MONROE COUNTY OFFICE OF MENTAL HEALTH
ADULT SINGLE POINT OF ACCESS REFERRAL PACKET

Thank you for your interest in referring to the Adult Mental Health Residential Programs of Monroe County. The following information will assist you in understanding the process, choosing the appropriate level of care and submitting the necessary information to proceed with this referral.

Referral Process:

Referrals can be received from a variety of sources. Residential referrals can be faxed to 585-753-2885. The office for Monroe County OMH is located at 1099 Jay St., Bldg J, 3rd Floor, Rochester, NY 14611. Attn: Lisa Babbitt, or Courtney Ponder.

Each referral packet should be thoroughly completed. All information is required, and must include a signed Consent for Release of Information Form (included in this packet). All required documents must accompany this referral to avoid delays in the process. If a completed consent form does not accompany this referral, then an explanation on the form must be provided.

All Residential referrals are forwarded to the Monroe County Single Point of Access Manager and will be presented to the Central Intake Committee. The committee meets on a weekly basis.

The Residential Committee consists of a representative from Rochester Psychiatric Center, including Family Care, John Romano Community Residence and Elmwood Transitional Residence. Also present is someone from East House Corporation, and DePaul Community Services. Having representation from all of these services assures more efficient placement in the appropriate service.

Subsequent to a case presentation, one of the following outcomes will occur:

- The client will be screened for a residential program.
- The client will be enrolled in one of the programs.
- The client will be placed on a waiting list.
- A recommendation will be made for an alternative plan, if the referral request cannot be met, and justification for non-acceptance will be provided.

For individuals to qualify for residential services they must meet the following criteria:

- They must be diagnosed with a primary mental illness.
- They must be at least 18 years old.
- They must be impaired in several areas of functioning due to their mental illness.

A response indicating the Central Intake Committee's decision will be provided to the referring agency.

Any questions regarding this process can be directed to the Single Point of Access (SPOA) Program.

Lisa Babbitt 585-753-2874 lbabbitt@monroecounty.gov
Courtney Ponder 585-753-2617 courtneyponder@monroecounty.gov

MONROE COUNTY OFFICE OF MENTAL HEALTH
ADULT RESIDENTIAL SERVICES

Below are the descriptions of the different levels of residential care.

Community Residence: DePaul and East House offer Community Residence Programs. They all have 24-hour staffing. Clients work on rehabilitation plans to develop skills to live more independently. These programs house 9-14 individuals. The community residence programs are transitional with time-limited lengths of stay.

State Operated Community Residence (SOCR): Rochester Psychiatric Center offers Community Residence Programs, known as John Romano Community Residence, for up to 12 beds, and the Elmwood Transitional Residence, for up to 29 beds. They have 24-hour staffing and clients work on rehabilitation skills to move onto another Community Residence Program or independent living. This program often has enhanced staffing, is transitional and time limited for 6 months to 2 years.

Treatment Apartment Programs: East House and DePaul offer Treatment Apartment Programs. These are smaller settings for one to three individuals. These have a variety of staffing patterns. Individuals work on rehabilitation plans to develop skills to live more independently. These programs are transitional with time-limited lengths of stay.

Single Room Occupancy (SRO): DePaul operates Single Room Occupancy residences. Each program has 75 - 100 residents in single bedrooms. This program provides transitional housing with 24-hour staffing. Meals are included, medication can be supervised, and activities are planned.

Family Care: Rochester Psychiatric Center offers a Family Care Program in five counties. It is a program in which private individuals are paid a stipend for taking into their homes people who are recovering from mental illness. There are one to four residents in each home. These homes cannot offer 24-hour supervision. The residents are expected to attend some day program and must be medication compliant. These are homes in Rochester and in surrounding rural settings. There is no time limit on how long a resident may stay in the program.

Supported Housing: DePaul Community Services, East House Corp., IBERO American Action League, and Recovery Options Made Easy have Supported Housing Programs. These programs assist the individuals in finding and maintaining independent housing in the community. Rental assistance is provided to eligible individuals. Staff has contact with individuals on an occasional basis and assist with all housing related needs. Individuals must have case management needs and require a rent stipend to stay in the program.

Single Site Supportive Housing (SPSRO): DePaul Upper Falls Square Apartments, a Single-Site Supportive Housing Program, is a non-certified New York State Office of Mental Health program that provides long-term or permanent housing where residents can access the support services they require to live successfully in the community. East House Corp. also has a SPSRO, Alexander Commons, which has a health care coordinator to assist with medications and health needs.

Criteria for Severe and Persistent Mental Illness (SPMI) among Adults

To be considered an adult diagnosed with SPMI ***A*** must be met. In addition, ***B*** or ***C*** or ***D*** must be met:

A. Individual must be 18 years of age or older and have a designated Mental Illness Diagnosis as listed in the most recent Diagnostic and Statistical Manual (DSM) for Mental Disorders (DSM-IV) other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions.

AND

B. The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

OR

C. Extended impairment in functioning due to mental illness (the individual 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:

- ***a.*** Marked difficulties in self-care (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- ***b.*** Marked restriction of activities of daily living (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- ***c.*** Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
- ***d.*** Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

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

OR

D. Individual has demonstrated ongoing reliance on psychiatric treatment, rehabilitation, and supports.

A documented history shows that the individual, at some prior time, met the threshold for ***C*** (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

MONROE COUNTY OFFICE OF MENTAL HEALTH
ADULT SPOA REFERRAL PACKET

Referral Date: _____

❖ **Level of Residential Care Requested:**

☐ Community Residence ☐ Treatment Apartment Program ☐ Family Care ☐ SOCR
☐ Unknown ☐ Supported Housing ☐ SRO ☐ SPSRO

Residential agency preference, if any:

Reason for Residential Referral vs. remaining in current living situation:

In order for this packet to be complete for mental health residential services, the following items must be included (incomplete packets will not be presented):

1. Pages 4 through 13 filled out thoroughly.
2. The client completes the "Permission to use and disclose confidential information" form (pages 14-15), including the Social Security Administration consent (pages 17-18).
3. The client completes the "Dreams and Wishes" form (page 19).
4. The Physician's Authorization for Rehabilitative Services form for Community Residences and Treatment Apartment Programs needs to be filled out by a M. D. and the *ORIGINAL* to be included with the referral (pages 20-21).
5. Attach the client's complete psychosocial or intake assessment along with 2 recent progress notes from the mental health provider.
6. Attach a verification of Tuberculosis screening and result completed within the past 12 months. If the result if positive, then results of a chest x-ray is required.
7. Attach a copy of a complete physical exam completed within the past 12 months.

Client's Name: _____ Date of Birth: _____

Social Security #: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Trans(☐ MTF or ☐ FTM)

Current Address

Street: _____ City: _____ State: _____ Zip: _____

County of Origin: _____ Phone #: _____

Referral Contact: _____ Agency: _____

Referral Agent's Address

Street: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email: _____

Emergency Contact

Name: _____

Contact Information: _____

Therapist/Social Worker Name: _____ Agency: _____

Phone Number: _____ Email Address: _____

Care Manager's Name: _____ Agency: _____

Phone Number: _____ Email Address: _____

Do you currently own pets? ☐ Yes ☐ No Is it a Certified Therapy Pet? ☐ Yes ☐ No

How many? _____ What kind? _____

❖ **Medicaid Status:**

☐ Application Pending ☐ Eligible ☐ Disapproved ☐ Unknown
☐ No Application Submitted ☐ Not Applicable

Medicaid # (if applicable): _____

❖ **Primary Language:**

☐ ASL ☐ Chinese ☐ Creole ☐ English ☐ French ☐ German ☐ Greek
☐ Indic (ex. Hindi, Urdu) ☐ Italian ☐ Polish ☐ Spanish ☐ Yiddish ☐ Unknown
☐ Other, specify: _____

❖ **English Proficiency** (if language is other than English)**:**

☐ Does not speak English ☐ Poor ☐ Fair ☐ Good ☐ Excellent

❖ **Client's Race** (Check all that apply)**:**

☐ White ☐ Black, African American ☐ American Indian or Alaskan Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Samoan ☐ Unknown ☐ Guamanian or Chamorro
☐ Other, Specify: _____

❖ **Is this client Spanish / Hispanic / Latino?** (Select one response)

☐ Not Spanish/Hispanic/Latino ☐ Unknown
☐ Yes, Dominican ☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Other, Specify: _____

❖ **Current Living Situation:**

☐ Private residence alone
☐ Private residence with spouse or domestic partner
☐ Private residence with parent, child, or other family
☐ Correctional Facility
☐ Supervised living
☐ Assisted / Supported living
☐ Family Care
☐ Homeless – street, parks
☐ Dept. of Health Adult Home
☐ Drug or alcohol abuse residence or inpatient setting
☐ Inpatient, general hospital or private psychiatric center
☐ Inpatient, State Psychiatric Center
☐ Nursing Home/medical setting
☐ Children & Youth Residential
☐ Homeless shelter or emergency housing
☐ Unknown

☐ Other, specify: _____

Length of time in current living situation: _____

Anticipated discharge/release date from current living situation: _____

Previous Residential History (include independent and supervised situations)

❖ **Highest level of education completed:**

☐ No formal education
☐ Grammar School (K – grade 6)
☐ Junior high school (grades 7 & 8)
☐ Some H. S. 9th – 12th, but no diploma
☐ High school / GED
☐ Some college but no degree
☐ Business, vocational or technical training
☐ Associate's Degree
☐ Bachelor's Degree
☐ Graduate Degree
☐ Unknown
☐ Other

❖ **Current employment status:**

☐ No employment of any kind
☐ Non-paid work experience
☐ Sporadic or casual employment for pay
☐ Other employment situation
☐ Employment in sheltered (non-integrated) workshop run by state or local agency
☐ Community-integrated employment run by a state or local agency
☐ Competitive employment (employer paid) with no formal supports
☐ Competitive employment (employer paid with ongoing supports)
☐ Unknown

Average hours of employment or non-paid work experience:

☐ 1 to 10 hours ☐ Over 30 hours ☐ 21 to 30 hours
☐ 11 to 20 hours ☐ None ☐ Unknown

❖ **Criminal Justice Status:**

- ☐ Client is not in the criminal justice system at this time
- ☐ Under Parole supervision
- ☐ Under arrest, in jail, lockup, or court detention
- ☐ CPL 330.20 Order of Conditions and Order of Release
- ☐ In NYS Dept. of Correctional Services (State Prison)
- ☐ Released from jail or prison within last 30 days
- ☐ On bail, released on own recognizance (ROR), or conditional discharge, or other alternative to incarceration status
- ☐ Other
- ☐ Under Probation supervision
- ☐ Unknown whether or not client has a criminal justice history

❖ **Marital Status:**

☐ Single, never married ☐ Widowed ☐ Currently married ☐ Unknown
☐ Divorced/separated ☐ Cohabiting with significant other/domestic partner

❖ **Child Custody Status:**

- ☐ No children
- ☐ Have children all over 18 years old
- ☐ Minor children currently in client's custody
- ☐ Minor children not in client's custody but have access
- ☐ Minor children not in client's custody, have no access
- ☐ Unknown

❖ **Income or benefits currently receiving** (select all that apply and enter amounts, if applicable)**:**

- ☐ Medicare # _____
- ☐ Medicaid # _____
- ☐ Medicaid pending
- ☐ Hospital-based Medicaid
- ☐ Medication grant
- ☐ Wages/salary or self employment $ _____
- ☐ Supplemental Security Income (SSI) $ _____
- ☐ Social Security Disability Income (SSDI) $ _____
- ☐ Veteran benefits $ _____
- ☐ Worker's Compensation or disability ins. $ _____
- ☐ Unemployment or union benefits $ _____
- ☐ Private insurance, employer coverage, no fault or third party insurance (Name of ins: _____)
- ☐ Social Security retirement, survivor's or dependent's (SSA) $ _____
- ☐ Any public assistance cash program: Family Assistance (TANF), Safety Net, Temp. Disability $ _____ $ _____
- ☐ Railroad Retirement, retirement pension (excluding SSA) $ _____
- ☐ Debts (court mandated payments, credit cards, loans, etc.) $ _____
- ☐ Other benefits/resources: _____
- ☐ Unknown
- ☐ None

_____ _____ _____
Representative Payee (If applicable) Phone Number Agency/Relationship

❖ **Diagnosis:**
Description (*Include all Diagnoses; Mental Health, Substance Use Disorder, Developmental Disorder and Medical*)

_____

_____

_____

_____

_____

_____

_____

(select all that apply):

- ☐ Problems with primary support group
- ☐ Problems related to the social environment
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Unknown
- ☐ Other psychosocial and environmental problems
- ☐ Economic problems
- ☐ Problems with access to health care services
- ☐ Problems related to access with the legal system/crime
- ☐ Housing problems

❖ **Describe the medication regimen in the client's current treatment plan:**
Does the client currently have medications prescribed for a psychiatric condition?

- ☐ Yes (Please specify on the lines below)
- ☐ Unknown
- ☐ No

Current Medications:	Total Daily Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(attach a medication list if more medications need to be added)

Client's adherence to medication regimen:

- ☐ Takes medication exactly as prescribed
- ☐ Takes medication as prescribed most of the time
- ☐ Sometimes takes medication as prescribed
- ☐ Rarely or never takes medication as prescribed
- ☐ Medication not prescribed
- ☐ Client refuses medication
- ☐ Unknown
- ☐ Other

❖ **Client's services within past 12 months, other than current:** (check all that apply)

- ☐ ACT
- ☐ AOT
- ☐ Health Home Care Management
- ☐ Non Medicaid Care Management
- ☐ MH outpatient: clinic, partial hospital, PROS Program
- ☐ CSP nonresidential mental health program (e.g. clubhouse, vocational services)
- ☐ Self help/peer support services
- ☐ Unknown
- ☐ Alcohol/Drug abuse outpatient treatment
- ☐ State Psychiatric Center inpatient unit
- ☐ General hospital psychiatric unit or certified psychiatric hospital
- ☐ Alcohol/drug abuse inpatient treatment
- ☐ Prison, jail or other court mental health service
- ☐ Local MH practitioner
- ☐ Emergency mental health (nonresidential)
- ☐ None
- ☐ Other, specify: _____

Current services:

If no current services, then recommended program:

_____

Previous psychiatric treatment/hospitalizations (please provide facilities and dates):

Behavior/circumstances precipitating most recent hospitalization:

Signs/symptoms of decompensation (please be specific):

- **Legal Issues/Legal History/Mandated to Treatment**
  (please describe charges and convictions and provide dates):

Termination date of parole or probation (if applicable): _____

Current legal supervision, i.e., probation, parole, drug and mental health court, etc. (if applicable):

Contact person: _____ Agency: _____

Phone number: _____ Email Address: _____

- **RISKS** (enter one response for each)**:**
  If occurred, provide dates and describe below:

Physical Harm to self and/or suicide attempt _____

Physically abused and/or assaulted someone_____

Victim of physical abuse_____

Victim of sexual abuse_____

Engaged in arson_____

Destruction of property_____

History of sexual offenses towards others_____

If any of the above events/behaviors have occurred, please explain:

Co-occurring disabilities, if any:

- ☐ Drug or alcohol abuse
- ☐ Cognitive disorder
- ☐ Mental retardation or developmental disabilities
- ☐ Blindness
- ☐ Impaired ability to walk
- ☐ Hearing impairment
- ☐ Deaf
- ☐ Visual impairment
- ☐ Wheelchair required
- ☐ Amputee
- ☐ Incontinence
- ☐ Bedridden
- ☐ None
- ☐ Speech impairment
- ☐ Other, specify: _____

Medical issues:

Special diet (if any, please explain):

Allergies:

Medical Doctor's Name: _____ Phone Number: _____

Agency: _____

❖ **Alcohol and other drug use** (select one response for each):

Scale

0 – Never
1 – More than 6 months ago
2 – Not in the past 6 months
3 – Once or more in the past 6 months, but not in the past 3 months
4 – Once or more in the past 3 months, but not in the past month
5 – Once or more in the past month, but not in the past week
6 – Once or more in the past week
U – Unknown

Alcohol	_____	Heroin/Opiates	_____
Cocaine	_____	Marijuana/Cannabis	_____
Amphetamines	_____	Hallucinogens	_____
Crack	_____	Sedatives/Hypnotics/Anxiolytics	_____
PCP	_____	Other prescription drug abuse	_____
Inhalants	_____	Other, specify: _____	

Date of last chemical use: _____

Longest period of sobriety (give dates): _____

Does the client smoke cigarettes? ☐ Yes ☐ No If yes, how many per day? _____

Does the client currently receive chemical dependency treatment? ☐ Yes ☐ No

If yes, is it inpatient or outpatient and what is the anticipated discharge date?

Chemical Dependency Treatment Agency/Provider: _____

Phone Number: _____ Email Address: _____

Has the client received chemical dependency treatment in the past? ☐ Yes ☐ No

If yes, was it inpatient or outpatient? (Please provide dates)

❖ **Community Survival Skills:** (Check appropriate response in the boxes provided below)

	Independent, needs no assistance	Can do with help	Dependent
Activities of Daily Living (ADLs)			
Eating	☐	☐	☐
Dressing	☐	☐	☐
Grooming	☐	☐	☐
Toileting	☐	☐	☐
Personal Safety			
Crossing street safely	☐	☐	☐
Exit in emergency	☐	☐	☐
Smoking safely	☐	☐	☐
Community Living			
Using public transportation	☐	☐	☐
Shopping	☐	☐	☐
Cooking	☐	☐	☐
Cleaning	☐	☐	☐
Managing own money	☐	☐	☐

Explanation of the above information:

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 mental disabilities. 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
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

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME _____ *ADDRESS _____

_____ _____

_____ _____

_____ _____

*I want this information released because:
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____

If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.

- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Dreams and Wishes

(to be **printed** and filled out by the client)

You are being referred for Residential Services. Information about you will be sent to the Single Point of Access (SPOA) that processes these referrals for Monroe County. In order to help arrange for the appropriate level of service, the SPOA would like to know your thoughts about this referral.

- Do you agree that you could benefit from this sort of assistance? If yes, why?

- Please share with us any specific goals you have that you think Residential Services might help you achieve.

- Is there anything else about you that you think would be helpful for us to know?

Client's Signature

Date

Rev. 11/01/15

PHYSICIAN AUTHORIZATION FOR
REHABILITATION SERVICES OF COMMUNITY RESIDENCES

DEPAUL
1931 Buffalo Road
Rochester, NY 14624
(585) 426-8000

_____Initial Authorization (face to face)
_____Semi-Annual Authorization (CR)
_____Annual Authorization (TAP)

Client's Name_____

Client's Medicaid Number_____

Based on review of the assessments made available to me, or as the result of a face to face assessment with the client in need of an initial authorization, I, the undersigned licensed physician, have determined that this individual would benefit from the provision of mental health rehabilitation services provided in a congregate care residential setting as defined pursuant to Part 593 of 14 NYCRR.

Period Covered:

_____/_____/_____ to _____/_____/_____
Month Day Year Month Day Year

_____
Primary Mental Health Diagnosis and ICD-10 Code

_____
M.D. License Number

_____ _____ _____
Print Name of M.D M.D. Signature **Date**

Authorization for Restorative Services

☐ Initial Authorization *(requires physician signature & face-to-face assessment)*

☐ Semi-Annual Reauthorization (*requires renewal every 6 months for congregate residences)*

☐ Annual Reauthorization *(requires renewal every 12 months for treatment apartment programs)*

**Reauthorizations can only be signed by a physician, physician assistant (PA), or nurse practitioner specializing in psychiatry in NY State (NPP).*

Client Name: _____Date of Birth_____Medicaid Number:_____

ICD.10 Diagnosis: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me (*and a face-to-face contact with the client for the initial authorization*), have determined that:

_____would benefit from the provision of mental health restorative
(Client Name)
services as known to me and defined pursuant to Part 593.4 (b) of 14 NYCRR and successor documents.

This authorization is in effect for the duration period of:

_____/_____/_____ to _____/_____/_____
Month Day Year Month Day Year

_____ _____ _____
M.D. Signature *Printed Name of M.D.* *Date*

_____
M.D. License Number

***Reauthorization only**:*

_____ _____ _____
Signature of Physician Assistant (PA)/ Nurse Practitioner in Psychiatry (NPP) *Printed Name of PA / NPP* *Date*

_____
PA/NPP License Number