Lewis County Department of Community Services (LCDCS)
Single Point of Entry (SPOE) Universal Referral Form

A complete application must include:

- **The Universal Referral Form. Please answer all questions. If information is Unknown (U/K) or Not Applicable (NA) please indicate.**
- **SPOE Request for Screening/Signed Release of Information (attached)**
- **Clinical information including available psychiatric assessments, psychological evaluations, and a psychosocial summary and attached signed eligibility forms as appropriate.**

IDENTIFYING DATA	
Name:	**Current Address:**
Social Security Number:	
Date of Birth:	**EMERGENCY CONTACT:**
Telephone Number:	**Name:**
Medicaid:	**Relationship:**
Medicare:	**Address:**
Private/Other Insurance:	**Marital Status: S M W D Sep Cohabiting/Residing with SO**

Home Visit Safety:

Who else resides in the home? _____

Are there safety issues associated with the person or others in the household? Y N

Are there weapons in the home? Y N

Are there potentially dangerous animals in the home? Y N

If yes to any of the above, please explain:

AOT: Yes No If Yes: Effective Date: _____ Expiration Date: _____

AOT Contact Person: _____ Phone Number: _____

Care Coordination: What other agencies/services is the client involved in?

PSYCHIATRIC DATA:		
Diagnosis:		**Code**
Axis I:		
Axis II:		
Axis III:		
Axis V:	**GAF _____Current**	

Therapist:		**Tel:**
Psychiatrist:		**Tel:**
Medical Provider		**Tel:**

SPMI Criteria	
☐ Meets criteria	**A. Designated Mental Illness Diagnosis:** The individual is 18 years-old or older and currently meets the criteria for a DSM-V or ICD-10-CM diagnosis other than: 1) alcohol and drug disorders, 2) developmental disabilities, 3) dementia or other mental disorders due to general medical conditions, except those with predominant psychiatric features, or 4) social conditions (V Codes). DSM-V categories and codes that do not have an equivalent ICD-10-CM are not included as designated mental illness diagnoses.
☐ Meets criteria	**B. SSI or SSDI Enrollment due to Mental Illness:** Is currently enrolled in SSI or SSDI due to a designated mental illness.
	C. Extended Impairment in Functioning due to Mental Illness (*Individual must meet criteria 1 or 2*):
	The individual has experienced two or more of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:
☐ Meets criteria	**1a**) Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing health care or adhering to medical advice.)
☐ Meets criteria	**1b**) Marked restrictions in activities of daily living (maintaining a residence, using transportation, day-to-day money management, accessing community services)
☐ Meets criteria	**1c)** Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interactions with primary partner, children, other family members, friends, neighbors, social skills; compliance with social norms; appropriate use of leisure time)
☐ Meets criteria	**1d)** Frequent difficulties with concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings
☐ Meets criteria	**2)** The individual has met criteria for ratings of 50 or less on the GAF due to a designated mental illness over the past year on a continuous or intermittent basis.
☐ Meets criteria	**D) Reliance on Psychiatric Treatment, Rehabilitation, and Support**: 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 that may affect functional limitations imposed by the mental disorder. *Psychiatric rehabilitation and supports* refers to highly structured and supportive setting which may reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.
☐ Meets criteria	The individual is considered a high risk for inpatient hospitalization and/or has had multiple admissions in outpatient psychiatric programs
☐ Meets criteria	The individual has not entered into treatment in a certified mental health program and current health services are deemed ineffective as demonstrated by the likelihood of an impending admission or a history of unplanned movement our of treatment.
☐ Meets criteria	The individual has a history of excessive use of crisis services, mental health programs, or emergency rooms
☐ Meets criteria	The individual is in an inpatient facility and has been there long-term (90+ days) and is not being discharged because of an absence of needed resources in the community
☐ Meets criteria	The individual is homeless (lives on the street or in a shelter)
☐ Meets criteria	The individual has multiple disabilities, including a primary diagnosis of mental illness

	Current Medications: (Dosage and Frequency) (Psychiatric and Medical)		
	Name	Dosage	Is patient compliant?
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______
______ Psych ______ Med			Y ______ N ______

FINANCIAL INFORMATION			
FUNDING SOURCE	ELIGIBLE		AMOUNT RECEIVING
Social Security:	YES	NO	
SSI			
Disability:			
Survivors:			
Retirement:			
Disabled Child:			
Public Assistance/DSS Benefits FUNDING Source	 YES	 NO	DSS Caseworker_____ Phone: AMOUNT RECEIVING
Veteran's Benefits			
Payee Status	Own Payee __	Representative Payee __	Name: Address: Phone:
Employed			Where?:

SOCIAL DATA	
Education Level:	VESID INVOLVEMENT: yes___ no___
Employment/Training History:	
Current Day/Social Programs:	
Any previous Supervised Living(date/location):	
Describe any previous living environment the individual cannot return to along with specific Problems or reasons:	
Interests and Hobbies:	

SPECIFIC PROBLEMS	Yes	No	COMMENTS
Resistant to Tx. and/or medications			
Multiple Psychiatric Hospitalizations			When/Where/Frequency?
Long Term Psychiatric Hospitalization (over 1 year)			When/Where/Length of Stay?
MICA			
Alcohol Abuse			
Drug Abuse			
Substance Abuse Treatment			When/Where?
History of Suicidal Ideation			Specify:
History of Suicide Attempts			Specify:
History of Homicidal Ideation			Specify:
Self-Injurious Behaviors			Specify:
History of Violence			Specify:
Criminal History			
Is client currently on Probation or Parole?			Current officer name and phone #
History of Homelessness			Specify:
Frequent Crisis Contacts(crisis calls, ER visits, police contact etc.)			Specify:
History of Assaultive Behaviors			Specify:

History of Sexually Assaultive Behaviors			Specify:
History of Trauma			Specify:
Co-occurring Disabilities (TBI, Developmental, Physical Impairment, etc.)			Specify:

Case management Service Areas	**Service Needs**
☐ **Advocacy** the process of interceding on behalf of the individual to gain access to needed services and supports.	
☐ **Coordination of Treatment**	
☐ **Linking** the process of referring the individual to all required services and supports as specified in the individual service plan	
☐ **Monitoring** the process of observing the individual to assure that all needed supports and services are received	

OTHER COMMENTS (Please add any additional information that you feel would assist us in making an appropriate deter services.

Referring Agency Information

Date: _____

Referring Agency/Unit: _____

Primary Contact: _____

Telephone#: _____

Form completed by: _____ Signature: _____

Relationship to client: _____

Lewis County Single Point of Entry (SPOE)
Request for Screening AND Release of Information

Name of Individual: _____ Date of Birth _____

I am requesting that my referral packet be submitted to the Lewis County SPOE Committee to determine eligibility for services. I understand that the screening committee includes representatives from the following community organizations/agencies:

Lewis County Community Services
Lewis County Department of Social Services
Lewis County Probation Services
North Country Transitional Living Services
Behavioral Health and Wellness Center
Lewis County ARC
Planned Parent Hood of the North Country
ACR Health
St. Lawrence Psychiatric Center/MIT Team
Sunmount DDSO
Northern Regional Center for Independent Living
Mountain View Prevention
Lewis County General Hospital,
CNY DSO
St. Joseph's Hospital
Carthage Behavioral Health
Credo Community Center for the Treatment of Addictions

I understand I can participate if I choose to do so.

I understand the referral packet will be checked for completeness and someone from the committee may need to contact me or the referral source for further clarification or to request additional information.

I understand that this screening is necessary to determine eligibility for community services but it does not constitute acceptance into a program. I authorize the disclosure of my referral and all related supporting documents to members of the SPOE Committee so that they can share information regarding my referral in order to determine eligibility for services. I understand that I can withdraw this request at any time.

Consent to Release Information

Signature: _____ Date: _____

Name (print): _____

Witness Signature: _____ Date: _____

Witness Name (print): _____

This authorization will expire 1 Year from the date signed.

Withdrawal of Request

I voluntarily withdraw the request for an initial screening of my eligibility for these services. I understand that this withdrawal does not jeopardize my current treatment or any future requests for screening. All information forwarded for review will continue to be maintained in a confidential manner.

Signature _____ Date: _____

Name (print) _____

Witness Signature _____ Date: _____

Witness (print) Name _____

DEV. 12/15