# FRANKLIN COUNTY SINGLE POINT OF ACCESS (SPOA) for ADULT SERVICES

**REQUEST FOR HOUSING/SOCIAL CLUB/ COMMUNITY RESIDENCE SERVICES**

SUBMIT COMPLETED REQUEST TO: Franklin County Community Services, 136 Broadway, Suite 5, PO Box 1337, Saranac Lake, NY 12983
kkmen@co.franklin.ny.us | Phone: (518) 891-2280 | Fax: (518) 891-2080
Attn: Kathleen Kmen, Deputy Director of Community Services

## FRANKLIN COUNTY ADULT'S SINGLE POINT OF ACCESS (SPOA) OVERVIEW

Single Point of Access (SPOA) is part of the NYSOMH 2000-2001 initiatives designed to expand the county's existing community based mental health system and help make it a more cohesive and better coordinated system. The goal is to create a system that promotes recovery-oriented services, which are widely available, flexible, personally tailored and responsive to individual needs. Individual's preferences will be integrated into the process.

The Adult Single Point of Access (SPOA) serves Seriously and Persistently Mentally Ill (SPMI) consumers who are Franklin County residents and may have difficulty accessing housing or case management services. The Adult SPOA establishes an efficient and comprehensive single entry point for consumers into the service system while providing systems management. Consumers of services are able to enter the system more seamlessly, be served more appropriately, and gain more from the experience of being served by one or more of Franklin County's agencies. All stakeholders have the opportunity to view themselves as partners in a collaborative system. Adult SPOA also receives referrals, screens and prioritizes OASAS Permanent Supported Housing despite not being under the auspice of New York State Office of Mental Health. Adults referred to Health Home Care Management (HHCM) are also processed throughout the SPOA committee and non-Medicaid referees are prioritized to receive service with the SPOA committee stakeholders each month.

## REFERRAL PROCESS

- Complete the attached *Franklin County Single Point of Access for Adult Services* referral and return to:
  Franklin County Community Services
  Attn: Kathleen Kmen, Deputy Director
  136 Broadway, Suite 5
  PO Box 1337
  Saranac Lake, NY 12983
  or Email: kkmen@co.franklin.ny.us
- The Deputy Director reviews the referral to ensure completion and forwards the referral on to the associated program manager or screener for screening assignment:
  *Crimson Phoenix, Mountain Crest: Brandon Titus and Health Home Care Management (HHCM):* April Riley
  *Supported Housing, Community Residence, Apartment Treatment, OASAS:* Lindsay Hendricks
  *Lakeside House Community Residence: Sally Walrath*
- The screener contacts the referred individual to coordinate a screening to obtain information related to the service need such as areas of functioning, past and current services, and diagnostic/clinical/medical/ and/or substance use disorder information
  - HHCC referred individuals can be enrolled independent of the SPOA Committee approval for those receiving Medicaid *but* non-Medicaid HHCC referrals must be prioritized through the SPOA process.
  - The screener obtains authorization from the individual to confirm any information related to eligibility. The referral includes eligibility information specific to the services.
- Referred individuals and completed screenings are presented at the monthly SPOA Committee meetings so that stakeholders can prioritize services available and/or make recommendations about alternative service options.
  - The committee may also assist in identifying additional services and plans for the referred adults that are not deemed eligible for SPOA services or when requested services are not immediately available.
- An adult prioritized by the SPOA Committee to receive available service will be notified and offered the service following the SPOA Committee meeting or any other additional admission/discharge approval process.
  - If no requested service is available then the screener completes monthly updates to present at the SPOA Committee meeting until services are received, service is no longer needed, or the adult wishes to closes the referral.

The Deputy Director can be contacted by email or phone (518) 891-2280 for any additional information regarding the referral process and eligibility and/or to request referrals.

*If a waiver is requested, the CSS form (Page 6) ***MUST*** be signed by an LCSW or by an LMSW; the local LGU will sign once the packet is received complete

All services are voluntary. Recommendations for services can be made based on needs/desires and will be presented and considered at the SPOA meetings.
Revised 2/26/2018

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| Prospective recipient name: | | | Date of request: |
|---|---|---|---|
| Prospective recipient address: | | Email address: | |
| Phone: | Medicaid/Insurance #: | DOB: | SSN: |
| Name and relationship of person requesting services: | | | Phone: |
| In case of emergency please notify: | | | Phone: |

1) **List Diagnoses and Chronic Conditions** (mental health, medical, and substance use [MUST HAVE FOR OASAS]):

2) **List Current Service Providers and Phone Numbers** (include primary care physician and psychiatric providers):

3) **Reason for Referral** (briefly describe):

4) **Social Information** (describe any history of violence, assault, arson, or sexual offenses/misconduct):

| | | |
|---|---|---|
| ***Veteran Status:*** | ☐ ***Yes*** | ☐ ***No*** |
| ***If yes, are you interested in veteran benefits?*** | ☐ ***Yes*** | ☐ ***No*** |
| ***AOT Status:*** | ☐ ***Yes*** | ☐ ***No*** |
| ***Do you have access to your own or to other means of transportation?*** | ☐ ***Yes*** | ☐ ***No*** |

| **Signature of person completing referral:** | **Date:** |
|---|---|

| **DDCS/SPOA and Manager Use:** | | |
|---|---|---|
| **Date Received by DDCS/SPOA:** | **DDCS/SPOA Assigned to:** | **Date Assigned:** |
| **Date Received by Manager:** | **Screener Assigned:** | **Date Assigned to Screener:** |

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**Check the box ☐ for the service/program you are referring the prospective recipient to:**

All services, with the exception of Lakeside House services, are provided through North Star Behavioral Health Services.

| | | |
|---|---|---|
| **Psycho-Social Club**<br>****CSS Eligibility Form required*** | ☐**Crimson Phoenix*: (Malone)**<br>A club designed to be available as part of a long-term support network and a home-away-from-home. Members are empowered through growth, support, and caring. Members participate in social activities and outings, receive support to connect to appointments/services, educational activities, and participate in daily living skills tasks. | ☐**Mountain Crest*: (Saranac Lake)**<br>A club designed to be available as part of a long-term support network and a home-away-from-home. Members are empowered through growth, support, and caring. Members participate in social activities and outings, receive support to connect to appointments/services, educational activities, and participate in daily living skills tasks. |
| **Housing Services**<br>****CSS Eligibility Form required*** | ☐**North Star- Supported Housing:**<br>(Malone/Saranac Lake)<br>A housing program licensed under New York State Office of Mental Health that provides temporary rental assistance and furnishings in conjunction with case management services to individuals who have a primary diagnosis of serious mental illness and experience substantial impairment in functioning. The goal of the program is to aide individuals in securing and maintaining long-term/permanent, safe, decent and affordable housing. The Supported Housing approach is intended to foster integration into the existing community services system including: employment support, mental health and substance abuse treatment, transportation, etc. | ☐**Lakeside House-Supported Housing:**<br>(Saranac Lake)<br>A housing program licensed under New York State Office of Mental Health that provides temporary rental assistance and furnishings in conjunction with case management services to individuals who have a primary diagnosis of serious mental illness and experience substantial impairment in functioning. The goal of the program is to aide individuals in securing and maintaining long-term/permanent, safe, decent and affordable housing. The Supported Housing approach is intended to foster integration into the existing community services system including: employment support, mental health and substance abuse treatment, transportation, etc. |
| **Community Residence**<br>**(Diagnosis and SPMI status must be substantiated)** | ☐**Webster Street: (Malone)**<br>A 10-bed residential program that provides 24-hour assistance to adults with serious and persistent mental illness to prepare them for independent community living. Individuals are supported by staff members to identify their life goals and build a recovery oriented plan. Some services provided include: community integration, daily living skills training, medication management, and symptom management.<br><br>☐**Apartment Treatment Program:**<br>(Malone)<br>A 9-bed apartment-type residential program that provides individualized support to the needs and goals of adults with serious and persistent mental illness. Staff members are available 7-days a week with additional 24-hour crisis on-call availability. Apartments are scattered within the community and individuals are prepared for independent living by receiving assistance including gaining employment, becoming more independent in their medication management and appointment attendance, and being linked to socialization. | ☐**Lakeside House: (Saranac Lake)**<br>Lakeside House is a community residence facility that provides accommodation and treatment services for adults with various mental illnesses. The center specializes in serving patients who are transitioning from psychiatric hospitals to independent living environments. Lakeside House is a five-plus-bed residential facility that offers psychiatric rehabilitation services and assists patients to recover from mental disorders. It provides community integration, daily living, and assertiveness and self-advocacy training programs to residents. The center provides lessons in the areas of dressing, grooming, environment, personal hygiene, food preparation and money management. Lakeside House s services are approved by the New York State Office Mental Health.<br><br>☐ **OASAS Permanent Supportive Housing*:**<br>(Saranac Lake/Malone)<br>An 8-bed program that serves adults who have a primary diagnosis of a substance use disorder, a history or are at-risk of homelessness, and meet specific hospitalization criteria. The program assists individuals in obtaining and maintaining affordable and permanent housing options in combination with providing case-managed supportive services that focus on housing counseling and employment services. Some other services provided are substance abuse services, assertiveness/self-advocacy, parenting training, and skill development. |
| **Care Coordination**<br>**(Diagnosis and SPMI status must be substantiated)** | ☐**Health Home Care Coordination (HHCC)*:**<br>HHCMs determine individual needs and goals to help oversee and provide access to all of the medical, social, and behavioral health care services an individual needs to ensure the recipient obtains the right care, at the right time, and in the right setting. Examples of HHCM services are: help connecting to benefits, transportation coordination to medical and behavioral health appointments, connection to some social activities, referral to community services and programs, support and advocacy, and collaboration with Medical, Mental Health (MH) and/or Substance Providers. Eligibility criteria options: 1) Two chronic conditions [MH, Substance Use, and/or Medical], 2) One chronic condition [HIV/AIDS] and the risk of developing another or 3) One serious mental illness. | |

*Direct referral to program can occur through the agency.

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## Request for Adult Case Management/Housing Services and Release Authorization to Franklin County Single Point of Access (SPOA) Committee

| Name of individual: | |
|---|---|
| DOB: | SSN: |

By initialing the listed "Acknowledgements" you confirm your awareness of and/or agreement to/that:

____**Acknowledgement:** I agree to be considered for one of the following adult case management and/or housing services: Health Home Care Management, Supported Housing, Apartment Treatment Program, and Community Residences: Webster Street in Malone or Lakeside House in Saranac Lake or OASAS Permanent Supportive Housing.

____**Acknowledgement:** I have been informed as to the nature of these services and understand that participation in any of these programs is voluntary.

____**Acknowledgement:** I understand that acceptance into one of the above programs is decided by Franklin County's SPOA Committee.

____**Acknowledgement:** I understand that this committee is comprised of representatives from community agencies as well as consumer advocates. Community agencies represented include but are not limited to: **North Star Behavioral Health and Residential Services, Franklin County Community Connections, Department of Social Services, Department of Probation, Office of Mental Health, Office of People with Developmental Disabilities, Saint Regis Mohawk Mental Health Services, Saint Regis Mohawk Alcohol and Chemical Dependency Program, Partridge House, St. Joseph's Inpatient/Outpatient Programs, Mobile Integration Team, Veteran Affairs, Adirondack Health Institute, Catholic Charities, Franklin County Public Health, Franklin County Office of the Aging, Planned Parenthood of the North Country and Franklin County Community Services.**

____**Acknowledgement:** I understand that the members of this committee are bound to maintain the highest standards of confidentiality defined by law (HIPAA 45 CRF Parts 160 and 164; and 42 CFR, Section 2), and are not to disclose information that identified me personally, outside of the SPOA Committee process. I understand that it is the role of the committee to oversee the use of adult care management/housing services in Franklin County and to decide which level of service, depending upon availability and program eligibility requirements, is most appropriate for each individual based on their needs and desires. In making its decision, the committee will use and possibly discuss all information proved by the individual agency representatives regarding my circumstances.

____**Acknowledgement:** The SPOA process includes secured sharing of information, including encrypted electronic mechanisms, between referral screener and the Franklin County Director and Deputy Director of Community Services for preparation of the monthly agenda, updates, meeting minutes preparation, and data tracking.

____**Acknowledgement:** I understand that I may request that an agency which possesses my protected health information, exclude or hold private specific information from SPOA Committee consideration.

By signing this authorization I give my permission for members of the SPOA Committee to share information necessary to describe my situation, and to determine the most appropriate service or services based on my needs and desires. I understand that I will first be contacted by a representative of the program for which I am requesting services, who will meet with me to determine my eligibility for that service. That representative will present findings for review by the SPOA Committee. I understand that upon my written request, I may withdraw my permission to share information (except for actions already taken) at any time without jeopardizing my current treatment or any future applications for these services. Unless my permission is withdrawn I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

| Individual's Signature: | Date: |
|---|---|
| Witness Signature: | Date: |

**Withdrawal of Request/Authorization:**

I voluntarily withdraw my request for case management and housing services and in doing so withdraw my authorization for the Single Point of Access Committee to continue to share information regarding my circumstances. I understand that this withdrawal does not cover actions that have already been taken by this committee.

| Individual's Signature: | Date: |
|---|---|
| Witness Signature: | Date: |

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## ELIGIBILITY INFORMATION

**PSYCHOSOCIAL CLUBS**

- 18 years of age
- Have a primary psychiatric diagnosis

**SUPPORTED HOUSING SERVICES**

- Current NYS OMH Serious and Persistent Mental Illness (SPMI) diagnosis
- Meet General income requirements
- Written lease is required
- Must apply to HUD's Section 8 Rental Assistance Program and not currently receiving assistance from HUD
- Possess basic living skills necessary to be able to live in the community with minimal assistance and/or utilize case management services, including the ability to administer own medication
- Live in an apartment that is deemed safe and affordable by staff
- Agree to meet with staff on a periodic basis

**COMMUNITY RESIDENCE**

- Primary diagnosis of psychiatric illness with acute psychiatric symptoms adequately controlled with or without medication; unable to live independently in the community
- Potential to improve fundamental independent living skills

**APARTMENT TREATMENT PROGRAM**

- Primary diagnosis of psychiatric illness with acute psychiatric symptoms adequately controlled with or without medication
- Agree to meet with staff on a periodic basis
- Possess basic living skills necessary to be able to live in the community with minimal assistance

**OASAS PERMANENT SUPPORTIVE HOUSING**

- Medicaid recipient or Medicaid Eligible
- At least 18 years of age
- SUD primary diagnosis (can be co-occurring with Mental Health)
- Homelessness, history of homelessness, at risk of homelessness
- High Medicaid Utilization – This is defined as 2 inpatient stays, or 5 ER visits, or a combination of 4 ER's and 1 inpatient. This has to have happened in a 12 month period. Inpatient stays can be SUD, MH, or chronic medical.

**HEALTH HOME CARE MANAGEMENT SERVICES**

- Two chronic conditions (e.g., mental health condition, substance abuse disorder, asthma, diabetes, BMI over 25) or
- One qualifying chronic condition (HIV/AIDS/ and the risk of developing another, or one serious mental illness

**Appropriateness:**

- Probable risk of adverse event (e.g., death, disability, inpatient or nursing home admission)
- Lack of adequate social/family/housing support
- Lack of adequate connectivity with healthcare system
- Recent release from incarceration or psychiatric hospitalization
- Deficits in activities of daily living such as dressing, eating and so forth
- Learning or cognition issues

**Community Support Services**
**ELIGIBILITY DETERMINATION**

1. Facility Name | Facility Code | 2. Unit Name | Unit Code

3. Client Name PRINT (Last) (First) (M.I.)

4. Social Security Number

5. Address (Number) (Street)

6. NYS ID Number

(City) (State) 5a. Zip Code

7. Date of Birth — MO DAY YEAR

8. Sex
- Male
- Female

9. **Most Recent Diagnosis** (Principal diagnosis must be psychiatric. USE DSM V and specify codes as well as diagnoses).

A. Principal Diagnosis — **DIAGNOSTIC CODE**

B. Other diagnosis — **DIAGNOSTIC CODE**

10. **Functional Disability**

A. Client is functionally disabled due to mental illness, and without provision of community support services the client's ability to remain in the community would be serioulsy jeopardized:

YES NO

B. Client is functionally disabled in the areas indicated (Check all that apply: three areas are needed to establish eligibility for CSS):

Self Care
Activities of Daily Living
Self Direction
Social Functioning
Economic Self Sufficiency
Ability to Concentrate

11. The client is eighteen years of age or older, functionally disabled due to mental illness, has a principal psychiatric diagnosis, and:

A. Meets the permanent eligibility criteria (complete item 12 below).
B. Meets the categorical eligibilty criteria (complete items 13 and 14 below).
C. Waiver is requested (complete item 15 below).

12. Permanent Eligibility (Check all which apply):

A. One six month stay in an inpatient psychiatric unit.
B. Two stays of any length in an inpatient psychiatric unit preceding two years.
C. Client is Chapter 620/621 Eligible
D. Three or more admissions to an Office of Mental Health operated or licensed mental health outpatient program or a forensic satellite unit operated by the Office of Mental Health within the preceding 18 months; or three or more contacts with crisis or emergency mental health services within the preceding 18 months; or a combination of three admissions or contacts within the preceding 18 months.
E. SSI/SSD recipient due to mental illness.
F. Twelve months active enrollment as a waived client.
G. Six months consecutive residency in a designated adult home.
H. Six months consecutive residency in a community residence.
I. Six months consecutive residency in a Residential Care Center for Adults (RCCA).
J. Six months consecutive residency in a family care home.
K. Six months consecutive residency in a Residential Treatment Facility (RTF).

13. Categorical Eligibity

A. Resident in a desgnated adult home, less than six months.
B. Resident in a designated shelter for the homeless.
C. Resident in a designated single room occupancy hotel (SRO).
D. Resident in a community residence, less than six months.
E. Resident in a family care home, less than six months.
F. Resident in a Residential Care Center for Adults (RCCA), less than six months.
G. Inpatient in a state-operated psychiatric facility and scheduled for placement within ninety days to community residence, Residential Care Center for Adults (RCCA), or Fammily Care.

14. Initial Date of Residency

MO DAY YEAR

15. **Waiver Request**

A. Waiver Requested by: — Name (Last) PRINT (First) (M.I.) | Title

B. Local Government Action: — Name (Last) PRINT (First) (M.I.) | Title
- 1. Approved
- 2. Disapproved

MO DAY YEAR

16. **Certification:** I certify that this client, who is eighteen years of age or older, functionally disabled due to mental illness, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the permanent or categorical eligibility requirements or a request has been submitted to waive such criteria.

Signature | Name signed (Print)

Title | Today's Date — MO DAY YEAR