NEW YORK STATE | Office of Mental Health
Buffalo Psychiatric Center

Buffalo Psychiatric Center Family Care Housing Application

Application's Name: _____

Date Completed: _____

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

Family Care referrals should be faxed to 716-816-2547 Attention: Family Care

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 Family Care Residential Services

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.

Applicant' s Name: _____

For Housing Provider Use Only
Date Received: _____
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

Applicant' s Name: _____

III. Referred by

Name: _____

Telephone Number: _____

Agency: _____

Program: _____

Contact (if other than above):

Address: _____

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 medial attention
☐	☐	☐	Three episodes of loss of housing in the last 12 months
☐	☐	☐	Medical Needs that conned be addressed by the housing Provider
☐	☐	☐	History of alcohol abuse/dependence
☐	☐	☐	A history of substance abuse/dependence (if yes, not below: onset and frequency of use, type of substance, date of last use, and method of administration)
☐	☐	☐	A history of arrests and depositions (i.e. currently in jail or facing charges, released from jail or prison within the last year, probation/parole supervision, CPL 30.20 (alternative to incarceration, etc.)

Applicant' s Name: _____

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 application 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 12 and 14 of this referral packet):

_____

_____

_____

_____

Applicant' s Name: _____

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

VII. Sources of Income/Financial Responsibilities: (please check all that apply)

☐ No Assets or Founds 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
  - Application Date: _____
  - Case Worker: _____
- ☐ Pending
  - Application Date: _____
  - Type Applied For: _____

Applicant' s Name: _____

Payee Status ☐Self ☐Representative

Payee: _____

Address: _____

City/State: _____

Zip Code: _____

Telephone: _____

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

Applicant' s Name: _____

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: $_____

VIII. Previous Residential Services

Agency	Admission Date	Discharge Date

IX. Previous Psychiatric hospitalization/Institutionalizations

(Include inpatient rehabilitation for substance abuse. Attache discharge summaries as available. Use other attachment if needed.)

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

Applicant' s Name: _____

ER Visits (list dates over last 6 months):

_____

_____

_____

_____

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:

_____

_____

_____

_____

Applicant' s Name: _____

Other Social Supports:
☐Family
☐Job
☐Other

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

XIV: Current Health Care Provider

Clinic: _____

Contact: _____

Telephone #: _____

Address: _____

Primary Care Physician: _____

Advance Directive ☐Yes ☐No

Contact Person: _____

Telephone 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 conditions(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: _____ Time: _____

Applicant' s Name: _____

XVI. Tuberculosis Test Results (To be completed by a Nurse, Nurse Practitioner, Physician, or Physician's Assistant)

It is necessary that all applications 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 Check X-Ray (if indicated): _____

Results of Check X-Ray: ☐Negative ☐Positive

Signature and credential of person completing this form: _____

Date: _____ Time: _____

Alternate Documentation of Test Results can be attached in place of the above