SINGLE POINT OF ACCESS
APPLICATION FOR RESIDENTIAL SERVICES
V2024

This application must be completed prior to a formal interview being conducted. Incomplete application packet will delay referral process.

Please attach the following additional information. These documents must be legible.

1. Psycho-social history (within one year)
2. Psychiatric assessment (within one year)
3. Recent medical examination (within one year, including TB test Documentation)
4. Medicaid Authorization Forms (attached - required for IPRT & Residential programs)
5. Homeless Eligibility
6. Disability Eligibility

Program(s) applying for (check all that apply)

- ❑ **PROS**
- ❑ **Philmont Hearth** (High Cliff Terrace Greene County), Residential staff on site 24 hours.
- ❑ **Columbia Street Apartments (CSA)** Clustered Apartment Programs, Residential staff on site 24 hours.
- ❑ **Hudson Community Apartments (HCA)** Clustered Apartment Programs, Residential staff on site 24 hours.
- ❑ **Comprehensive Apartment Program (CAP)** Supportive Apartment
- ❑ **Supported Housing Urban Development (SHUD)** Supported Apartment
- ❑ **Permanent Support Homeless Housing (PSHP)**
- ❑ **Greenport Garden Apartments (SPSRO)**

Name of applicant: _____
Applicant's current residence _____Phone_____
Home address (if different)_____
DOB_____ SSN_____
Marital status: S M W D Sep. (circle one)
Names & ages of children: _____
Family contact name: _____ Relationship: _____
Address: _____Phone: _____
In emergency contact_____ Relationship: _____
Address: _____Phone: _____

Are there any other agencies with which applicant is involved? (I.e., probation dept., private therapists, substance abuse, etc.) Please explain and supply contact person for each:
_____
_____
_____

Reason for referral: _____
_____

Current DSM V Diagnoses:

_____

_____

_____

_____

_____

List all Health Insurance applicant receives:
Medicaid number_____ Date of eligibility_____ Medicare number_____ Date of eligibility_____
Other health insurance and ID numbers: _____
Current medical problems/physical disabilities/restrictions (allergies, special diets, ambulation, etc.)_____

List all medications & dosages (use back if more space is needed):

Medication	Dosage	Prescribing Physician	Any recent change reason for change

_____
_____
_____
_____
_____
_____

Physician: _____Phone: _____
Address: _____
Psychiatrist_____ Phone: _____
Address: _____
Therapist: _____Phone: _____
Address: _____

PSYCHIATRIC HISTORY

_____
_____
_____
_____
_____
_____
_____

List admission and discharge dates of all psychiatric inpatient/outpatient treatment including first and last admission:

_____
_____
_____
_____

use back if more space is needed

Explain each living arrangement, whether independent living or in a residential program, tried in the past 5 years (dates, reason for success or failure):

_____
_____
_____
_____
_____
_____
_____
_____
_____

FINANCIAL/INSURANCE INFORMATION

List all income:

	monthly amount	If pending...
SS Disability:	_____	Date of application_____
SSI Income:	_____	Date of application_____
Public Assistance	_____	Date of application_____

Wages_____
Retirement benefits/annuities (specify)_____
Worker's Compensation, unemployment ins. (specify)_____
Other (specify)_____
List all resources:
Bank accounts (type & amount)_____
_____
Life Insurance policies (cash face value)_____
Property: _____
Outstanding financial obligations (e.g., child support, etc.)_____

PERSONAL HISTORY

Highest level of education completed: _____

Work history (list all jobs, training programs, sheltered workshops and volunteer experience, etc. Include dates and brief description of success or failure)

_____
_____
_____
_____
_____
_____
_____
_____

Describe present daily activity schedule of applicant:

_____
_____
_____
_____
_____
_____

Will this change if admitted to this program? _____How?

_____
_____
_____
_____
_____

Does applicant have a history of the following? If yes, please explain.

Arson?

No_____Yes_____
_____
_____

Suicide attempts?

No_____Yes_____
_____
_____

Suicide gestures?

No_____Yes_____
_____
_____

Criminal offenses?

No_____Yes_____
_____
_____

Assaultive behavior?

No_____Yes_____
_____
_____

Drug/alcohol abuse?

No_____Yes_____
_____
_____

Medication non-compliance?

No_____ Yes_____
_____
_____

Please note that positive answers to the preceding questions do not rule out admission to our programs.

SUBSTANCE ABUSE HISTORY

(Please include all substances used in past or present)

Type	Last Use	Frequency of Use	Longest Period of No Use

Other relevant information:

_____
_____
_____
_____
_____

List admission and discharge dates of all Substance Abuse Inpatient/outpatient treatment including first and last admission:

_____
_____
_____
_____
_____
_____

RESIDENTIAL FUNCTIONAL ASSESSMENT SURVEY

Please rate by circling the appropriate number:

1 = no problem; 2 = minor problem; 3 = moderate problem; 4 = severe problem

PSYCHIATRIC PROBLEMS

IN THE LAST 30 DAYS, HAS THIS APPLICANT EXHIBITED:

-	Somatic Concerns (preoccupation with physical health, fear of physical health, fear of physical illness)	1	2	3	4
-	Anxiety (worry, fear, over-concern for present or future)	1	2	3	4
-	Emotional Withdrawal (lack of spontaneous interaction, isolation, deficient in relating to others)	1	2	3	4
-	Unusual thought content or conceptual disorganization (odd, disorganized, bizarre or confused thoughts)	1	2	3	4
-	Tension (motor manifestation, nervousness, hyperactivity)	1	2	3	4
-	Mannerisms, posturing (bizarre motor behavior)	1	2	3	4
-	Hostility (animosity, contempt, belligerence)	1	2	3	4
-	Suspiciousness (mistrust, believes others harbor malicious or discriminatory intent)	1	2	3	4
-	Hallucinatory behavior (perceptions without normal external stimuli)	1	2	3	4
-	Motor retardation (slowed, weakened movements or speech)	1	2	3	4
-	Blunted Affect (reduced emotional tone, reduction in normal intensity of feeling, flatness)	1	2	3	4
-	Excitement (heightened emotional tone, agitation, increased reactivity)	1	2	3	4
-	Disorientation (confusion or lack of association for person, place or time)	1	2	3	4
-	Uncooperativeness (resistance, guardedness, rejection of authority)	1	2	3	4

DOES THE APPLICANT:

Take medication as prescribed	1	2	3	4
Keep clinic or other appointments	1	2	3	4
Use money correctly for purchases	1	2	3	4
Perform home maintenance, cleaning	1	2	3	4
Maintain an adequate diet	1	2	3	4
Use public transportation	1	2	3	4
Maintain adequate personal hygiene	1	2	3	4
Use telephone correctly	1	2	3	4
Smoke in a safe manner	1	2	3	4
Arise promptly	1	2	3	4
Attend a day program	1	2	3	4
Demonstrate basic cooking skills	1	2	3	4

PROBLEM SOLVING AND INTERPERSONAL SKILLS

Apologize when appropriate	1	2	3	4
Act assertively when appropriate	1	2	3	4
Listen and understand	1	2	3	4
Resolve conflicts appropriately	1	2	3	4
Exercise good judgment	1	2	3	4
Plan in cooperation with others	1	2	3	4
Treat own minor physical problems	1	2	3	4
Obtain help for physical problems	1	2	3	4
Follow through on advice of doctor	1	2	3	4
Socialize with others	1	2	3	4
Take initiative or seek assistance with problems	1	2	3	4

TO BE COMPLETED BY APPLICANT:
(With assistance if necessary)

What do you expect to gain by working with this program? _____
_____
_____
_____

What are your strengths and positive qualities? _____
_____
_____
_____

What are your hobbies and interests?
_____
_____
_____
_____

_____
Applicant Signature Date

Referring person's signature: _____ Date _____

How long have you been working with this individual? _____
Who will provide outpatient Mental Health services? _____

****

FOR RESIDENTIAL PROGRAM USE ONLY

Date Application Received: _____ Date of Interview: _____

Circumstances of Interview: _____
_____
_____
_____

Assessment:
_____
_____
_____
_____
_____

Staff Signature: _____ Date: _____
Title: _____

CLIENT DISABILITY ELIGIBILITY DOCUMENTATION

Client Name: _____Date of Intake_____

Check the current status and attach the appropriate documentation to verify eligibility.

Disabling Condition	Type of Documentation	Documentation Attached
ANY	Income from US Social Security Administration based on disability - - SSI/SSD. Statement or Copy of Check.	
Serious Mental Illness	Documentation (diagnosis) from a credentialed psychiatric professional, - signed & dated psych/social	
Chronic Substance Abuse must be a documented history & must impede ability to live independently	Documentation including diagnosis from a Credentialed psychiatric or medical professional that is trained to make such a determination	
HIV+/AIDS or AIDS related diseases must impede ability to live independently	Documentation including diagnosis from a Credentialed medical professional	
Physical Disability - must be long-term and of indefinite duration; substantially impedes ability to live independently	Documentation including diagnosis from a Credentialed medical professional	
Developmental Disability - severe & chronic. Attributable to mental or physical impairment; manifested before 22 yrs old results in substantial functional limitations - Requires combo or long term care/ treatment	Documentation including diagnosis from a Credentialed psychiatric or medical professional that is trained to make such a determination	
Other Mental or Emotional Impairments	Documentation including diagnosis from a Credentialed psychiatric or medical professional that is trained to make such a determination	
Other:		
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND - documentation of disability	

NOTES:

STAFF MEMBER:_____DATE_____

CLIENT: I verify this information is true & accurate. I confirm that I have been determined to be disabled.

DATE_____

Signature of Client _____

CLIENT HOMELESS ELIGIBILITY DOCUMENTATION

Client Name: _____ Date of Intake: _____

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant.	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less that 31 days; and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of receiving homeless assistance AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	
Other:	Written verification from client or referring agency	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND - documentation of disability	

Check the current housing status and attach the appropriate documentation to verify homelessness eligibility.

NOTES:

STAFF MEMBER: _____DATE:_____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.
Signature of Client_____ Date: _____

AUTHORIZATION FOR
RESTORATIVE SERVICES
COMMUNITY RESIDENCE PROGRAMS

- ❑ Initial Authorization
- ❑ Semi-Annual Authorization (HCT, Hearth)
- ❑ Annual Authorization (CAP, HCA, CSA)

CLIENT NAME: _____

CLIENT MEDICAID NUMBER: _____

ICD.10 DIAGNOSIS: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me have determined that _____ would benefit from the provision of Mental Health Restorative services
(Consumer Name)
defined pursuant to Part 593 of 14 NYCRR. If applicable, a copy of the most recent residential service plan review is attached.

** IF this is an **Initial Authorization,** the prescribing physician must see the consumer face-to-face prior to authorizing services.

_____/_____/_____ _____ _____
Mo Day Yr. Physician Name (Please Print) Licensure #

_____
Signature

Day Program Recommendation

As this Residential Program maintains a rehabilitation focus, it is expected that all residents will engage in gainful activities during the weekday. This activity should be tailored to the individual, addressing his or her individual needs, strengths, goals, etc. Options for day activities can include: Greene or Columbia PROS, attending school, VESID Supported Employment, Supported Education, volunteer work, Sheltered Employment or competitive employment. Our goal is to promote independence to the highest degree that the individual is able to attain. We value working collaboratively with the individual consumer, as well as with all collateral service providers in reaching this end.

To be filled out by referring clinician at time of referral and the quarterly:

The recommended day activity for _____is

_____.

This document will become part of the residential service plan.

_____ _____

Resident Primary Clinician

_____ _____

Program Director Date