergency? (Evacuating housing safely) ☐ Yes ☐ No

MENTAL HEALTH HISTORY
High Risk Alerts: Check if any history of the following in the past year.

☐ Suicide/Attempts ☐ Inappropriate Sexual Behavior ☐ Violence
☐ Suicidal Threats ☐ Self Injurious Behaviors ☐ Assault
☐ Fire Setting ☐ Frequent crisis requiring readmission ☐ Medical Issues
☐ Other _____
If checked, provide brief detail: _____

_____

_____

_____

SERVICE UTILIZATION
Check any services used. If checked, give dates and provider.
☐ Inpatient treatment: _____
☐ Outpatient treatment: _____
☐ OPWDD Service: _____
☐ Care Coordination: _____
☐ Other: _____

HOUSING
Check if applicant has experienced. If checked, give date and location.
☐ Homelessness _____
☐ Group home/Community Residence (OMH)_____
☐ Group home/Community Residence (OASAS)_____
☐ Other Supported or Supervised Living Environment _____
☐ Independent Living, alone _____
☐ Independent Living, with others _____
☐ Supported Housing Assistance _____
☐ Section 8 Application and/or Subsidy_____
☐ Evictions? If yes, please explain:_____

VOCATIONAL

Check applicant's experience. If checked, give dates and locations.

☐ Highest Grade Level Completed_____ ☐ GED _____

☐ Special Education _____ ☐ College Degree_____

☐ Competitive Employment _____ ☐ VESID _____

CRIMINAL JUSTICE SYSTEM

Check if current or past history of the following - Provide name of Probation/Parole Officer if current.

☐ Probation _____ ☐ Charges Pending

☐ Parole _____ ☐ CPL Date _____

Provide Details: _____

_____

_____

FAMILY, SOCIAL & COMMUNITY SUPPORTS

Check applicant's current supports and note names when possible.

☐ Family _____

☐ Friends _____

☐ Religious _____

☐ Support Groups _____

☐ Care Coordinator_____

CLINICAL ASSESSMENT

****Primary must be a Mental Health Diagnosis.**

	ICD 10 Codes	Diagnosis
Primary	__ __ __ - __ ___ ___ ___	_____
Secondary	__ __ __ - __ ___ ___ ___	_____

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Mail: Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
ATTN: Supported Housing Program Coordinator

By e-mail: info@ccocc.org

By Fax: (607) 756-5999

NYS OMH - SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

This form must be completed by a licensed clinician or other mental health professional.
Information can be requested from collateral sources.

Client Name: _____

In order to be considered an adult with Serious and Persistent Mental Illness (SPMI), the individual must meet criteria in **"1"** *and* either **"2"** *or* **"3"** *or* **"4"** as defined below.

Circle the answer that applies

1. Designated Mental Illness

The individual is at least 18 years of age and currently meets the criteria for a psychiatric diagnosis, according to DSM 5. Yes No

Principle Diagnosis: _____
DSM 5 Code: _____
ICD-10 Code: _____

AND

2. SSI or SSDI due to Mental Illness

The individual is currently receiving SSI/SSDI due to a designated mental illness. Yes No

OR

3. Extended Impairment in Functioning due to Mental Illness:

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

a.) Marked Difficulties in Self-Care Yes No
i.e.: personal hygiene, diet, clothing, avoidance of injury, securing appropriate health care and/or compliance with medical advice

b.) Marked Restriction of Activities of Daily Living (ADLs) Yes No
e.g.: maintaining a residence, using transportation, day-to-day money management, accessing community services

c.) Marked Difficulties in Maintaining Social Functioning Yes No
e.g.: establishing and maintaining social relationships; interpersonal interactions with primary partner, children or other family members, friends, and/or 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 Yes No
i.e.: inability 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 are repeatedly unable to complete tasks or require assistance in the completion of tasks

OR

4. Reliance on Psychiatric Treatment, Rehabilitation and Supports

The individual has a documented history showing that, at some time prior, he/she met the threshold for **"3"** (above), but his/her symptoms and/or functioning problems are currently attenuated by medication and/or psychiatric rehabilitation and supports.* Yes No

Signature: _____ **Date:**_____

Title: _____

***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 (e.g. congregate or apartment treatment programs), which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient's Name (Last, First, M.I.)	"C" No.
	Sex	Date of Birth
	Facility Name: Catholic Charities of Cortland County	Unit/Ward: Supported Housing Program

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

☐ Contact Information ☐ Current Medications ☐ Current Services ☐ Daily Living Skills ☐ Diagnosis
☐ Education ☐ Entitlements ☐ Emergency Contact Info. ☐ Functional Abilities ☐ Mental Health Status
☐ Psychosocial information ☐ Characteristics/ Photograph ☐ Electronic Files
☐ Other: _____

Purpose or Need for Information:

1. This information is being requested:
   ☐ by the individual or his/her personal representative; or
   ☒ Other (please describe) Catholic Charities (Cortland County)
2. The purpose of the disclosure is (please describe)

☐ Screening/Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Coordinating Services
☐ Electronic Database
☐ Other: _____

Exchange of Information, in either direction, between the parties below
(Include: Name, Address, Title of person/Organization/Facility/Program)

Catholic Charities (Cortland County) Residential Services 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 753-3550 Fax: (607) 756-4697	(Two Way) ⇔	Admissions Committee: Including Representatives from Family Counseling Services, Cortland County Mental Health, Cortland Police Department, Cortland Regional Medical Center, Cortland County Probation Department, Catholic Charities Care Coordination Services

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:
   1. Only this information may be used and/or disclosed as a result of this authorization.
   2. This information is confidential and cannot legally be disclosed without my permission.
   3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
   4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
   5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
   6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1. **One-Time Use/Disclosure**: I hereby permit the one-time use or disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above.

My authorization will expire:

☐ When acted upon;
☐ 90 Days from this Date;
☐ Other:

Facility/Agency Name Catholic Charities (Cortland County)	Patient's Name (Last, First, M.I.)	"C"/ID. No.

B-2. Periodic Use/Disclosure**:** I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☒ When I am no longer receiving services from: Supported Housing Program

☐ One year from this date ☐ Other:

C. **Patient Signature**: I certify that I authorize the use of my health information as set forth in this document.

Signature of Patient or Personal Representative Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization)*

D. **Witness Statement/Signature**: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided to: _____

Date: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information

Title Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

Signature of Patient or Personal Representative Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*