Please review the following instructions before sending the SPOA Application:

1. Complete the Eligibility Checklist (page 2)

SPOA UNIT
Adult Mental Health Services
Westchester County Department of Community Mental Health
112 East Post Road, 2nd Floor
White Plains, NY 10601

2. Please review REQUIRED DOCUMENTATION FORM below. Referrals will NOT be considered complete without:
   - Complete SPOA Application
   - Clinical Information as specified below.

3. Upon receipt, application will be reviewed by DCMH for completeness. Incomplete Applications will be returned to the referring party.

For questions regarding the SPOA Application, please call 995-5245.

**REQUIRED DOCUMENTATION**

<table>
<thead>
<tr>
<th>Required Documents</th>
<th>ACT</th>
<th>ICM/SCM</th>
<th>CR</th>
<th>SRO</th>
<th>TX APT</th>
<th>SH</th>
<th>SPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Determination</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Referral Form</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Psychiatric Evaluation (Including DSM VI and Current within 90 days)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Psychosocial (Must support Eligibility Determination)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Physical Exam &amp; Immunization Record</td>
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<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Authorization for Restorative Services</td>
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<td>X</td>
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<tr>
<td>(MUST BE ORIGINAL)</td>
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<tr>
<td>Disability Verification for HUD Shelter Plus Care</td>
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<td>X</td>
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<tr>
<td>Eligibility (MUST BE HOMELESS)</td>
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</tbody>
</table>
Eligibility Determination

In order to be eligible for services through DCMH, applicants for Housing, Case Management or ACT Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, **B, C, or D** must be met:

Yes ___ No _____ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary DSM-IV diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions (V-codes).

Please complete: DSM-IV code: __________

Yes ___ No _____ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI **DUE TO A DESIGNATED MENTAL ILLNESS.**

Yes ___ No _____ **C.** Extended Impairment in Functioning due to Mental Illness. The applicant must meet 1 or 2 below:

1. 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. (Documentation in psychosocial assessment required.)

   Yes ___ No ___ a. Marked difficulties in self care.
   Yes ___ No ___ b. Marked restrictions of activities of daily living.
   Yes ___ No ___ c. Marked difficulties in maintaining social functioning.
   Yes ___ No ___ d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home of school setting.

2. The individual has met criteria for ratings of **50 or less** on the Global Assessment of Functioning Scale (Axis V of DSM-IV) due to a designated mental illness over the past 12 months on a continuous or intermittent basis.

   Yes _____ Date: From ______ To: ______ Score: __________

Yes ___ No _____ **D.** Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)

Yes ___ No _____ One six month stay in an inpatient psychiatric unit

Yes ___ No _____ Two stays of any length in an inpatient psychiatric unit in the preceding two years.

Yes ___ No _____ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.

Yes ___ No _____ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.

Yes ___ No _____ Six months consecutive residency in a designated Adult Home.

Yes ___ No _____ Six months consecutive residency in a Residential Care Center for Adults (RCCA)

Yes ___ No _____ Six months consecutive residency in a Residential Treatment Facility (RTF)
Applicant Information

Name: __________________________ Date of Birth: __________________________
Social Security #: __________________________ Medicaid #: __________________________ Military Service: Yes ___ No ___
Address: __________________________ Apt. #: __________________________
City: __________________________ State: __________________________ Zip: __________________________
Telephone: __________________________ Male ___ Female ___ Citizenship: Yes ___ No (if no, immigration status): __________________________

Ethnicity

- White (Non-Hispanic) ___
- Black (Non Hispanic) ___
- Latino/Hispanic ___
- Asian/Asian American ___
- Native American ___
- Pacific Islander ___
- Other ___

Primary Language

- English ___
- Spanish ___
- Chinese ___
- French ___
- Italian ___
- Russian ___
- German ___
- Japanese ___
- Other ___

Custody Status of Children

- No children ___
- Children are all above 18 years of age ___
- Minor children currently in client’s custody ___
- Number of children: _______ Gender: _______
- Minor children not in client’s custody but have access ___
- Minor children not in client’s custody – no access ___

Current Living Situation

- Room ___
- Own apt ___
- Supervised Living ___
- Supported Housing ___
- Nursing Home ___
- Homeless (shelter) ___
- Homeless (streets) ___
- Lives with spouse ___
- Lives with Parents ___
- Correctional facility ___
- Other ___

Insurance and Financial Information: Currently Receives

Social Security  □  Earned Income/Wages  □
SSI/SSD  □  Food Stamps  □
Public Assistance  □  VA Benefits  □
Medicaid  □  Representative Payee  □
Medicare  □  Other  □

Referral Source

Name: __________________________ Phone: __________________________
Agency: __________________________ Fax: __________________________
Address: __________________________
Program: __________________________ Relationship: __________________________

Psychiatric Information:

Diagnosis  DSM IV Codes

Axis I: __________________________________________

Axis II: __________________________________________

Axis III: Current Medical Problems
________________________________________________

Axis IV Diagnosis: psychosocial and environmental problems: Please list below
________________________________________________

Axis V: Global Assessment of Functioning (GAF Score) __________________________

Risk Assessment

Cruelty to Animals  □  Suicidal Behavior  □
Fire Setting  □  Severe Violence  □
Homicidal Behavior  □  Sexual Offense  □
Current Medications: Please List


Outpatient Treatment Provider:

Agency: ______________________________ Program: ______________________________
Contact: ______________________________ Telephone: ______________________________

Substance Abuse History: Please List Drugs of Choice

Length of Time Recipient Has Been Substance Free: ______________________________

Criminal Justice – Current Status

<table>
<thead>
<tr>
<th>None</th>
<th>Incarcerated-Jail</th>
<th>Incarcerated-Prison</th>
<th>CPL 330.20/730</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation</td>
<td>Parole</td>
<td>TASC/MHATI</td>
<td>Other:______________</td>
</tr>
</tbody>
</table>

P.O. Name: ______________________________ Telephone: ______________________________

Number of arrests/incarcerations in past year ________ Number of lifetime arrests ________

Reason for Arrest: ______________________________ Date: __________

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra’s Law? ______ Yes ______ No

Is an AOT under Kendra’s Law currently being pursued? ______ Yes ______ No

Case Management Service Requested

____ Supportive (SCM) ____ Intensive (ICM) ____ Adult Home (AHCM)

Is there a specific case management program requested? ______________________________

Act Services Requested ______ Is there a specific ACT Team requested? ______________________________

Residential Services Requested

____ Supervised Community Residence ____ Supported Single Room Occupancy (SRO)

____ Supervised MICA Community Residence ____ Treatment Apartment Programs

____ Supervised Community Residence MI/MR

____ Supported Housing ______ Individual ______ Family

____ Shelter Plus Care ______ Individual ______ Family

Geographical Preference/Community: ______________________________

Recipient Requests: ______________________________

Recipient Signature: ______________________________ Date: __________

Referring Party Signature: ______________________________ Date: __________
AUTHORIZATION FOR RESTORATIVE SERVICES

☐ Initial Authorization
☐ Semi-Annual Authorization
☐ Annual Authorization

CLIENT’S NAME: ____________________________________________

CLIENT’S MEDICAID NUMBER: ________________________________

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____________________________________________.

__________________________________________
Mo/Day/Yr                                     Signature & Licensure #

Print Name

DISABILITY VERIFICATION FOR HUD SHELTER PLUS CARE ELIGIBILITY
(MUST BE HOMELESS)

CLIENT’S NAME: ____________________________________________

I, the undersigned licensed professional, based on my review of the assessments made available to me, have determined that _____________________________________________.

I meet criteria for the primary diagnosis of _____________________________ and that this disability is expected to be long-continuing and of indefinite duration, and substantially impedes his/her ability to live independently. This disability could be improved by the provision of more suitable housing conditions.

__________________________________________
Mo/Day/Yr                                     Signature & Licensure #

Print Name