ERIE COUNTY LICENSED HOUSING APPLICATION COVER SHEET

Applicant's Name: **Date Completed:**

Check the type of housing the consumer is interested in. See page 2 for housing descriptions.

□ Supervised CR (SCR & SOCR)	□ Supervised SR CR (SSCR)	□ Treatment/Supervised Apt. (TSA)
□ Young Adult Housing (YAH)	□ Residential Care Center (RCCA)	□ Family Care (FC)
□ Adult Home (AH)	□ Single Room Occupancy (SRO)	□ MICA Housing (MICA)

Supported Housing Applicants must complete a separate application and submit directly to the Erie Housing Coordinator. *All referrals must include: authorization for rehab services of community residences signed by physician and also an authorization for release of information signed by the client.*

Please check each housing provider applied to

□ Buffalo Federation of Neighborhood Centers 421 Monroe St Buffalo, NY 14212 Phone: 852-5065 Fax: 852-6270 **SCR - TSA**	□ DePaul Community Service 2240 Old Union Road Cheektowaga, NY 14227 Phone: 608-1000 Fax: 608-0131 **SCR - TSA**	□ Southern Tier Environments for Living, Inc. 715 Central Ave. Dunkirk, NY 14048 Phone: 366-3200 Fax: 366-7840 **SCR – TSA – SRO - SSCR**
□ Transitional Services, Inc. 389 Elmwood Ave. Buffalo, NY 14222 Phone: 874-8190 Fax: 874-4429 **SCR – SSCR – TSA – YAH – MICA - AHS**	□ Greenwood Residence, Inc. 660 Mineral Springs Rd. West Seneca, NY 14224 Phone: 827-4060 Fax: 827-4063 **SSCR**	□ Ransomville Residence 3509 Ransomville Rd. Ransomville, NY 14131 **AH**
□McKinley/Kensington/Seneca Square **Forward Referrals to:** DePaul Community Service 2240 Old Union Road Cheektowaga, NY 14227 Phone: 608-1000 Fax: 608-0131 **SRO**	□ CMI – Choices 1570 Buffalo Ave. Niagara Falls, NY 14303 Phone: 285-3425 Fax: 085-5908 **SCR - TSA**	

All BPC referrals should be emailed to Nancy Johnson at Nancy.Johnson@omh.ny.gov, or faxed to 816-2547. Please include first 3 months of progress notes.

Please check each housing provider applied to

□ Cudmore Heights RCCA 400 Forest Ave., Buffalo, Ny 14213 Phone: 816-2392 **RCCA**	□ Grant Street Residence 6565 Grant Street Buffalo, NY 14213 Phone: 883-9334 **SCR**	□ BPC – Family Care 400 Forest Ave. Buffalo, NY 14213 Phone: 816-2951 **FC**
□ Olmsted SOCR 3 Rees St. Buffalo, NY 14213 Phone: 884-3445 **SCR**	□ Strozzi SOCR (*For BPC inpatients only with a LOS greater than 1 year)* Strozzi Building – Third Floor 400 Forest Ave. Buffalo, NY 14213 Phone: 816-2959 **SCR**	□ Waterfront SOCR 2 Duquesne Celeron, NY 14720 Phone: 664-4313 **MICA**

***Self-Referrals welcomed* –** contact The Mental Health Peer Connection if you need assistance (716) 836-0822

Admission decisions are determined within 30 days of receiving a **complete** referral package. In accordance with federal, state, and municipal fair housing laws no person shall be denied housing because of his/her race, color, religion, national origin, sex, marital status, age, disability, familial status, sexual orientation, or income.

Revised February, 2011

Descriptions of Licensed Housing Programs

LICENSED HOUSING

Supervised Community Residences - SCR & SOCR are congregate care facilities (group homes) which house 10 to 24 residents 18 years of age or older. These Programs are considered transitional and rehabilitative in nature, as the resident's goal is to move to a less restrictive living environment within 24 months. Bedrooms are often shared but some programs have single bedrooms. Residents participate in the upkeep of the house which includes meal planning and preparation. Recreation activities are provided. Some group homes include an attached training apartment (TSI) for residents ready to test independent living skills. Staff is on site 24/7. SCR services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, Transitional Services, Inc., CMI and the Olmsted (SOCR)* and Grant Street Residences (SOCR).
*State Operated Community Residence (BPC)

Supervised Senior Community Residences - SSCR operate the same as Supervised Community Residences but are for consumers who are 55 years of age or older. Residences are encouraged to identify independent living goals but there is less emphasis placed on moving to an apartment. SSCR are provided by Greenwood Residences (all single bedrooms), Southern Tier Living Environments and Transitional Services, Inc.

Treatment/Supervised Apartments - TSA provides transitional housing in shared one, two and three bedroom apartments in the community. The apartments are either located at a single site which has staff on site 24/7 or scattered site apartments which staff visit from 3 to 7 days each week and are on call for emergencies 24/7. Staff provide services designed to assist residents obtain or refine skills necessary for independent living. Cash allowances for groceries and clothing are provided by some programs. Residents are expected to develop individual goals which focus on living more independently. The typical length of stay is 18 to 24 months. TSA housing services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, CMI and Transitional Services, Inc.

MICA Housing - MICA are Group Home and Treatment Apartment Programs capable of providing specialized staffing and services for consumers who are diagnosed with an addictions disorder as well as a psychiatric disability. MICA Group Homes are operated by Transitional Services, Inc. and the Waterfront Residence (BPC). Transitional Services, Inc. also operates a 10 bed supervised apartment program for MICA. Single bedrooms are available.

Young Adult Housing - YAH is a group home and supported housing program providing specialized services for individuals 18 to 21 years of age who are transitioning from Residential Treatment Facilities or congregate living environments for adolescents. Services are similar to other group settings. There is staffing capacity to provide more intensive services for individuals participating in the supported housing component of the program. YAH services are provided by Transitional Services, Inc.

Residential Care Centers for Adults - RCCA offers congregate care support facilities for transitional and extended stays for up to 101 residents. While it is anticipated that, over time, residents will move to more independent housing, there is no set time for completing the program. RCCA's are designed to work with individuals who need more focused ADL skills training and other rehabilitative services. Staff are on site 24/7, and nursing staff is available 5 days a week. The RCCA is operated by BPC.

Family Care - FC provides housing for up to four adults with an unrelated family in the community. Providers offer support, furnished rooms, meals, companionship and security. The host family also provides 24-hour supervision, laundry, housekeeping and medication management services. The Family Care Program is operated by BPC.

Single Room Occupancy - SRO's provide housing that is specifically designed to offer permanent housing in a service-enriched setting. These programs are intended to provide housing and services for individuals capable of living independently. A social service team provides services on-site which includes case management, interactive groups, activities, medication management, money management and vocational linkage. SRO housing is provided by DePaul Community Services.

For Housing Provider Use Only

Date Rec'd
Disposition

1. APPLICANT DATA

*Name:
*Social Security Number:
*Current Address:
*Telephone #:
*Months in current living situation

Previous Address: *County: ☐ Erie ☐ Other

*Date of Birth: *Sex:

*Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Religion (optional): *Race (optional):

*Highest Level of Education Completed: Literate: ☐ Yes ☐ No

*Family Contact: Relationship:

Address: Telephone #:

***II. DIAGNOSIS** (DSM IV Code)

AXIS I

AXIS II

AXIS III

AXIS IV (a) Stressor (b) Severity (c) Duration

AXIS V (a) Current GAF Score Past Year GAF Score (if available)

(ENTER TWO DIGIT SCORES FROM 01-90)

Intellectual Level (IQ): ☐ Below 70 ☐ 70-84 ☐ Above 84

***III. REFERRED BY**

Name:

Telephone Number:

Agency:

Program:

Contact (if other than above):

Address:

Applicant's Name:

IV. RISK ASSESSMENT

Is the consumer identified as high-risk, high-need due to any one of the following characteristics?

YES	NO	DON'T KNOW	
☐	☐	☐	A history of sexually abusing others
☐	☐	☐	A history of fire setting
☐	☐	☐	A history of indiscriminate serious assault (consumer arrested and/or victim required medical attention)
☐	☐	☐	A history of homicide
☐	☐	☐	A history of suicide attempts
☐	☐	☐	A history of repeated episodes of serious self-harm requiring medical attention
☐	☐	☐	Three episodes of loss of housing in the last 12 months
☐	☐	☐	Medical needs that cannot be addressed by the housing provider
☐	☐	☐	History of alcohol abuse/dependence
☐	☐	☐	History of substance abuse/dependence (if yes, note below: onset and frequency of use, type of substance, date of last use and method of administration)
☐	☐	☐	History of arrests and dispositions (i.e. currently in jail or facing charges, released from jail or prison within the last year, probation/parole supervision, CPL 330.20, Alternative to incarceration, etc.)

If you answered yes to any of the above, please provide details in the space provided below or include in a psychosocial history:

Describe Signs of Decompensation and/or Prodromal Symptoms:

V. FUNCTIONAL STRENGTHS AND DEFICITS

Does Applicant Currently	independently	needs help	unable	unknown
Manage personal needs (grooming/hygiene/laundry)	☐	☐	☐	☐
Budget Money	☐	☐	☐	☐
Respond appropriately to emergency situations (e.g. fire, first aid)	☐	☐	☐	☐
Comply with medication regimen	☐	☐	☐	☐
Use public transportation and other community resources	☐	☐	☐	☐
Plan menus, grocery shop, prepare meals	☐	☐	☐	☐
Self medicate	☐	☐	☐	☐

VI. Please attach copies of most recent progress notes, Service Plan Reviews and Psychiatric evaluations or psychosocial history (see outline).

Applicant's Name:

***VII. SOURCES OF INCOME/FINANCIAL RESPONSIBILITIES** **P**lease Check All That Apply

☐**No Assets or Funding Source**

☐**Public Assistance**
☐Active Monthly Amount $ County Telephone #
☐Pending Application Date Case Worker
☐**Supplemental Security Income (SSI)**
☐Active Monthly Amount $ County Telephone #
☐Pending Application Date Overpayment? SSI Worker
☐**Social Security (SSD or SSA)**
☐ Active Monthly Amount $ Type of Benefit (i.e. Disability) Claim #
☐Previously Recd./Inactive ☐ Pending Application Date Type Applied For
***Payee Status** ☐Self ☐ Representative

Payee:
Address Telephone
City/State Zip Code

Wages (Include Sheltered Workshop) ☐Full Time ☐ Part Time
Employer Wages $ per week

☐**Union Benefits** $ / month
☐**Unemployment Insurance Benefits** $ / month
☐**New York State Disability** $ / month
☐**Railroad Retirement Benefits** $ / month
☐**Workers Compensation Benefits** $ / month
☐**Pensions/Annuity** $ / month
☐**Veterans Benefits** $ / month

☐**Family Support** (Child & Adolescent Referrals **Only**) Wage Earner's Gross Income $ /Year

Other Assets:
☐Alimony/Child Support Received $ / month
☐Home Owner
☐Bank Account(s) - List Banks:
☐ Stocks ☐ Bonds ☐Trusts ☐Burial Fund ☐Motor Vehicle ☐ Life Insurance

Food Stamps
☐Active Amount $ /Month ☐Pending Application Date:
Health Insurance
☐Medicaid # Access # Seq.#
☐Medicare #
☐Other Type: Policy #:

FINANCIAL RESPONSIBILITIES (Include Monthly Amounts)
☐No Known Financial Responsibilities ☐ Student Loans $ Medical Expenses $
☐Alimony/Child Support $ Motor Vehicle $ Other

Applicant's Name:

***VIII. PREVIOUS RESIDENTIAL SERVICES**

Agency	Admission Date	Discharge Date

***IX. PREVIOUS PSYCHIATRIC HOSPITALIZATIONS / INSTITUTIONALIZATIONS**
(Include inpatient rehabilitation for substance abuse. Attach discharge summaries as available. Use other attachments if needed.)

Facility	Service (i.e., detox)	Adm. Date	D/C Date

ER VISITS (list dates over last 6 months)

***X. PREVIOUS OUTPATIENT TREATMENT / CASE MANAGEMENT SERVICES** (within the past 6 months)

Agency	Type of Service	Adm. Date	D/C Date

***XI. CURRENT OUTPATIENT TREATMENT**

Agency Address Contact

Telephone Date Linkage Completed

Prescribing Psychiatrist Telephone #:

***XII. CURRENT CARE COORDINATION/CASE MANAGEMENT**

☐None ☐ ACT ☐ ICM ☐ TCM ☐SCM ☐ Other Case Manager

☐ Active Agency

Case Manager's Name Telephone #

☐ Pending - Referral has been made.

☐Assisted Outpatient Treatment (A.O.T.)

Applicant's Name:

Medication	Dosage	Frequency

***XIII. CURRENT COMMUNITY REHABILITATION AND SUPPORTS**

(If an activity or support is pending or recommended, please note under comments.)

	Agency	Contact	Telephone #
☐ IPRT			
☐ Work			
☐ CDT			
☐ P.R.O.S			
☐ Peer Services			
☐ Self-Help Groups			
☐ Social Clubs			
☐ Clubhouses			
☐ School			

Please note days and hours of activities:

Comments:

Other Social Supports: ☐ Family ☐ Job Other

*Transportation Access: ☐ Public ☐ Own Car ☐ Program Van ☐ Family ☐ Medicaid Cab

***XIV. CURRENT HEALTH CARE PROVIDER**

Clinic

Contact

Tel. #

Address

Primary Care Physician

*Advanced Directive ☐ Yes ☐ No

Contact Person:

Phone number:

Applicant's Name:

XV. MEDICAL EXAMINATION

Date of most recent medical examination:
(Completed by a Physician, Nurse Practitioner or Physician's Assistant)

A current (within 12 months) and legible history and physical examination may be substituted for the information requested below.

Please check ALL that are current or historic medical concerns If yes, please comment.

	Unknown	No	Yes	Comments
allergies/medication sensitivity	☐	☐	☐	
arteriosclerosis	☐	☐	☐	
communicable diseases	☐	☐	☐	
diabetes	☐	☐	☐	
hearing impairment	☐	☐	☐	
heart disease	☐	☐	☐	
hepatitis	☐	☐	☐	
history of cancer	☐	☐	☐	
hypertension	☐	☐	☐	
incontinency	☐	☐	☐	
lung disease	☐	☐	☐	
mobility limitations	☐	☐	☐	
podiatry	☐	☐	☐	
seizure disorder	☐	☐	☐	
skin condition(s)	☐	☐	☐	
special diet(s)	☐	☐	☐	
speech impairment	☐	☐	☐	
tuberculosis	☐	☐	☐	
visual impairment	☐	☐	☐	

Other (Please Specify)

For any of the above conditions checked YES, please indicate specific instructions to be followed by the applicant.

Signature and title of person completing this form: _____

Date: _____

Applicant's Name:

XVI. <u>TUBERCULOSIS TEST RESULTS</u> (To be completed by a Nurse, Nurse Practitioner, Physician or Physician's Assistant)
It is necessary that all applicants be screened for tuberculosis within *one year* of the referral. The following documentation is required. Medical records verifying administration of the PPD test may be submitted in lieu of this form.

Date of PPD (Mantoux) Test:

PPD (Mantoux) Test Administered by:

Results of PPD (Mantoux) Test: ☐Negative ☐Positive

Date of Chest X-Ray (if indicated):

Results of Chest X-Ray: ☐Negative ☐ Positive

Signature and credentials of person completing this form: _____

Date: _____

XVII. PHYSICIAN AUTHORIZATION FOR REHABILITATION SERVICES OF COMMUNITY RESIDENCES

APPLICANT'S NAME:

APPLICANT'S MEDICAID NUMBER:

ICD.9 DIAGNOSIS:

(Please enter code and description) 5 Digit Code

I, the undersigned licensed physician, based on clinical information and my face to face assessment of this client, have determined that (Client's Name) meets one of the following criteria (A, B, C or D) for severe and persistent mental illness (SPMI).

☐ A. **The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*.**

☐ B. **Extended Impairment in Functioning due to Mental Illness -**

The individual has experienced two of the following four functional limitations due to a designated mental illness over the past twelve months on a continuous or intermittent basis:

- ☐ **Marked difficulty in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- ☐ **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- ☐ **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).
- ☐ **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.)

☐ C. **The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale** (Axis V of DSM-IV) due to a designated Mental Illness over the past twelve months on a continuous or intermittent basis.

☐ D. **Reliance on Psychiatric Treatment, Rehabilitation and Supports**.

A documented history shows that the individual at some prior time, met the threshold for items B or 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 of 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 the underlying mental disorder.

The client would benefit from the provision of mental health Community Rehabilitation Services within a Community Residence Program defined pursuant to Part 593 of 14 NYCRR (see reverse side). This determination is in effect for the period from to at which time there will be an evaluation for continued stay.

Month/Day/Year MD Name (please print) Licensure #

MD Signature Medicaid License #

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

Managed Care Physician Managed Care Provider ID#

COMMUNITY REHABILITATION SERVICES NOTATION CODES

AT - Assertiveness/Self Advocacy Training - Training which promotes the individual's ability to assess his or her needs to make a life status change and to increase self-awareness about his or her values and preferences. Training is intended to increase an individual's ability to respond to medical, safety and other personal problems. Activities are also intended to improve communication skills and facilitate appropriate interpersonal behavior.

CI - Community Integration Services/Resource Development - Activities designed to help individuals to identify skills and community supports necessary for specific environments; to assess their skill strengths and deficits in relationship to environmental demands; to assess resources available to help the individual; to develop a natural support system; by accessing social, educational and recreational opportunities.

DLS- Daily Living Skills Training - Activities which focus on the acquisition of skills and capabilities to maintain primary activities of daily life; services are provided by addressing areas of functioning in categories such as: dressing, personal hygiene and grooming, selection and/or preparation of food, cleaning and washing of clothes, maintenance of environment, budgeting and money management. Training is intended to increase those competencies needed by the individual to live in his or her goal environment.

HS - Health Services - Training to maximize independence in personal health care by increasing the individual's awareness of his or her physical health status and the resources required to maintain physical health; including regular medical and dental appointments, basic first aid skill, basic knowledge of proper nutritional habits and family planning. Also, includes training on special topics such as AIDS awareness.

MMT-Medication Management and Training - The storage, monitoring, record keeping and supervision associated with the self-administration of medication. This does not include prescribing, but does include a certain degree of reviewing the appropriateness of the residents' existing regimen with the appropriate physician. Activities which focus on educating residents about the role and effects of medication in treating symptoms of mental illness and training in the skill of self-medication are also included.

PT - Parent Training - Structured activities intended to promote positive family functioning and enable the resident to assume parenting responsibilities. Activities include peer support groups to foster skills around effective parenting, assistance in selecting and obtaining housing appropriate for families, and linkage with the children's service system. Psycho-education programs on parenting skills, single parenting issues, child care and the nature of mental illness and its effect on the family are also included.

RC - Rehabilitation Counseling - A therapeutic modality which includes assisting the individual in clarifying future directions and the potential to achieve rehabilitation goals; identifying and specifying behaviors that impede goal setting; improving understanding regarding the influence of environmental stress; and helping an individual to apply newly learned behaviors to housing and other situations outside the program structure.

SD - Skill Development Services - Activities which assist clients to gain and utilize the skills necessary to undertake employment or pursue educational opportunities. This may include skills related to securing appropriate clothing, scheduling, work related symptom management, and work readiness training.

S - Socialization - Activities whose purposes are to diminish tendencies toward isolation and withdrawal or overly aggressive behavior by assisting residents in the acquisition or development of social and interpersonal skills. "Socialization" is an activity whose purpose is to improve or maintain a resident's capacity for social involvement by providing opportunities for application of social skills. This occurs through resident/staff interaction in the program and through exposure with staff to opportunities in the community. Modalities used in socialization include individual and group counseling and behavior interventions.

SAS -Substance Abuse Services - Services provided to increase the individual's awareness of alcohol and substance abuse and reduction or elimination of its use; including verbal and medication therapies, psycho-educational approaches, and relapse prevention techniques.

SM - Symptom Management - Activities to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of residents' mental illness symptoms and response to treatment, interventions designed to help residents manage their symptoms, and assisting residents to develop coping strategies to deal with internal and external stressors. Services range from providing guidance around everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques.