ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH

"Serving people with Mental Illness, Chemical Dependency, and Developmental Disabilities"

Lacey Trimble, LCSW
Commissioner

Leah Roth, LCSW
Deputy Commissioner

Steven M. Neuhaus
County Executive

30 Harriman Drive, Goshen, New York 10924
Tel: (845) 291-2600 | Fax: (845) 360-9058
www.orangecountygov.com

Please review the following instructions before sending the SPOA Application:

We scan all documents, please do not staple or paperclip and we accept single sided copies only.

Email, Mail or Fax to:

SPOA Unit – Adult Mental Health Services
Orange County Department of Mental Health
30 Harriman Drive, Goshen, NY 10924
SPOA Fax (845) 360-9074
AdultSPOA@orangecountygov.com

REQUIRED DOCUMENTATION:

				HOUSING	
REQUIRED DOCUMENTS	ACT	CARE MANAGEMENT	CR	TX APT	SH
Eligibility Determination	X	X	X	X	X
Completed Application	X	X	X	X	X
Bio Psychosocial (Including ICD-10 diagnosis within 1 year	X	X	X	X	X
Physician's Authorization			X	X	

ACT = Assertive Community Treatment
CR = Community Residence
TX Apt = Licensed Treatment Apartment
SH = Supportive Housing

CHECKLIST

SPOA Applicants Name (First, MI, Last): _____

SPOA ELIGIBLITY DETERMINATION

In order to be eligible for services through OCDMH, applicants for Housing, Care Management or ACT Services must be diagnosed with serious and persistent mental illness (definition of SPMI)
Please complete the checklist below to determine if the applicant is eligible for services. **A** must be met. In addition, **B**, **C**, or **D** must be met:

Yes ☐ No ☐ **A.** The individual is 18 years of age or older and currently meets the criteria for a primary **ICD-10-CM** diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorder due to general medical conditions, except those with predominantly psychiatric features, or social conditions.

Please complete: Primary **ICD-10-CM** code:

Yes ☐ No ☐ **B.** SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI **DUE TO A DESIGNATED MENTAL ILLNESS**.

Yes ☐ No ☐ **C.** Extend Impairment in Functioning due to Mental Illness.

Yes ☐ No ☐ 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.* (Documentation in psychosocial assessment required.)

Yes ☐ No ☐ **a. Marked difficulties in self-care.**

Yes ☐ No ☐ **b. Marked restrictions 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 setting.**

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form).

Yes ☐ No ☐ One six months stay in an inpatient psychiatric unit.

Yes ☐ No ☐ Two stays of any length in an inpatient psychiatric unit in the preceding two years.

Yes ☐ No ☐ Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH.

Yes ☐ No ☐ Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.

Yes ☐ No ☐ Six months consecutive residency in a designated Adult Home.

Yes ☐ No ☐ Six months consecutive residency in a Residential Care Center for Adults (RCCA).

Yes ☐ No ☐ Six months consecutive residency in a Residential Treatment Facility (RFT).

APPLICANT INFORMATION

Name: First Middle Last Medicaid # (please include a copy of Medicaid Card)

Social Security # **Date of Birth:**

Address: **Apt. #:**

City: **State:** **Zip:** **Email:**

Telephone: **Gender:** **Citizenship: Yes** **No** **(if no, immigration status):**

Ethnicity: **Primary Language:**

Military Status: N/A **Active** **Veteran** **Other:**

If you have military services include a copy of your DD214 with this application

Custody Status of Children

- No Children
- Children are all above 18 years of age
- Minor Children currently in client's custody
  - Number of children: Gender:
- Minor children not in client's custody but have access
- Minor children not in client's custody – no access

Current Living Situation

- Room
- Own Apt./Home
- Supervised Living
- Supported Housing
- Lives with Family
- Correctional Facility
- Homeless (shelter)
- Homeless (streets):
- Nursing Home
- Psychiatric Hospital
- Lives with Others
- Other:

Insurance and Financial Information: Currently Receives

- Social Security
- SSI/SDI
- Public Assistance
- Medicaid
- Medicare
- Earned Income/Wages
- SNAP
- VA Benefits
- Representative Payee: Name:
- Other:

Referral Source Contact:

Person: **Phone:** **Fax:**

Agency: **Email:**

Full Mailing Address:

Program: **Relationship:**

FAMILY AND SIGNIFICANT RELATIONSHIP INFORMATION:

Next of Kin/Legal Guardian/Significant Other:

Address:

Relationship: **Phone:** **Email:**

Is the applicant's family involved? Yes No

Describe the quality of relationships (include emotional and health factors of family when applicable):

Permission to Contact? **Yes** **No**

APPLICATION CONTINUED…

SPOA Applicants Name (First MI Last):

Psychiatric Information: ***"see attached" is not acceptable***

Please list Diagnosis:

Current Medical Conditions:

DLA-20 Score:
(please include a copy of the most recent DLA-20)

Current Medications: Please list

APPLICATION CONTINUED…

SPOA Applicants Name (First MI Last):

Mental Health or any Outpatient Treatment Provider:

Agency: **Program:**

Contact: **Telephone:**

Substance Abuse History: Please List Drugs of Choice

Length of time recipient has been substance free:

Criminal Justice – Current Status:

☐ **None** ☐ **Incarcerated-Jail** ☐ **Incarcerated-Prison** ☐ **CPL 330.20 / 730**

☐ **Probation** ☐ **Parole** ☐ **Other:**

Probation Officers Name: **Telephone:**

Number of arrests/incarcerations in the past year: **Number of lifetime arrests:**

Reason for Arrest: **Date:**

Risk Assessment: (Check all that apply)

☐ **Cruelty to Animals** ☐ **Suicidal Behavior**

☐ **Fire Setting** ☐ **Severe Violence**

☐ **Homicidal Behavior** ☐ **Sexual Offense**

Assisted Outpatient Treatment (AOT)

Does the person have court ordered AOT under Kendra's law or Enhanced AOT? ☐ Yes ☐ No

Is an AOT under Kendra's law currently being pursued? ☐ Yes ☐ No

Care Management Services Requested

☐ **Peer Support:** services are aimed at helping people with disabilities, including those at continuing risk of homelessness, to overcome stigma, connect with needed supports, build constructive relationships with peers, advocate on their own behalf, define and pursue their personal journeys to wellness, and make the transition form system dependence to independence.

☐ **Care Management:** applicant is assisted with linkage to a community-based system of care. Coordinates service with the applicant, family, treatment provider and assists with negotiating various service systems. Develops an individualized community service plan and facilitates implementation, monitors services received, documents activities and initiates periodic reviews. CM services are available through Sunriver, HONOR & HVCS, ASFL, MHA, RSS, RPC, Hamaspik Choice, Astor Services, People USA, and Cornerstone Family Healthcare.

☐ **Transitional Care Coordination (ages 16-25):** is a collaborative process of working with young adults who have mental health challenges and are seeking independence, Our Care Coordinators, who are trained as NYS certified Peer Specialist and Youth Peer advocates, help the young adult plan for their transition into adulthood by connecting them to their community.

☐ **Invisible Children's Project (ICP) Care Manager:** is a program of MHA was developed to address the needs of, and gap in services for parents with mental illness and their children through Family Case Management. ICP services are family-centered, strength-based and comprehensive.

☐ **ACT Team:** Assertive Community Treatment is an evidenced-based practice that offers treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals to have been diagnosed with serious mental illness (SMI). ACT services include assertive outreach, mental health treatment, vocational support, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support. Services are provided to individuals by a mobile, multi-disciplinary team in community settings. The The goal of Assertive Community Treatment services is to assist individuals to achieve their personal meaningful goals and life roles.

If requesting ACT Team, please enter name of current Care Management Agency:

APPLICATION CONTINUED…

SPOA Applicants Name (First MI Last): _____

Residential Services Requested: (Please check one (1) based on applicants current level of need)

☐ **Family Care:** Licensed private homes, located throughout Orange and Sullivan Counties, with a maximum capacity to care for six residents who have a psychiatric diagnosis. Servies provided in this clean and home-like environment are medication monitoring, financial monitoring, provisions of three meals and daily snacks, and ensuring that all medical appointments are made and kept. The care providers also make sure that ther is access to social, family, and community resources. APPLICANT MUST BE RECEIVING SSDI OR SSI PRIOR TO PLACEMENT OR PRIVATE PAY.

☐ **Supervised Community Residence LEVEL 1 (24 HOUR SUPPORT/SUPERVISION):** These residences provide 24-hour supervision. Residents develop goal plans based on principles of Psychiatric Rehabilitation. Skill training is provided in areas including medication management, daily living skills, assertiveness, skill development, and community integration. Other areas are addressed depending on the needs of each individual. The program is highly structured, with an emphasis on movement towards and increased level of independent living. Locations include Monroe, Washingtonville, Middletown and Bloomingburg. Physicians Authorization form required.

☐ **Licensed Treatment Apartment Programs LEVEL 2 (MODERATE SUPERVISION):** These apartments are located throughout Orange County. Both individual and shared (roommate) placements are available. Staff visit recipients to provide supervision with apartment maintenance, socialization, interpersonal relations, and general daily living skills. Emphasis at this level of housing is on maintaining a high level of functioning in daily living, medication compliance, emotional stability, and possible movement toward more independence. Physicians Authorization form required.

☐ Individual ☐ Shared

☐ Please check here if you are a Young Adult (18-25)

☐ **Supportive Housing LEVEL 3 (Independent):** Support services are provided to applicants capable of living independently. An applicant must be willing and able to take their medications as prescribed, maintain clinical involvement, pay the bills necessary to maintain an apartment, and possess the daily living skills essential to living independently in the community. Applicants are assisted in securing permanent housing and, through donations and/or limited funding, in obtaining initial furnishings and basis start-up supplies for an apartment. Each applicant will apply for a Section 8 Certificate, and interim rent stipends will be provided until the Section 8 application is approved. The program works to ensure that residents pay no more than 30% of their total household income for rent. For HUD funded housing programs, applicants must be homeless, and on the coordinated entry list. (for coordinated entry information contact: 845-343-7115 ext. 314)

☐ Homeless Family with Children under 18 apply through Coordinated Entry

☐ Please check here if you are a Young Adult (18-25)

Geographical Preference/Community: _____

Recipient Requests:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA AND 42 C.F.R. PART 2

Client Name:		Date of Birth:		Social Security Number:	
Client Address:					

Orange County Single Point of Access (SPOA) is committed to facilitating appropriate referrals for residential and/or care coordination services, determining eligibility for such services, and assessing appropriateness of applicant for the various programs available through SPOA. By signing this form, you agree to the sharing of information by and between the entities listed in items 7, which are not able to share information without your authorization. You may limit the amount of time this authorization is effective or cancel this authorization at any time. You are entitled to receive a completed copy of this authorization.

Having read the above paragraph, I, or my authorized representative, by signing, request that health information regarding my care and treatment be released between and among the applicable entities as set forth on this form. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal law prohibits disclosure or redisclosure of my information unless such disclosure or redisclosure is expressly permitted by my written consent or otherwise provided for by applicable regulations.

I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT (as permitted by 42 CFR Part 2), MENTAL HEALTH TREATMENT (except psychotherapy notes), and CONFIDENTIAL HIV[1] RELATED INFORMATION. If applicable, this information will only be disclosed among the entities listed if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to and from any of the entities set forth in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to any of the entities listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure, however, I acknowledge that cross system collaboration is the best practice for my care.
5. Information disclosed under this authorization may be shared among all entities listed below to the degree necessary to fulfill the reason for release of information (item 9).
6. This authorization authorizes the entities listed in Item 7 to discuss my health information or medical care only with the other entities listed in item 7.

7. Entities authorized to release this information:

Orange County Dept. of Mental Health	Crystal Run Health Care	Hudson Valley Community Services	RECAP
Orange County Dept. of Social Services	Crystal Run Village, Inc.	Independent Living, Inc.	Rehabilitation Support Services, Inc.
Access Supports for Living, Inc.	Evercare	Mental Health Association in Orange County, Inc.	Rockland Psychiatric Center
Action Towards Independence, Inc.	Garnet Health Counseling Services	Montefiore St. Luke's Cornwall Hospital	Safe Homes of Orange County/ Fearless
Astor Services	Garnet Health Medical Center - Orange	NAMI/AMICO	Skyward Health
Bon Secours Community Hospital	Garnet Health Medical Center - Catskill	Orange County Correctional Facility	Sun River Health
Catholic Charities of Orange, Ulster & Sullivan	Hamaspik Choice	People USA	YesCare, Corp.
Community Home Health Care	HONORehg.	Preferred Home Care	
Cornerstone Family Health Center	Hudson Valley Care Coalition	Project Life	

8. Specific information to be released:

☐ Medical Record, include: psychiatric assessment/core evaluation, including current clinical updates, psychosocial assessment/core history, hospital admission and discharge plan if appropriate, physical examination and TB test results, if appropriate, Over-the-Counter PRN Medication Form, Physician's Authorization

☐ Other _____

_____

(Indicate approval by Initialing) _____

Include: **(Indicate by Initialing)**

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

_____ Primary Care Provider

9. Reason for release of information: SPOA Determination and Coordination

10. Expiration: Authorization will expire when SPOA determination is complete, client is no longer on the SPOA waitlist, and client is no longer receiving services/supports coordinated through SPOA.

11. If not the client, name of person signing form:

12. Authority to sign on behalf of client (see instructions):

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____ _____ _____

Signature of client or representative authorized by law | Date | Signature of Witness | Date

State of New York

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

NOTE: This form must be attached to all disclosures/releases of information concerning substance abuse patients.

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING SUBSTANCE ABUSE PATIENT

(To accompany disclosure of information made with consent of substance abuse patient)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

TRS-1 (5/03)

Footnotes: 1 Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

2 Item 5 does not compel an entity to release all information. Program must review applicable laws and regulations and determine the appropriate information to release based on the content of the release and the applicable laws and regulations as they apply to each specific entity. Release of information should be limited to what is necessary to fulfill the intent of the consent. Entities listed in item 7 may choose to release different information to each entity listed in item 8 in order to comply with the laws and regulations while still meeting the individual's needs. Redisclosure is not permitted without specific written consent.

Instructions:

Must include name and date of birth or Social Security number.

8. Specific Information to be released

Individual must initial next to each line to indicate the type of information that may be released.

11. If not the client, name of person signing the form. 12 Authority to sign on behalf of client.

The individual named in item11 must have the legal authority to sign the authorization for release of health information. That legal authority must be indicated in number 12. Proof of this legal authority must accompany this release when requesting documentation (i.e. power of attorney, parent, legal guardian, etc.). Each entity must follow the laws and regulations as they pertain to them and therefore legal authority that is sufficient for one entity may not be for another which may limit the ability to share information. If the client is a minor both the parent or legal guardian and client must sign the form for OASAS licensed programs.

PSYCHES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_____	_____	_____
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
_____	_____	
Signature of Patient or Patient's Legal Representative	Date	
_____	_____	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
_____	_____	
Signature of Witness	Print Name of Witness	

Details about patient information in PSYCKES and the consent process:

1. How Your Information Can be Used. Your electronic health information can only be used by your treatment provider to:

- Provide you with medical treatment, care coordination, and related services
- Evaluate and improve the quality of medical care provided to all patients
- Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. What Types of Information About You Are Included? If you give consent, Orange County Dept. of Mental Health can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3. Where Health Information About You in PSYCKES Comes From. If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see “About PSYCKES” or ask your treatment provider to print the list for you.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: Orange County Department of Mental Heatlh's doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for the SPOA Coordinator and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Orange County Dept. of Mental Health at 845-291-2626 or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by Orange County Dept. of Mental Health; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. Effective Period. This Consent Form will remain in effect until 3 years after the last date you received any services from Orange County Department of Mental Health or until the day you withdraw your consent, whichever comes first.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Orange County Dept. of Mental Health. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling Orange County Dept. of Mental Health at 845-291-2626. Note: Organizations that access your health information through Orange County Dept. of Mental Health while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. Copy of Form. You are entitled to receive a copy of this Consent Form after you sign it.

ORANGE COUNTY RESIDENTIAL REFERRAL APPLICATION
PHYSICIAN'S AUTHORIZATION FOR COMMUNITY SERVICES

A. Type of Authorization: ☐ Initial Authorization

☐ Re-Authorization

B. Applicants Name: _____

C. Applicants Medicaid Number: _____

I, the undersigned licensed physician/practitioner, based on either:

a) **INITIAL AUTHORIZATION:** Must be signed by a physician ONLY and based upon clinical information and a face to face assessment of the individual.

OR

b) **RE-AUTHORIZATION:** Must be signed by a Physician, Physician Assistant or Nurse Practitioner in Psychiatry.

D. have determined that _____ would benefit from the provision
(applicant's name)
of community rehabilitation services as known to me and defined pursuant to 14 NYCRR Part 593.

E. This determination is in effect for the period _____ to _____, at which time there will be an evaluation of continued stay.

F. ICD.10 Primary Mental Health Diagnosis Code F☐☐.☐☐
ICD.10 Diagnosis _____

Name of Practitioner (Please Print): _____

☐ Physician ☐ Physician Asst. ☐ Nurse Practitioner in Psychiatry Practitioner's License# _____

G. Signature of Practitioner _____ Date _____ Practitioner's NPI # _____

INSTRUCTIONS:

Initial Authorization: Must be a Face to Face visit with a PHYSICIAN: Residents, PA's or NPP's cannot sign for the physician. Complete sections F and G.

Re-Authorization: PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTIONER IN PSYCHIATRY Complete sections F and G

DISABILITY VERIFICATION FOR HUD ELIGIBILITY

(MUST BE HOMELESS)

Applicant's NAME: _____

I, the undersigned licensed professional, based on my review of the assessments made available to me, have determined that _____
(applicant's name)
meeting criteria for the primary diagnois of _____
and that this disability is expected to be long-continuing and of indefinte duration, and substantially impedes his/her ability to live independently. This disability could be improved by the provision of more suitable housing conditions.

_____ Mo/Day/Yr

_____ Signature & Licensure#

_____ Print Name