2018 Onondaga County Adult SPOA Application

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

<table>
<tr><th colspan="5">Referral Information</th></tr>
<tr><td>Referral is for:
*See OMH SMI High Priority Eligibility Criteria</td><td colspan="4">☐ 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____________________</td></tr>
<tr><td>Date of Referral:</td><td></td><td>Applicant Gender:</td><td colspan="2">☐ Male ☐ Female</td></tr>
<tr><td>Applicant Name:</td><td></td><td>AKA:</td><td colspan="2"></td></tr>
<tr><td>Social Security Number, last 4 digits:</td><td colspan="4">Applicant DOB:</td></tr>
<tr><td>Home Street Address:</td><td colspan="4"></td></tr>
<tr><td>(City, State, Zip)</td><td colspan="4"></td></tr>
<tr><td>Current Location:</td><td colspan="4"></td></tr>
<tr><td colspan="5">If inpatient, anticipated release date:______________________</td></tr>
<tr><td colspan="2">Alternate Contact, Address and/or Phone # for Client when in the community:

May we leave a message? ☐ Yes ☐ No</td><td colspan="3">Emergency Contact Name, Address & Phone #:</td></tr>
<tr><td colspan="5">Referring person contact information: Provider Type: ____
Name: ____ Role____
Agency: ____
Address: ____
Phone: ____ Fax: ____
Email Address: ____</td></tr>
<tr><th colspan="5">Legal Status</th></tr>
<tr><td colspan="5">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: ___________________________</td></tr>
</table>

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

Jennifer Feliciano x4997, Jan Moag x4696

Name____________________________________