SINGLE POINT OF ACCESS (S.P.A.)
c/o Long Island Residential Association (LIRA)
1300 Veterans Highway
Hauppauge, New York 11788
(631) 231-3562
Fax (631) 231-4568

Thank you for your interest in applying for residential services through the Suffolk County Single Point of Access (SPA). Enclosed please find the revised Long Island Universal Housing Application.

Please be aware that as of June 1, 2002, all applications for Mental Health Adult Housing services will be processed through the new Single Point of Access (SPA). At this time, all waiting lists for Mental Health Adult Housing Services will be transferred to the SPA for processing and the Individual Housing Providers will no longer maintain a separate agency waiting list.

In order to process the application in a timely manner, the following must be included:

- The application completed in its entirety signed by the applicant.
- A Psychiatric Evaluation signed by a licensed psychiatrist.
- A detailed Psycho-Social Summary.
- A Physical exam including a PPD.
- A Physician's Authorization Form signed by a licensed physician (needed for any supervised, intensive supportive or supportive programs)
- Completed Housing Preferences Form.

All materials mentioned above must be signed and dated within one year of the application date.

Incomplete referrals will result in the application being placed on hold and may delay potential placement.

In addition, it is recommended that you keep the original copy of the referral and that a copy be submitted to the SPA.

Please mail this referral to:

Single Point of Access (SPA)
c/o Long Island Residential Association (LIRA)
1300 Veterans Highway
Hauppauge, New York 11788

Long Island Mental Health Housing Application

Applicant's Name (Please Print Clearly): **SS#**

INSTRUCTIONS

Completed applications **MUST** include:

- ☐ Psychosocial History
- ☐ Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)
- ☐ Recent Physical Exam (including PPD exam within 1 year of application date signed off by licensed physician)
- ☐ Physician's Authorization Form (licensed: Supervised and Apartment Treatment only)
- ☐ Completed Housing Preference Form.

Any omissions will delay potential placement.

Please indicate the program for which you would like to be considered (Please see summary):
(Check A, B and / or C)

_____ A. Supervised Community Residence
_____ B. Apartment Treatment A
_____ C. Apartment Treatment B
_____ D. Supported Housing

Please check any specific program you would be appropriate for (see summary for details)

_____ M.I.
_____ M.I. / M.R.
_____ Senior Citizens / Geriatric (Nassau Only-Over 55)
_____ MICA
_____ SOCR
_____ RCCA (RCCA) (Suffolk Only)
_____ Young Adult (Ages 18-25)
_____ Family Housing (Supported Housing Only)
_____ Couples (Supported Housing Only)
Specify other individual: _____
(May require additional application for other individual)
_____ HUD – Homeless Housing
_____ HIV / AIDS Housing (requires additional consent)
_____ Other _____

Agency Preference (if any): _____

Geographic Preference (if any): _____

☐ Please check here if the applicant is **not** interested in services of the Peer Specialist Team. In the event the above is not checked, the Housing Preferences Form will be forwarded to the Peer Specialist Team.

I agree with this referral and give my consent for information about myself to be shared with agencies in connection with my referral to a housing program. I also agree that all the information contained herein is accurate to the best of my knowledge and is reflective of my current situation. See consent form.

Current Contact Info: **( )** _____

Date _____ Signature of Applicant **(Required)**

_____
Signature of Witness

Summary

Program descriptions

The following programs are operated by private, not-for-profit organizations licensed by the New York State Office of Mental Health. The programs are supervised by trained professionals who are available (via beeper or telephone) as needed in addition to regularly scheduled on-site hours. Residents are offered Restorative Services and are trained in the following areas:

Assertiveness / Self-Advocacy Training; Community Integration / Resource Development; Daily Living Skills; Health Services; Medication Management / Training; Parent Training; Rehabilitative Counseling; Skill Development; Socialization; Substance Abuse Services; Symptom Management

These programs are considered transitional housing. Individuals applying for Senior Citizen / Geriatric CRs (Nassau Only) must be 55 and over. Individuals applying for placement in MI / MR housing must fall between 65-85 IQ. There are three levels of care under the title Community Residence Program:

Supervised CR (Licensed):
These programs are supervised 24 hours per day. Overnight staff members are available. These residences typically house 8-12 individuals in one large house. Residents are offered all restorative services (listed above), generally with an emphasis on Daily Living Skills such as cooking, cleaning, personal hygiene, food shopping and money management. Medication is supervised as needed.

State Operated Community Residence (SOCR)(Licensed):
This level houses between 10-24 residents, staffed 24 hours a day, meals and social activities provided. Services are the same as above.

Residential Care Center for Adults (RCCA)(Licensed) Suffolk Only: RCCA is a structured environment. This level houses 130 residents, staffed 24 hours a day, meals and social activities are provided. Medication is monitored by staff.

Apartment Treatment A and B (Licensed):
These programs typically receive staff visits from 5-7 (A) times per week to 1-4 (B) times per week. There are generally 2-3 residents per house or apartment. Residents are expected to have good daily living skills and be able to hold their own medication. Food is not provided. Instead, residents receive an allowance, which is used to purchase food and cleaning supplies.

Supported Housing:
Supported Housing programs vary. Programs may offer individual bedrooms or triple accommodations in individual placement or with family. Individuals residing in Supported Housing pay 30% of their monthly income toward their rent. The rest of their rent is subsidized. Residents of these programs live fairly independently and may receive visits 1-4 times monthly. Supported Housing is considered long-term housing.

Homeless Housing:
All homeless programs are subject to the HUD definition of homelessness as there are different regulations for homeless housing.

Long Island Mental Health Housing Application

Section A: Identifying Information: *(Please print clearly)*

1. First Name: _____ Last Name: _____
2. AKA: _____
3. Date of Birth: ____ / ____ / ____ (age: _____)
4. Social Security #: _____ / _____ / _____
5. Gender: ( ) Male ( ) Female
6. Current Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Domestic Partner
7. Homeless: ( ) Yes ( ) No If Yes, check type: ( ) Currently ( ) Pending ( ) Other (Please use Page 6 to explain)
8. Address: (if applicant is homeless, indicate location. If applicant is hospitalized, list address / location prior to hospitalization on A side. If applicant currently lives in a Mental Health Facility, list address and info on B side.)
   (A) Street: _____ Apt. # _____ (B) Agency Name: _____
   City: _____ State: _____ Zip Code: _____ Street: _____
   Phone #: ( ) _____ City: _____ State: _____ Zip Code: _____
   Phone #: ( ) _____
9. Emergency Contact Name: _____
   Address: Street: _____ Apt #. _____
   City: _____ State: _____ Zip Code: _____ Phone #: ( ) _____
   Number of Children to be housed? _____ Age(s) and Sex: _____
   Special Conditions: _____
**10. Applicant's Ethnicity: _____
   Citizenship: ( ) USA ( ) Other
   If other, specify: _____
11. Is the applicant a Veteran? ( ) Yes ( ) No
   Type of Discharge: _____
12. List all Entitlements and income which the applicant receives or which are pending:

	Monthly Dollar ($) Amount	ID Number or "P" for Pending
( ) Social Security		
( ) SSI		
( ) SSD		
( ) PA		
( ) Veterans		
( ) Medicare		
( ) Medicaid		
( ) Food Stamps		
( ) Pension		
( ) Wages		
( ) Worker's Comp		
( ) Unemployment		
( ) Other		

Does the applicant have a Representative Payee? ( ) Yes ( ) No
If yes: Name: _____
Phone: ( ) _____
Is the applicant paying an overpayment: ( ) Yes ( ) No
How much? _____ To what agency? _____
13. Is the applicant currently receiving or eligible for any of the following?

CSS:
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

CSS Waiver:
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

ICM:
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

AOT:
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

AOT Service Enhancement (Diversion):
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

ACT:
Contact Person: _____ Phone: ( ) _____ ( ) Yes ( ) No ( ) Pending

****** *This question is asked for statistical purposes only. Applicants will not be discriminated against based on race, color, creed, religion, sex, national origin, age, familial status, handicap or sexual preference.*

Long Island Mental Health Housing Application

Applicant Name (Please print clearly): SS #:

Section B: Housing, Employment and Education History & Preferences

1. Please list where the applicant has resided for the past five years and detail any history of homelessness. Include shelters, drop-in centers, streets, hospitals, prison, supportive residences, SRO's, family and independent housing (please start with most recent location):

Dates	Location	Reason for Leaving

2. Has applicant been employed during the last five years?
( ) Yes ( ) No ( ) Unknown
If yes, please list dates and positions:

Dates	Position / Title / Type of Employment

3. Educational / Training History *(check all relevant items):*
   - ( ) Special Education
   - ( ) Some High School
   - ( ) H.S. Diploma or GED
   - ( ) Some College
   - ( ) College Degree
   - ( ) Master's Degree or higher
   - ( ) Vocational Training, Trade: _____
   - ( ) VESID Sponsorship: _____

4. What is the reason this referral is being made at this time? (Please answer on Page 5).

Section C: Skills / Supports Assessment

1. Rate the degree to which the applicant can accomplish the following: (1=Cannot Accomplish, 2= Accomplish with Assistance, 3=Can Accomplish Independently, U=Unknown):

	1	2	3	U
Paying Rent	( )	( )	( )	( )
Housekeeping	( )	( )	( )	( )
Money Management	( )	( )	( )	( )
Program Participation	( )	( )	( )	( )
Use kitchen appliances safely	( )	( )	( )	( )
Use of leisure time	( )	( )	( )	( )
Communicate in non-threatening manner	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Access and use of medical services	( )	( )	( )	( )
Prepare or obtain meals	( )	( )	( )	( )
Obtain food	( )	( )	( )	( )
Securing / Maintaining Benefits	( )	( )	( )	( )
Manage medication regimen	( )	( )	( )	( )
Maintain personal hygiene	( )	( )	( )	( )
Smoke safely (if applicable)	( )	( )	( )	( )
Manage symptoms	( )	( )	( )	( )
Refrain from substance abuse	( )	( )	( )	( )

2. Indicate all services the applicant regularly utilizes:

Program Name	Contact	Phone

3. Indicate all support services needed once the applicant is housed:
   - Health ( )
   - Educational Program ( )
   - MICA (Dual Dx) Day Program ( )
   - MIMR ( )
   - Psychiatric Day Program ( )
   - Therapy ( )
   - Clubhouse ( )
   - Psychiatric Clinic / Psychiatrist ( )
   - Alcohol / Drug Treatment Services ( )
   - Alcoholics / Narcotics Anonymous ( )
   - Vocational Program ( )
   - On-site Case Management Services ( )
   - Probation / Parole ( )
   - Cognitive Rehab ( )
   - None ( )
   - Other: _____ ( )

Long Island Mental Health Housing Application

Applicant Name (Please Print Clearly): SS#:

Section D: Psychiatric Information

1. Current Diagnosis *(Include ALL Axis I and Axis II diagnoses and Diagnostic and Statistical Manual (DSM-IV Codes)*:

Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:		

If available, IQ test used: _____
Score: _____ Date: _____
Psychiatrist's Name: _____
Address: _____
Phone: ( )

2. Does the applicant have a history of, or is the applicant currently exhibiting any of the following?
(Fill in all items: **C** = Current, **H** = History, both **C** and **H** if appropriate, **N** = Neither or **U** = Unknown.)

	C	H	N	U
Homicidal Ideas / Attempts	( )	( )	( )	( )
Delusions	( )	( )	( )	( )
Hallucinations	( )	( )	( )	( )
Disruptive Behavior	( )	( )	( )	( )
Severe Depression	( )	( )	( )	( )
Highly Disorganized Thought Processes	( )	( )	( )	( )
Criminal Activities / Arrests	( )	( )	( )	( )
Cognitive Impairment	( )	( )	( )	( )
Aggressive / Assaultiveness	( )	( )	( )	( )
Suicidal Ideas / Attempts	( )	( )	( )	( )
Arson / Firesetting	( )	( )	( )	( )
Sexual Acting Out	( )	( )	( )	( )
Compulsive Behaviors	( )	( )	( )	( )
Inappropriate Touching	( )	( )	( )	( )
Substance / Alcohol Abuse	( )	( )	( )	( )

3. Current Psychotropic Medications:

Name	Dosage	Schedule

4. What level of support does the applicant require to achieve medication compliance?
( ) None, Independent
( ) Supervision ( ) Refuses / Non-compliant
( ) Reminders ( ) Not Applicable

5. Is the applicant currently hospitalized? ( ) Yes ( ) No
If so, date of admission: _____
Hospital name and ward: _____
Contact Person: _____
Phone: ( ) _____

6. To the degree known, list all psychiatric hospitalizations and psychiatric emergency room use:

Hospital / ER	Adm. Date	Dis. Date	Reason

Total length of time hospitalized: _____

7. Does the applicant have a history of substance abuse?
( ) Yes - Substance(s): _____

Frequency of use:
( ) Daily ( ) Less than once a week
( ) Several times / week ( ) Not Applicable
( ) Once weekly ( ) Unknown

( ) No

8. Does the applicant have a history of substance abuse treatment?
( ) Yes ( ) No

Name of Treatment Program	Date

Length of time the applicant has spent substance free:
Alcohol: since _____/_____ ( ) Not Applicable
Drugs: since _____/_____ ( ) Not Applicable

Long Island Mental Health Housing Application

Applicant Name (Please print clearly): **SS#:**

Section E: Medical Information
The disclosure of HIV-Related Information is not required, but if the applicant wishes to release it, this form must include a special consent to Release Information Form signed by the applicant. This is to be added as Page 7.

1. Medical Diagnosis: *(Include ALL Axis III Diagnoses):*

Allergies: _____

2. Current non-psychotropic medications:

Name	Dosage	Schedule

3. To the degree known, list all medical hospitalizations during the past *three* years:

Hospital	Adm. Date	Dis. Date	Chief Complaint

4. Physical Functioning Level *(Answer each of the following):*

	Yes	No
Fully Ambulatory	( )	( )
Climbs one flight of stairs	( )	( )
Bedridden	( )	( )
Wheelchair Required	( )	( )
Amputee	( )	( )
Blind	( )	( )
Deaf	( )	( )
Mute	( )	( )
Incontinent	( )	( )
Needs help with toileting	( )	( )
Can fully bathe self	( )	( )
Can feed self	( )	( )
Can dress self	( )	( )

Does the applicant have a medical condition that requires special services? ( ) Yes ( ) No

If so, indicate which services:

( ) Special medical equipment
Please Specify: _____
( ) Medical supplies
Please Specify: _____
( ) Ongoing physician support
( ) Nursing services
( ) Home Care
( ) Therapeutic diet
( ) Injectable medication
( ) Other _____

What medical services is the applicant currently receiving?

Name, address and telephone number of treating physician:

Does applicant have pets? ** ( ) Yes ( ) No
If yes, please specify: _____
** Please be aware that different programs have varying policies regarding pet ownership. In addition, pets may affect your entry into mental health housing.

Is the applicant allergic to animals? ( ) Yes ( ) No
If yes, please specify: _____

Does applicant smoke cigarettes? ( ) Yes ( ) No

Does applicant have any additional challenges or issues that may impact placement into mental health housing?

Long Island Mental Health Housing Application

Applicant Name (Please print clearly): _____ **SS#:** _____

What is the reason this referral is being made at this time?

Referring Agency: _____

Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

Facility / Agency Type: _____

Referring Worker:
I also attest that all the information contained herein is accurate to the best of my knowledge and is reflective of the applicant's current situation.

Worker Name ***(Please Print Clearly)*** _____

Title: _____

Phone: ( ) _____ Fax: ( ) _____

Please be certain the following information has been included with and in addition to this application before signing:

☐ **Signature of Applicant (Required)**
☐ **Psychosocial History**
☐ **Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)**
☐ **Recent Physical Exam (including PPD within 1 year of application date signed off by licensed physician)**
☐ **Physician's Authorization Form (Licensed programs only: Supervised and Apartment Treatment only)**
☐ **Completed Housing Preference Form**

Referral Signature: _____ Date: _____

AUTHORIZATION FOR RESTORATIVE SERVICES
OF COMMUNITY RESIDENCES

☐ Initial Authorization
☐ Semi-Annual Authorization
☐ Annual Authorization

Client's Name: _____

Client's Medicaid Number: _____

ICD.9 Diagnosis: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____ (client's name) would benefit from provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period _____ to _____ at which time there will be an evaluation for continued stay.

Month	Day	Year	Name (Please Print)	Licensure #

_____
Signature

☐ Check here if client is enrolled Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter primary care physician name and managed care provider identification number.

Physician	Managed Care Provider ID #

HOUSING PREFERENCES FORM

Applicant's Name: _____ SS#: _____

The applicant should fill out this form, with assistance if necessary. The questions are intended to clarify the applicant's housing preferences and to highlight the areas where a substantial difference between types of housing supports exist. The applicant is to specify his/her preferences today. The applicant, with assistance if necessary, may find it helpful to identify long-term housing goals and the immediate steps that may help to reach these goals. It is assumed that these preferences may change over time.

This information will be shared with the SPA Team to help identify your interests, but it does not provide a guarantee that y our preferences will be satisfied.

1. Do you have a particular town or area that you would like to live in?

   1st Preference _____

   2nd Preference _____

2. Please circle Yes or No in response to the following questions.

   Would you like assistance with learning how to:

   A. Prepare your own meals? YES NO

   B. Manage your money? YES NO

   C. Take your medication as prescribed? YES NO

   D. Have good personal hygiene skills? YES NO

   E. Travel (use buses, trains, etc.)? YES NO

   F. Keeping your personal area clean? YES NO

   G. Do your own laundry? YES NO

   H. Is there anything else you need help with? YES NO

   (If yes, please be specific)

   _____

(Please turn over)

3. In addition to your Service Plan, are your interested in:
A Community Based Alternative Treatment Program: (Clubhouse Model Program, Psychosocial Program, School or Vocational Training) _____

Employment or an Employment Readiness Program _____

Participating in the Housing Agency's Consumer Counsel _____

Other? Please specify: _____

4. Are you interested in participating in social or recreational activities sponsored by the housing agency?

YES NO

5. Do you require handicap-accessible housing?

YES NO

If yes, please be specific: _____

_____

6. What other services are you seeking? (Self-help, AA, NA, EA, Double Trouble, Social, etc.) Please be specific: _____

_____

_____

7. Is there anything else you would like the committee to know? _____

_____

_____