Monroe County Office of Mental Health
Adult Single Point Of Access (SPOA)

Empire State Supportive Housing Initiative (ESSHI)

Serious Mental Illness (SMI) referrals only

Preferred Location: ☐ Center City Courtyard-Eagle Star ☐ Canal Commons-East House

Resident Name/s: _____ Referral Date: _____

Resident Phone #: _____ Date of birth: _____

Email: _____ Gender Identity: _____

Preferred Language: _____ Interpreter needed for intake? Yes ☐ No ☐

Marital Status: ☐ Never Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Current Living Situation: Shelter Homeless At Risk of homelessness Unstably Housed

Household Size: _____

Current Address: _____

Social Security #: _____ Medicaid #: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Email: _____

Does the prospective resident have any therapy animals? Yes No

~ If yes, does the prospective resident have any documentation for the animal? Yes No

Referral Agency: _____ Referred by: _____

Phone #: _____ Email: _____

Medical Provider Name:

_____

Agency: _____

Phone #: _____

Mental Health Provider Name:

_____

Agency: _____

Phone #: _____

Substance Use Provider Name:

_____

Agency: _____

Phone #: _____

Other Clinical/Medical Provider Name:

_____

Agency: _____

Phone #: _____

Risks *(please check all that apply and note date of occurrence if appropriate - state NA if not applicable)*:

Engaged in arson (*date:* _____)

Destruction of property (*date:* _____)

Sexual offenses toward others (*date*: _____)

Violent criminal offenses toward others or property (*date:* _____)

Physical harm to others (*date:* _____)

Suicide attempt/self-injury (*date:*_____)

Victim of physical or sexual abuse (*date:* _____)

Other previous or current legal involvement:

Medical Issues *(please* check *all that apply)*:

History of falls Incontinence Hearing loss Vision loss

Impaired ability to walk? Yes No

~ If yes, the resident uses a (please check all that apply): Walker Wheelchair Transfer Chair

Medical Concerns/Comments/Other Information:

Mental Health Diagnoses:

Substance Abuse Diagnoses and frequency of use (be specific):

Please complete the following - responses should be 'No Assistance Required' or 'Assistance Needed':

Manage their personal care needs (grooming, hygiene, laundry, cleaning, etc):

Use their own transportation, public transportation, and other community resources:

Respond appropriately to emergency situations (i.e medical, fire):

Follow through with appointments and other responsibilities:

Plan, shop and prepare meals:

Manage their own money:

Please describe the resident's previous:

Independent living experience:

Drug/alcohol treatment history:

Interpersonal skills/supports (including family):

Hospitalizations (causes and dates):

Is the resident able to self-manage their medications? ☐ Yes ☐ No ~ If no, are supports in place to assist? ☐ Yes ☐ No

Is the resident filling their own prescriptions? ☐ Yes ☐ No ~ If no, are supports in place to assist? ☐ Yes ☐ No

Funding *(please check all sources of income recipient currently receives)*

SSI - $_____ per month

SSD - $_____ per month

SSP - $_____ per month

DHS - $ _____ per month

SNAP Benefits - $ _____ per month

Alimony - $_____per month

Employment - $_____ per month

Pension - $ _____ per month

Trust Fund - $ _____ per month

Other - $ _____ per month

Assets (please list all assets):

Debts (please list all debts, including past utilities, child support, credit card debt, etc):

Does the resident have:

~ Medicare? Yes No - If yes, Medicare #: _____

~ Medicaid? Yes No - If yes, Medicaid #:_____

~ Private Insurance? Yes No - If yes, plan and #: _____

~ Representative Payee? Yes No - If yes, agency: _____

Required Documents (please **check** all documents in resident possession):

DD-214

Social Security Card

Birth Certificate

Photo Identification

Social Security Award Letter

Bank Statements

Previous Year Tax Returns or 1099

Pay Stubs

Alimony/Child Support Documents

Proof of Assets or Mortgage

** Please provide the most recent psychosocial evaluation, psychiatric assessment, or needs assessment as indicated and any other assessments that may be helpful. This will expedite the referral process.

Signature below indicates this potential resident is medically and psychiatrically stabilized, does not need a higher level of care and is considered appropriate for the SMI Supportive Housing Program. To the best of my knowledge, the potential resident meets the eligibility criteria listed above.

Signature of Referral Agent: _____Date: _____

(required)

Print name and title: _____

Signature of Resident: _____ Date: _____

(required)

Print name: _____

Referrals can be securely emailed or faxed to:

lbabbitt@monroecounty.gov or
courtneyponder@monroecounty.gov

585-753-2885 (fax)

Questions?

Contact 585-753-2874 or
585-753-2617

Once referrals are received they will be reviewed for appropriateness and if there are questions, concerns or if additional paperwork is needed SPOA staff will reach out to the referral source. If individual meets program criteria, referrals will get sent to the preferred ESSHI Program.

ESSHI HOMELESS VERIFICATION FORM

Verification of status indicated below must be attached.

☑	Homeless Status
☐	The individual being referred is an un-domiciled person who is unable to secure permanent and stable housing without special assistance. (This includes those who are inappropriately housed in an institutional facility and can safely live in the community, and those who are at risk of homelessness.)
☐	The individual being referred is an adult or young adult reentering the community from incarceration or juvenile justice placement, who was released or discharged, and who is without permanent and stable housing.
☐	The individual being referred is a survivor of domestic violence in need of secure and stable housing.

Comments:

Referral Source Contact Information

Name _____

Agency _____

Email _____

Phone _____

I verify, to the best of my knowledge, that the above information and all additional verification documents submitted are true and accurate.

_____ _____

Signature of Referral Agent/Advocate Date

_____ _____

Signature of Prospective Tenant Date

Supporting Documentation

The following documentation is required for the property management company to certify acceptance.

The more of these documents that are provided with the referral form, the faster the process will go.

- **Photo ID- Government issued **(Required)**
- **Social Security Card **(Required)**
- **Birth Certificate **(Required)**
- **DD214 (If applicable)**
- **Current bank statement- checking and savings (needed during leasing process) (If applicable)**
- **If employed- most recent, consecutive 6 weeks of paystubs (If applicable)**
- **Current Social Security award letter SS/SSI/SSP (dated within 120 days) (If applicable)**
- **Current VA Disability award letter (dated within 120 days) (If applicable)**
- **Current Disability or workers compensation letter (If applicable)**
- **Current Pension letter (If applicable)**
- **Public Assistance budget (If applicable)**
- **Divorce agreement (If applicable)**
- **Child support disbursement print out (If applicable)**
- **Previous year tax return (1040 and w/2) or 1099 for Social Security (If applicable)**

***Additional documents may be needed from the leasing agent during the leasing process**

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with a mental illness. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination,delivery of services, payment for services and health care operations. This form complies with the requirements of §33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA)(20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1) I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2) The person whose information may be used or disclosed is:

Name: _____ Date of Birth: _____

3) The information that may be used or disclosed includes (check all that apply):
   - ☐ Mental Health Records
   - ☐ Alcohol/Drug Records
   - ☐ School or Education Records
   - ☐ Health Records
   - ☐ All of the records listed above

4) This information may be disclosed by:
   - ☐ Any person or organization that possesses the information to be disclosed
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations that provide services to me:

5) This information may be disclosed to:
   - ☐ Any person or organization that needs the information to provide service to the person who is subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations:

6) The purposes for which this information may be used and disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Monroe County of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and
   - Health Care Operations such as quality assurance

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information (con't)

7) I understand that New York State and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HERERBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8) This permission expires (check):
   ☐ On this date _____
   ☐ Upon the following event _____

9) This permission is limited as follows:

   ☐ Permission only applies to records for the following time period: _____ to _____
   ☐ Other limitations: _____

10) I understand that this permission may be revoked.
    I understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship is _____. I give permission to use and disclose records as described in this document.

_____ _____
Signature Date

_____
Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Monroe County.

Access-VR
Action for a Better Community
Adult Protective Services
Anthony Jordan Health Center
Baden Street Settlement
Balanced Care
Beacon Health Strategies, LLC (Medicaid Managed Care Organization)
Blue Cross/Blue Shield of Western New York/Health Now (Medicaid Managed Care Organization)
Catholic Family Center
Catholic Charities Community Services
Center for Youth
Child Protective Services
Community Care of Rochester, Inc. DBA Visiting Nurse Signature Care
Community Place of Greater Rochester
Companion Care of Rochester
Compeer Rochester
Conifer Park, Inc.
Coordinated Care Services, Inc.
Crestwood Children's Center
Daisy Marquis Jones Women's Residence
Delphi Drug & Alcohol Services
DePaul Community Services
Department of Corrections and Community Supervision
Eagle Star Housing
East House Corporation
Eldersource / Lifespan
Endeavor Counseling Services
Epilepsy-Pralid, Inc.
Excellus/Centene/Evolve Health (Medicaid Managed Care Organization)
Fidelis (Medicaid Managed Care Organization)
Finger Lakes Area Counseling and Recovery Agency (FLACRA)
Finger Lakes Developmental Disabilities Services Office (DDSO)
Gavia LifeCare Center
Greater Rochester Health Home Network (GRHHN)
Genesee County Mental Health Clinic
HCR Home Care
Health Homes of Upstate New York (HHUNY)
Helio Health, Inc.
Hickok Center
Hillside Family of Agencies
Hillside Children's Center
Huther-Doyle Memorial Institute, Inc.
Ibero-American Action League
Interim Mental Health
Jewish Family Service of Rochester
John L. Norris ATC
Liberty Resources
Lifetime Care
MC Collaborative
Mental Health Association of Rochester
Molina Healthcare
Monroe Correctional Facility
Monroe County Department of Human Services
Monroe County Jail
Monroe County Office of Mental Health
Monroe Plan for Medical Care, Inc.
MVP (Medicaid Managed Care Organization)
National Alliance on Mental Illness (NAMI)
New York Care Coordination Program, Inc.
NY Connects
Office of Addiction Services and Supports (OASAS)
Office of People with Developmental Disabilities (OPWDD)
OnTrack NY
NYS Office of Mental Health
Pathways Methadone Maintenance Treatment Program
Pathway Houses of Rochester
Partners Ending Homelessness
Prime Care (originally Correct Care Solutions)
Puerto Rican Youth Development
Recovery Options Made Easy (ROME)
Reentry Association of Western NY (RAWNY)
Rehabilitation Counseling & Assessment Services, LLC.
Rochester/Monroe Recovery Network
Rochester Regional Health
Rochester Psychiatric Center
Rochester Rehabilitation Center
Spectrum Health and Human Services
Steven Schwarzkopf Community Mental Health Center
The Healing Connection, Inc.
Threshold Center
Trillium Health
United Health Care (Medicaid Managed Care Organization)
University of Rochester/Strong Memorial Hospital
Urban League of Rochester
YWCA Supportive Living Program
Venture For the, Inc.
Veteran's Administration
Veteran's Outreach Center
Villa of Hope
Westfall Associates