

Department of Mental Health  
 50 Sanatorium Rd, Bldg F  
 Pomona, NY 10970  
 Phone: 845-364-2391 Fax: 845-364-2381  
**Susan L. Hoerter, D.O.**  
 Acting Commissioner

Services Requested	
<input type="checkbox"/> ACT	<input type="checkbox"/> Non-Medicaid ACT
<input type="checkbox"/> Care Management	<input type="checkbox"/> Non-Medicaid CM
<input type="checkbox"/> AOT CM	<input type="checkbox"/> AOT Non-MA CM
<input type="checkbox"/> Community Residence	
<input type="checkbox"/> Treatment Apartment	
<input type="checkbox"/> Supportive Housing	

### Adult Single Point of Access Application (A-SPOA)

Client Information				
Name:	Gender:	DOB:	SSN:	
Home Address:	City:	State:	Zip:	Phone:
Medicaid # required:	SSD Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount:			
Medicare # (if applicable):	SSI Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount:			
DSS Temporary Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the applicant their own payee? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Diagnoses- ICD10 – Primary diagnosis listed first				
<i>Primary Diagnosis</i>	<i>ICD. 10 Diagnosis</i>	<i>Medication &amp; Dose</i>		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		

#### Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults

To be considered an adult with severe and persistent mental illness, **A** must be met. In addition, **B** or **C** or **D** must be met.

**A. Designated Mental Illness Diagnosis**  
 Yes  No The individual is 18 years of age or older and has a primary DSM psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes, or developmental disabilities.  
 AND

**B. SSI or SSDI Enrollment due to Mental Illness**  
 Yes  No 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**  
 1. The individual has experienced two of the following four functional limitations due to a designated illness over the past 12 months on a continuous or intermittent basis.  
 Yes  No a. Marked difficulties in self-care  
 Yes  No b. Marked restriction 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 or school settings.  
 2.  Yes  No The individual has met criteria for rating of 50 or less on the Global Assessment of Functioning Scale.  
 OR

**D. Reliance on Psychiatric Treatment, Rehabilitation and Supports**  
 Yes  No 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 or 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 underlying mental disorder.

<b>Psychiatric Hospitalizations and/or Rehab Stays</b>		
Hospital/Rehab Name:	Dates:	Reason for Admission:
<b>Living Situations tried in the past 5 years (check all that apply)</b>		
<input type="checkbox"/> Independent Living	<input type="checkbox"/> Jail	
<input type="checkbox"/> Family	<input type="checkbox"/> Private Psychiatric Inpatient	
<input type="checkbox"/> Community Residence	<input type="checkbox"/> General Hospital Psychiatric Inpatient	
<input type="checkbox"/> Apartment Program	<input type="checkbox"/> State Psychiatric Inpatient	
<input type="checkbox"/> Shelter/Emergency Housing	<input type="checkbox"/> Other (specify): _____	
<b>Assisted Outpatient Treatment</b>		
Does the recipient have court ordered AOT under Kendra's Law?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is an AOT under Kendra's Law currently being pursued?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Psychosocial Additional Questions</b>		
<i>If yes to any of the following questions, please describe events in attached psychosocial history.</i>		
Has the recipient ever been suspected of sexual abuse to a child and/or adult? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the recipient ever physically abused and/or assaulted a child and/or adult? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the recipient ever engaged in arson? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the recipient ever been a victim of physical or sexual abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sex offender status? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes: <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III		
<b>Significant other/Emergency Contact</b>		
Name:	Relationship:	Address:
		Phone:
<b>Medical Information</b>		
Current Medical Conditions/Medical Alerts:		
Is the applicant responsible for taking their own medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If not, explain in attached psychosocial history.</i>		
<b>Please describe why the applicant requires this level of support service. Include service needs, any barriers to meeting those needs, the applicant's strengths and any informal support systems. (Add a page if necessary.)</b>		
Name of Person referring Applicant to SPOA:		Agency:
Signature of Person Referring Applicant to SPOA:	Title:	Date:

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

The following is a brief description of what I would find most helpful for myself:

### CHECKLIST

**This referral will not be processed without the following items attached and all sections of referral completed:**

- Current psychosocial history (within 90 days of signing Consent for Release of Information)
- Current psychiatric assessment (within 90 days of signing Consent for Release of Information)
- Completed and signed SPOA Consent for Release of Information (Page 4.)

**Additional information required at intake if found eligible for residential services:**

- Copy of Medicaid/Medicare Card
- Copy of Social Security Card
- Current physical or date of scheduled physical: \_\_\_\_\_
- Current tuberculosis test results (PPD/QuantiFERON/Chest X-Ray)
- Physician's Authorization for Restorative Services (*to be provided upon request*).

#### **Mail completed referral to:**

ADULT SPOA  
Rockland County Dept. of Mental Health  
50 Sanatorium Road  
Bldg. F  
Pomona, NY 10970

**OR**

#### **Fax or Email completed referral to:**

Eva Hernández, SPOA Chair: 845-364-2381  
[hernande@co.rockland.ny.us](mailto:hernande@co.rockland.ny.us)

**For any questions or assistance please contact the A-SPOA Coordinator, Eva Hernández at:  
Phone: 845-364-2391**

