BUFFALO PSYCHIATRIC CENTER RESIDENTIAL HOUSING APPLICATION

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

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

☐ State Operated Community Residence (SOCR)	☐ Family Care (FC)	

Please check other housing providers that have been applied to via SPOA and/or Direct Referral:

☐Buffalo Federation of Neighborhood Centers ☐DePaul Community Residences ☐Southern Tier Environments for Living, Inc. ☐Erie County ☐Southern Tier ☐Greenwood Residence, Inc. ☐Adult Home (s):_____ _____ _____	☐Transitional Services, Inc. ☐CMI – Choices ☐RSI ☐HOME ☐Spectrum ☐Supported Housing ☐Skilled Nursing Facility (s):_____ _____ _____

Please check each BPC Residential housing provider applied to

	☐Grant Street Residence 656 Grant Street Buffalo, NY 14213 Phone: 716-883-9334 **SOCR**	☐BPC – Family Care 400 Forest Ave. Buffalo, NY 14213 Phone: 716-816-2951 Fax: 716-816-2547 **FC**
☐ Olmsted SOCR 3 Rees St. Buffalo, NY 14213 Phone: 716-884-3445 **SOCR**	☐Strozzi SOCR **(*For BPC inpatients only with a LOS greater than 6 months)*** Strozzi Building – Third Floor 400 Forest Ave. Buffalo, NY 14213 Phone: 716-816-2251 **SOCR**	☐Waterfront SOCR 2 Duquesne Celeron, NY 14720 Phone: 716-664-4313 Fax: 716-488-1193

Please include 3 months of Progress Notes, Service Plan Review, Psychiatric Evaluations and Psychosocial History.

All SOCR referrals should be faxed to: 716-816-2450.
Family Care referrals should be faxed to: 716-816-2547.
Waterfront referrals should be faxed to: 716-488-1193.

***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.

Descriptions of Buffalo Psychiatric Center Residential Services

BUFFALO PYCHIATRIC CENTER HOUSING

State Operated Community Residences - SOCR are Congregate/Treatment facilities (group homes) which provide services to 14 to 26 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. Staff is on site 24/7. The BPC SOCR services are provided by Olmsted SOCR, Strozzi SOCR, and Grant Street SOCR

Family Care - FC homes provide housing for one to six adults, 18 years of age or older. Providers offer support, furnished rooms, meals, companionship and security. The host family also provides 24-hour supervision, laundry, housekeeping and medication management services. Most residents attend day programming 3-5 days per week.

For Housing Provider Use Only

Date Rec'd
Disposition

I. APPLICANT DATA

*Name:
*Social Security Number:
*C Number for BPC Patients:

*Date of Birth: *Sex:

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

*Religion (optional): *Race (optional):

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

*Current Address: *County: ☐ Erie ☐Other
*Months in current living situation

*Telephone #:

*Previous Address: *County: ☐ Erie ☐Other

*Family Contact: Relationship:

Address: Telephone #:

II. DIAGNOSIS

PRIMARY PSYCHIATRIC DIAGNOSIS:

SECONDARY PSYCHIATRIC DIAGNOSES:

MEDICAL DIAGNOSES

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:

Applicant's Name:

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	☐	☐	☐	☐

Indicate what Community Rehabilitation Services this individual is interested in (see page 13 and 14 of this referral packet):

VI. Please **attach copies** of most recent Progress Notes (3 months), Service Plan Review, Psychiatric Evaluations and Psychosocial History.

Applicant's Name:

VII. SOURCES OF INCOME/FINANCIAL RESPONSIBILITIES: Please 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 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/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: _____

ALTERNATE DOCUMENTATION OF TEST RESULTS CAN BE ATTACHED IN PLACE OF THE ABOVE

Applicant's Name:

XVII. PHYSICIAN AUTHORIZATION FOR REHABILITATION SERVICES OF COMMUNITY RESIDENCES

APPLICANT'S NAME:

APPLICANT'S MEDICAID NUMBER:

ICD.9 DIAGNOSIS:

5 Digit Code:

(Please enter code and description)

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.

Applicant's Name:

☐ 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 6 month 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.