RENSSELAER COUNTY
MENTAL HYGIENE SERVICES APPLICATION

Application forwarded to: *(check all that apply)*
Care Coordination__ Residential (Level?)__ Y/A or MICA CC (UH) __ AOT Status:____

Client Name:_____ **Date of Application:**_____
DOB: _____ **Referral Source:** _____
Address: _____ **Primary Clinician:**_____
_____ **Psychiatrist:**_____
Current Living Situation: _____ **Treatment Agency**_____
Phone: _____ **Phone:** _____
County of Origin:_____ **Emergency Contact:**_____
Parental Status/ages of kids:_____ **Phone #:**_____
Medicaid #:_____ **SSN:**_____

DSM V Diagnostic Information: *(Include numerical codes)*

_____

_____

_____

Medical Information:

Medication	Amount

Medical Conditions: _____
_____
Medical Provider Name/#:_____

Allergies:_____

Alerts:

List any factors including danger to self/others, legal involvement, assaultive behavior, AOT, arson, suicide attempts/gestures:
History of substance use/abuse:

RENSSELAER COUNTY APPLICATION

Psychiatric History
Brief History of Illness:_____
_____
_____

Length of current hospitalization:_____ Number of ER contacts (*past year):*_____

Reason for Applying to Program: (*include strengths, needs, and goals; specify per service)*
1._____
2._____
3._____

Many programs require group living and group participation. Please comment on this individual's ability to tolerate such an environment:_____
_____

Other service providers/agencies involved:
____Care Coordination ____Tx Program ____Voc/Educational ____Residential

Consumer Comments and Goals:

I plan to participate in my own recovery.	Yes	No
I agree with the recommendations indicated in this application.	Yes	No
I have read and signed the Authorization to Use and Disclose Protected Health information.	Yes	No
I understand the SPOA process.	Yes	No
I would like more information about peer support services (MHEP).	Yes	No

The main goal I want to work on is:_____

_____

Other comments or concerns:_____

_____

Consumer Signature:_____ Date:_____

Referent Signature:_____ Date:_____

Attachments required with this application:
_____Hospitalization Record
_____Physician's Authorization
_____SPMI Determination
_____Financial Information
_____Current Psychosocial/MSE

Rensselaer County Mental Hygiene Services Application SPMI Determination

To meet the criteria for Severe and Persistent Mental Illness, the following conditions of A and B, or C or D need to be met.

A. **Designated Mental Illness Diagnosis:**
The individual is 18 years or older and currently meets the criteria for a DSM V psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions. ICD-10-CM categories and codes that do not have an equivalent in the DSM V are also not included as designated mental illness diagnoses.

AND

B. SSI or SSD enrollment due to mental illness:
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 at least 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 functioning: (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, or 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).

OR

D. **Reliance on Psychiatric treatment, rehabilitation, and supports**
A documented history shows that the individual, at some prior time, met the threshold for item C (extended impairment), but the symptoms and/or functioning problems are currently attenuated by medications or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder (i.e. 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.

The following criteria is met: ___A AND ___B OR ___C OR ___D

Consumer Name:_____

Clinical signature _____date_____

Consumer Name_____

Hospital	Admit date	Discharge date	Total days	Comments (Psych, medical, rehab/detox)

FINANCIAL INFORMATION

Complete information is necessary to establish and maintain a source of funding and to assist in the screening process.

INCOME (check all that apply)

	Amount
____SSI	_____
____Social Security Disability (SSD)	_____
____Public Assistance	_____
____Wages	_____
____Workers Compensation	_____
____Unemployment Insurance	_____
____Food Stamps	_____

____Medicaid #_____

____Medicare #_____

____Applications pending for above: (Specify) _____

____Other Income: (Specify) _____

Is the applicant his/her own payee? _____Yes _____No

If no, indicate representative payee: _____

RESOURCES (Check all that apply)

	Value
____Checking account	_____
____Savings account	_____
____Patient Account	_____
____Car	_____
____Life Insurance	_____
____Stocks/Bonds	_____
____Property	_____

____Other Resources (Specify) _____

IDENTIFICATION (check all that applicant has)

____Birth Certificate ____Social Security Card

____Drivers License # _____ Exp Date _____

____Passport ____Sheriff's ID #_____

____Other (specify) _____

LIST OUTSTANDING DEBTS:	Amount Owed
_____	_____
_____	_____

Dear Dr. _____:

According to the Office of Mental Health and Medicaid regulations, individuals accepted into a Congregate Care Setting must have an initial Physician Authorization form completed and signed by a Physician prior to entry into a residential program. Per Medicaid Regulations 593.61, the Initial Authorization for Medicaid Restorative services must be based on clinical information and a face to face assessment.

The regulations also require that a resident's most recent quarterly review of the service plan be submitted to the physician for review, and re-authorization be obtained every six months for individuals living in community residence settings, and yearly for individuals living in treatment apartment programs.

Below you will find a Physician Authorization Form for our resident and attached a copy of the most recent service plan review - if this is not an initial authorization request. We ask that you please review the enclosed service plan review*(for the period _____ to _____), and complete and sign the Physician Authorization Form.

Please contact the Program Director at _____-_____ to request any additional documentation necessary to determine the need for provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR. Your timely attention to this matter will allow us to comply with the current Office of Mental Health and Medicaid regulations. Thank you for your time.

Sincerely,

Program Director Name (Please Print):	**Program Director's Signature:**
Program:	**Date:**

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

	Initial Authorization (Admission)
	Semi-Annual Authorization(Community Residence)
	Annual Authorization (Transitional Apartment Services)

Consumer Name:	**Primary Diagnosis:**
Consumer Medicaid Number:	**DSM V Code/ICD-10 Code:**

I, the undersigned physician, based on my review of the service plan review attached*, have determined that

_____

would benefit from the 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.

Physician's Name (Please Print):	**Physician's Signature:**
Physician's NY State Licensure #:	**Date:**