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Old Bethpage, NY 11804
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Instructions for SPA Paper Application

*This application is to be used by individuals whom **do not** have access to the online login system.
Please complete each field accordingly. Items left blank may cause the application to be placed on hold until that information is submitted. The requested documents must be submitted with the application in order for it to be processed completely.
The items below are to be used for your reference when completing the application. Please select only from these options for these particular items.

Individual Information Section (Pages 1-2)

*Please select the County where the applicant currently resides and is a resident.

Housing Program Requested - Please select from the following Levels of Care (LOC):
-Supervised Community Residence (CR)
-Supervised Single Room Occupancy Community Residence (CR-SRO)
-Apartment Treatment (ATP)
-Supported Housing (SHP)
-Supported Single Room Occupancy (SP-SRO) – Suffolk Only (NOT TO BE CHOSEN YET AS THIS LEVEL IS NOT DEVELOPED YET)

Specialized Housing – Please select from the following types:
- MICA
-Young Adult (Nassau 18-30, Suffolk 18-26)
-MI/MR (Mental Illness/Mental Retardation) (DO NOT CHOOSE IF CLIENT DOES NOT HAVE DOCUMENTATION TO SUPPORT A DEVELOPMENTAL DISABILITY)
-Family (Supported Housing Only)
-Couple (Supported Housing Only)
-Veterans (Limited, Suffolk Only)
-Senior Citizens/Geriatric (Nassau Only – Over 55)
-Forensic (Nassau Only)

Skills and Supports (Page 4)

Applicant Skills – Please select from one of the following:
1- (Cannot accomplish independently)
2- (Accomplish with assistance)
3- (Can accomplish independently)
4- (Unknown)

Psychiatric Information (Page 5)

Medication Adherence (Compliance) – Please select one of the following:
- Independent
- Supervision
- Reminders

Documents (Page 9)

*Please submit a Psychiatric Evaluation that is signed by a Psychiatrist (MD or DO) or Psychiatric Nurse Practitioner (NPP) and dated within 2 years of application being submitted.
*Please submit a Psychosocial Evaluation that is signed by Psychiatrist (MD or DO), Psychiatric Nurse Practitioner (NPP) or Licensed Social Worker and dated within 2 years of application being submitted.
*Physical Exam and PPD must be within 1 year of application being submitted.
*Physician's Authorization Form (PAF) must be signed by licensed Physician or Psychiatrist. (Only used for Supervised (CR) and Apartment Treatment)

SPA
Single Point of Access
Long Island

Referring Agency:		Phone Number:	
Address (Street):		E-mail:	
Contact Name:		This referral is a:	☐ NASSAU RESIDENT ☐ SUFFOLK RESIDENT

Individual Information

General Info

First name:		Last name:	
AKA:		Date of birth:	Age:
Social security #:		Gender:	
Homeless status:		Current marital status:	

Address

if applicant is homeless, indicate locations where client can be found if known. If applicant is hospitalized, list address / location prior to hospitalization. If applicant currently lives in a Mental Health Facility list address and info.

Residential type:			
Agency / Facility name:			
Program name:			
Street address:			
Apt. #:			
City:			
State:		Zip Code:	
Phone #:		Extension:	
Cell #:			
Email:			

Emergency Contact

First name:			
Last name:			
Street address:			
Apt. #:			
City:			
State:		Zip Code:	
Phone #:		Extension:	
Cell #:			
Email:			

Reason for Referral

What is the reason this referral is being made at this time?

Applicant's Ethnicity

Race: **

*** This question is asked for statistical purposes only. Applicants will not be discriminated against based on race, color, creed, religion, sex, national origin, age, familial status, handicap, or sexual preference.*

Is the applicant a US citizen? ☐ Yes ☐ No

If no, please specify:

Please be aware that federal regulations prohibit us from processing referrals for undocumented applicants.

Primary language:

Children To Be Housed

Children to be housed ? ☐ Yes ☐ No

Age	Sex	Special Considerations

Individual Information (Continued)

Entitlements and Income

List all entitlements and income which the applicant receives or which are pending:

Type	Amt	ID# / Pending / None

Who is the applicant representative payee?

Name:

Phone: Extension:

Housing Program Requested

Please indicate the type of housing program for which you would like to be considered:

Specialized Housing

Housing Type

Current Legal Supervision / Status

Active AOT status: ☐ Yes ☐ No

AOT coordinator (if Known) name: Phone:

Specialty treatment court:

Treatment Court

Probation / Parole: ☐ Yes ☐ No

Name: Phone:

Is the applicant a registered sex offender ? ☐ Yes ☐ No

Level:

List All Current Services That The Applicant Is Receiving

Please add other contact information.

Services	Agency Name	Contact Person	Phone Number

Veteran

Is the applicant a veteran? ☐ Yes ☐ No

Type of discharge:

Agency Preference

Agency preference (if any):

Geographic Preference

1. Do you have a particular town or area that you would like to live in?

1st Preference:

2nd Preference:

SPA will endeavor to accommodate placement preferences, but please be advised that housing is often based on availability. Specific location requests may lengthen the time spent waiting

Family Housing Section

Is there a specific individual you are requesting to reside with? ☐ Yes ☐ No

If yes, please provide full name:

Please explain why?

For specific information regarding couples or family housing please read SPA's Frequently Asked Questions.

History

Housing, Employment and Educational History & Preferences

1. Please list where the applicant has resided for the past five years and detail any history of homelessness. Include shelters, drop-in centers, streets, hospitals, prison, supportive residences, SRO's, family and independent housing (please start with most recent location):

Date Range	Location	Reason for Leaving
From: To:		
From: To:		
From: To:		

Employment

2. Has applicant been employed during the last five years? ☐ **Yes** ☐ **No**

If yes, please list dates and positions:

Date Range	Position	Title	Type of Employment
From: To:			
From: To:			
From: To:			

Education / Training History

3. Educational / Training history (Choose relevant items):

Education	Specify

Skills & Support

Applicant Skills

1. Rate the degree to which the applicant can accomplish the following:

Activity	Degree
Access and use of medical services	
Communicate in non-threatening manner	
Housekeeping	
Maintain personal hygiene	
Manage medication regimen	
Manage symptoms	
Money Management	
Obtain food	
Paying Rent	
Prepare or obtain meals	
Program Participation	
Refrain from substance abuse	
Securing / Maintaining Benefits	
Smoke safely (if applicable)	
Travel	
Use kitchen appliances safely	
Use of leisure time	

Services Currently Utilized

2. Indicate all services the applicant currently utilizes:

Service Name	Specify	Contact	Phone	Ext.

Support Services

3. Indicate all support services needed once the applicant is housed:

Program Name	Specify

Psychiatric Information

Current Diagnosis

List all current Axis I, Axis II, and Axis III diagnoses:

Axis #	Axis Code	Description

Has individual ever received services under OPWDD? ☐ Yes ☐ No

If so what?

If available, IQ test used:

Score: Date:

Functional assessments: Score:

Psychiatric Behavior

2. Does the applicant have a history of, or is the applicant currently exhibiting any of the following?

Psychiatric Behavior	Current	History	Unknown
Aggressive / Assaultiveness	☐	☐	☐
Arson / Firesetting	☐	☐	☐
Cognitive Impairment	☐	☐	☐
Compulsive behaviors	☐	☐	☐
Criminal Activities / Arrests and Convictions	☐	☐	☐
Delusions	☐	☐	☐
Disruptive Behavior	☐	☐	☐
Hallucinations	☐	☐	☐
Highly disorganized thought processes	☐	☐	☐
Homicidal ideas / attempts	☐	☐	☐
Inappropriate touching	☐	☐	☐
Severe Depression	☐	☐	☐
Sexual acting out	☐	☐	☐
Substance / alcohol abuse	☐	☐	☐
Suicidal ideas / attempts	☐	☐	☐

Psychotropic Medications

3. Current psychotropic medications:

Name

Medication Adherence (Compliance)

4. What level of support does the applicant require to achieve medication adherence / compliance?

Currently Hospitalized?

5. Is the applicant currently hospitalized? ☐ Yes ☐ No

Admission type: ☐ Psychiatric ☐ Medical

If so, date of admission:

Hospital name:

Ward / Unit:

Contact person:

Phone: Extension:

History of Psychiatric Hospitalizations

6. Does the applicant have a history of psychiatric hospitalizations and psychiatric emergency room use? ☐ Yes ☐ No

Hospital / ER	Adm. Date	Discharge Date	Reason

History of Substance Abuse

7. Does the applicant have a history of substance abuse? ☐ Yes ☐ No

Substance(s):

Current use:

Substance Abuse Treatment

8. Does the applicant have a history of substance abuse treatment? ☐ Yes ☐ No ☐ Yes, but treatment program is unknown

Name of Treatment Program	Adm. Date	Discharge Date

Length of time the applicant has spent substance free:

Alcohol: since ☐ Not Applicable

Drugs: since ☐ Not Applicable

Medical Information

The disclosure of HIV-related information is not required, but if the applicant wishes to release it, this form must include a special consent to release information form signed by the applicant

Medical Diagnosis

Medical diagnosis: (Include all Axis III diagnoses):

Allergies: ☐ Yes ☐ No

Non-Psychotropic Medications

Current non-psychotropic medications:

Name

Physical Functioning Level

Physical functioning level (answer each of the following):

Physical Function Level	Yes	No
Amputee		
Bedridden		
Blind		
Can dress self		
Can feed self		
Can fully bathe self		
Climbs one fight of stairs		
Deaf		
Fully Ambulatory		
Incontinent		
Mute		
Needs help with toileting		
Wheelchair Required		

Services

Does the applicant have a medical condition that requires special services?

☐ Yes ☐ No

If so, indicate which services:

☐ **Special medical equipment Please specify:**

☐ **Medical supplies Please specify:**

☐ **Ongoing physician support**

☐ **Nursing services**

☐ **Home care**

☐ **Therapeutic diet**

☐ **Injectable medication**

☐ **Other:**

What medical services is the applicant currently receiving?

Pets

Does applicant have pets? ☐ Yes ☐ No

If yes, please specify:

***Please be aware that different programs have varying policies regarding pet ownership. In addition, pets may affect your entry into mental health housing.*

Is the pet a certified service animal ? ☐ Yes ☐ No

Is the applicant allergic to animals? ☐ Yes ☐ No

If yes, please specify:

Medical Hospitalizations

To the degree known, list all medical hospitalizations during the past three years:

Hospital	Adm. Date	Dis. Date	Chief Complaint

Additional Challenges

Does applicant smoke? ☐ Yes ☐ No

Does applicant have any other needs to be considered?

Applicant's Input

Applicant Qualities

1. What qualities do you have that will make you a good housemate?

Housemate Qualities

2. What qualities in a housemate are you looking for?

Challenges Faced

3. What challenges are you facing that SPA housing would help?

Future Goals

4. What housing goals are you hoping to accomplish in the future?

Natural Supports

5. What are your natural supports (i.e family, friends, others)?

Anything Else

6. Is there anything else you would like a housing provider to know about you?

Documents

Documents Attached	Yes	No	Attached Notes
Psycho-Social History	☐	☐	
Psychiatric Summary (including current clinical assessment signed off by a licensed Physician/Psychiatrist)	☐	☐	
Recent Physical Exam (including PPD within 1 year of application date signed off by licensed physician)	☐	☐	
Physician's Authorization Form signed off by a licensed Physician/Psychiatrist (Licensed programs only: Supervised and Apartment Treatment only)	☐	☐	
PPD if separate from the Physical Exam	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

I agree with this referral and give my consent for information about myself to be shared with agencies in connection with my referral to a housing program. I also agree that all the information contained herein is accurate to the best of my knowledge and is reflective of my current situation.

_____
Date

_____
Signature of Applicant (Required)

_____
Signature of Witness

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

- ☐ Initial Authorization
- ☐ Semi – Annual Authorization
- ☐ Annual Authorization

Client's Name: _____

Client's Medicaid Number: _____

ICD. 10 Diagnosis: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that_____ (client's name) would benefit from 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.

_____/_____/_____ _____ _____

Month day year Name (Please Print) Licensure#

_____

Signature

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

_____ _____

Physician Managed Care Provider ID #