Patricia Hollister-Doyle
Executive Director

Search for Change, Inc.
95 Church Street, Suite 200
White Plains, NY 10601

www.SearchforChange.com

To Whom It May Concern,

Enclosed, please find the Westchester County Department of Community Mental Health (DCMH) application for services.

The enclosed application may be utilized to access Residential, Case Management, or Assertive Community Treatment (ACT) services. Please submit the application and all pertinent forms to DCMH at the following address:

Westchester County Department of Community Mental Health
112 East Post Road, Room # 219
White Plains, NY 10601
Attention: **SPOA**

If an individual is interested in one of Search For Change's residential programs, please document this clearly within the application or submit an additional request.

This application can be copied and distributed as needed. Please know that in order for an application to be processed, all supporting documentation must be attached.

If you have any questions or require further assistance, please do not hesitate to contact me at 914-428-5600, ext. 228. I can also be reached by fax 914-428-3388 or e-mail ***(abrody@searchforchange.com).***

Thank you for considering Search for Change, Inc.

Sincerely,

Ashley Brody

Ashley Brody
Associate Clinical Director

Enclosures

06/30/2009

Telephone: (914) 428-5600. Admin. Fax: (914) 428-5642. Residential Fax: (914) 428-3388. Vocational Fax: (914) 428-3497

Westchester County Department of Community Mental Health Application for Services

The Clinical provider must submit the following documents (*current within 90 days of application):*

- ☒ Comprehensive Psycho-Social Assessment
- ☒ Psychiatric Assessment including DSM IV diagnosis
- ☒ Hospital Admission and Discharge Plan as appropriate
- ☒ Recipients with HIV/AIDS may choose to sign the " Authorization for Release of Confidential HIV Related Information" form.

Applications for Community Residence and Licensed Treatment Apartment must also include:

- ☒ Copy of Physical Exam current within 6 months
- ☒ Authorization for Restorative Services signed by a Physician

All application should be submitted by fax or mail to: Westchester County Department of Community Mental Health
112 East Post Road, Room 219
White Plain, New York 10601
ATTN: **SPOA**

Consumer Information

Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #: _____

Address: _____ Apt#. _____

City: _____ State _____ Zip: _____

Tel. No.: __(___)_____ Gender: _____ Male _____Female

Citizenship: Yes No (If no, immigration status): _____

Ethnicity

_____ White (Non-Hispanic _____ Black (Non-Hispanic)
_____ Latino/Hispanic _____ Asian/Asian American
_____ Native American _____ Pacific Islander
_____ Other _____

Marital Status

___ Single never married ___ Married
___ Divorced/Separate ___ Widowed
___ Lives with significant other

Primary Language

___ English ___ Spanish ___ Chinese ___ French
___ Italian ___ Russian ___ German ___ Japanese
___ Urdu ___ Vietnamese ___ Creole
___ Greek ___ None ___ American Sign Lang.

English Proficiency

___ Does not speak English ___ Poor
___ Fair ___ Good ___ Hindi

Education Level

__ Some Grade Schl ___ Grade School ____ Some HS
__ HS Diploma/GED ___ Voc Training ____ Some College
__ College Degree ___ Master's Degree ____ Ungraded
___ No Formal Ed. ___Other _____

Employment Status

___ Full Time ___ Part Time
___ Not Employed ___ Other _____

Others In Home/Household:

Name	**Age**	**Gender**	**Relationship**

Custody Status of Children

____ No children

____ Children are all above 18 years of age

____ Minor children currently in client's custody

____ 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.

____ Supervised Living

____ Supported Housing

____ Lives with spouse

____ Correctional facility

____ Homeless (shelter)

____ Homeless (streets)

____ Nursing Home

____ Psychiatric Hospital

____ Lives with parents

____ Other _____

Insurance and Financial information:_____

Benefits or Insurance	Currently receives	Pending application submitted	Eligible no application submitted	Ineligible	Unknown
Social Security	❑	❑	❑	❑	❑
SSI/SSD	❑	❑	❑	❑	❑
Public Assistance	❑	❑	❑	❑	❑
VA Benefits	❑	❑	❑	❑	❑
Medicaid	❑	❑	❑	❑	❑
Medicare	❑	❑	❑	❑	❑
Food Stamps	❑	❑	❑	❑	❑
Pension	❑	❑	❑	❑	❑
Earned Income/Wages	❑	❑	❑	❑	❑
Worker's Comp	❑	❑	❑	❑	❑
Unemployment	❑	❑	❑	❑	❑
Private Insurance	❑	❑	❑	❑	❑
Trust Fund	❑	❑	❑	❑	❑
Medication Grant	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑
Representative Payee	❑	❑	❑	❑	❑

Referral Source

Name: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____

Program:_____ Relationship: _____

Person to Notify in Emergency

Name: _____ Phone: _____

Address: _____ Apt # : _____

City: _____ State : _____

Relationship: _____

Skills/Supports Assessment

Can the recipient function independently in the following areas?

	Yes	No	Unknown		Yes	No	Unknown
Paying Rent				House Keeping			
Money Management				Program Participation			
Nutrition				Use of Leisure Time			
Socialization				Travel			
Own Car				Use of Health Services			
Cooking				Shopping			
Securing/Maintaining Benefits				Grooming			
Personal Hygiene							

Indicate all services current or planned:

	Current	Planned		Current	Planned
Health			Club House		
Education			Psychiatrist/Clinic		
MICA Day Program			Substance Abuse Tx		
Psychiatric Day Program			AA/NA		
Vocational Services			Case Management		
MH Housing Program			Other		

Psychiatric Information

Diagnosis	DSM IV Codes
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

Current Psychotropic Medications:

Name **Dosage** **Schedule**

_____

_____

_____

_____

_____

_____

What level of support does the Recipient require to achieve medication compliance?

____ Dispensing ____ Reminders ____ Refuses/Non-complaint
____ Supervision ____ None-Independent ____ Not applicable

Is the person currently hospitalized? ___ Yes __ No Date of Admission: _____

Hospital: _____

Outpatient Treatment Provider

Agency: _____ **Program:** _____

Contact: _____ **Telephone:** _____

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

Hospital/ER	Admission Date	Discharge Date	Source of Information

Number of psych hospitalizations in the past year: _____ Number of ER visits in the past year _____

Behavioral Characteristics

	Current	History	None	Unknown	Date of most recent event
Childhood violence					
Cognitive impairment					
Criminal history					
Cruelty to animals					
Delusions					
Destruction of property					
Disruptive behaviors					
Fire Setting					
Hallucinations					
Homicidal ideas/Attempts					
Severe Depression					
Severe thought disorder					
Severe violence against others					
Significant difficulty in treatment compliance					

Suicidal behavior _____

_____

Substance Abuse History

Drugs of Choice

____ None ____ Any IV Drug Use ____ Alcohol ____ Marijuana
____ Cocaine ____ Crack ____ Heroin/Opiates ____ Hallucinogens
____ Amphetamines ____ PCP ____ Sedative/Hypnotics ____ Benzodiazapines
____ Prescription Drugs ____ Inhalant ____ Other _____

Frequency of use:

___ Not in last month ___ 1-2 times per week ___ Daily
___ 1-3 time in the last month ___ 3-6 times per week ___ Unknown

Alcohol/Substance Abuse Treatment Program within the Past 3 Years **Dates**

_____

_____

Length of time Recipient has been substance free:_____

Medical Information:

List all Significant Medical Hospitalizations:

Hospital	Admission Date	Discharge Date	Chief Complaint .

Current Non-Psychotropic Medications

Name	Dosage	Schedule

Does the person have a medical condition that requires special services? ___ Yes ___ No

If yes please describe service needed:_____

Turberculosis Clearance (CR only) **PPD Date:** _____ **Results:** _____
If positive PPD, Chest X-Ray date: _____ **Recommendations:** _____

_____

Criminal Justice History

Current Status

___ None ___ Incacerated-Jail ___ Incarcerated-Prison ___ CPL 330.20/730
___ Probation ___ Parole ___ TASC/MHATI ___ Other: _____

Contact: _____ **Telephone:** _____

Reason for Arrest **Dates**

_____

_____

Number of arrests in the past year: _____ **Number of incarcerations in the past year:** _____

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law? _____ **Yes** _____ **No**

If NO:

Is an AOT under Kendra's Law currently being pursued? _____ **Yes** _____ **No**

Has this individual ever had an AOT order under Kendra's Law? _____ **Yes** _____ **No**

If Yes: Date of Court Order: _____ Petitioner: _____

Please list any other significant community supports not otherwise noted in this application (i.e. Supportive family, representative payee, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TO BE COMPLETED BY THE RECIPIENT:
Please describe in your own words your requests for services.

_____
_____
_____
_____
_____
_____
_____
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_____
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_____
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_____
_____

Recipient Signature: _____ Date: _____

CASE MANAGEMENT SERVICES **Level of Case Management Requested**

_____ **Supportive Case Management (SCM)**

Recipients are assisted with linkage to a community-based system of care. Coordinates service with the recipient, 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. Staff client ratio is 1:30. The minimum face to face contracts per month is two.

_____ **Intensive Case Management (ICM)**

Recipient is engaged through outreach. Monitors and coordinates evaluations and assessments to identify a recipient's needs, coordinates with family and treatment providers the development of an individualized community service plan. Provides "on the street" support, training and assists with crisis intervention and stabilization. Staff to client ratio is 1:12. The minimum face to face contracts per month is four. Individual must also meet OMH eligibility criteria for this level of service (see Attachment 1-B).

_____ **Assertive Community Treatment**

Recipient receives all clinical and case management services in the community through a mobile multi-disciplinary team. ACT provides a full range of treatment, psychosocial rehabilitation and community support services through an individualized approach. The program is available seven days a week, 24 hours a day and offers engagement services, service planning and coordination, crisis intervention, medication management, integrated treatment for substance abuse, and employment services. This service is for individuals diagnosed with severe mental illness whose needs have not been well met by the more traditional service delivery system. The staff to client ratio is 1:10 and the minimum face to face is 6 visits. Applicant must meet OMH eligibility criteria for ACT services (See attachment 1-C).

Is there a specific case management/ACT program being requested? _____

Primary Preference: _____

Secondary Preference: _____

RESIDENTIAL SERVICES **Level of Residential Service Requested**

_____ **Supervised Community Residence**
These residence 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, community integration and other areas are addressed depending on the need of each individual. The program is highly structured with an emphasis on movement towards an increased level of independent living.

_____ **Supervised MICA Community Residence**
Supervised MICA Community Residence programs provide a service that parallels the Supervised Community Residence level of care for people with a dual diagnosis of mental illness and chemical dependency.

_____ **Supervised Community Residence MI/MR**
Supervised MI/MR Community Residence programs provide a service that parallels the Supervised Community Residence level of care for people with mental illness that also Have developmental disabilities.

_____ **Supported Single Room Occupancy (SRO)**
Supported SRO programs offer staff support 24 hours per day. Support is available in areas such as money management, medication mentoring/monitoring and socialization. recipients have their own room but share common living space with others.

_____ **Treatment Apartment Programs**
These apartments are located throughout Westchester County. Staff will visit recipients to provide supervision with apartment maintenance, socialization, interpersonal relations, continued medication management and general daily living skills. Staff is also available 24 hours daily to provide crisis intervention and support. Emphasis at this level of housing is on maintaining a high level of functioning in a daily living, emotional stability and possible movement towards more independence.

_____ **Supported Housing** _____ **Individual** _____ **Family**
Supported Services are provided to recipients desiring to live independently. Ongoing services are identified and planned on an as needed basis. Recipients will also be assisted in securing permanent housing and initial furnishings for their apartments. Each recipient 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 income for rent.

_____ **Shelter Plus Care** _____ **Individual** _____ **Family**
The Shelter Plus Care program provides a service that parallels supported housing for those individuals that are homeless or at risk of homelessness due to imminent eviction. There is an expectation that recipients participating in the Shelter Plus Care Program will participate in treatment services.

Is there a specific residence being requested?
Primary Preference: _____

Secondary Preference: _____

Geographical Preference/Community: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV (Human Immunodeficiency Virus) related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV-related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV-related information without a release form by calling the HIV Confidentiality Law Hotline at 1-800-962-5065.

If you sign this form, HIV-related information can be given to the people listed on the form, and for the reason (s) listed on the form. You do not have to sign the form to obtain housing and you can change your mind at any time. If you experience discrimination because of release of HIV-related information, you may contact the New York State Division of Human Rights at (212) 961-8624. This agency is responsible for protecting your rights.

Name and address of facility/agency/provider obtaining release:
Name of person whose HIV-related information will be released:
Name and address of person(s) who will be given HIV-related information: **Search For Change, Inc.**
Reason for release of HIV-related information: **Coordination of Services**
Time during which release is authorized: **Six months from date that release is signed.**

I authorize the disclosure of HIV-related information to the people/agencies listed on this form, and for the reason(s) listed on the form. My questions about this form have been answered. I know that I do not have to allow release of HIV-related information and that I can change my mind at any time.

Date:_____ **Signature**: _____

Authorization for Restorative Services of Community Residences

☐ Initial Authorization

☐ Semi-Annual Authorization

☐ Annual Authorization

Client's Name: _____

Client's Medicaid Number: _____

DSM IV Diagnosis: _____

I, the undersigned licensed physician, based on my review of the assessment made available to me, have determined that _____
(Client Name)
would benefit from the 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)

_____
Signature

Licensure # _____ NPI (National Provider Identifier) # _____

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

_____ _____
Physician Name Managed Care Provider ID#

ATTACHMENT I

A. **Westchester County Department of Community Mental Health Outline for a Comprehensive Psychosocial Summary**

1. Identifying Information
2. Chief Complaint
3. Present Illness
4. Past Psychiatric History
5. Medical History
6. Psychosocial History
   - **a.** Development and Family History
   - **b.** Education and Work History
7. Alerts
8. Assets/Strengths
9. Treatment Recommendations (Full DSM IV: Axis I-V)
10. Plan

B. New York State Office of Mental Health Intensive Case Management Eligibility Criteria

In order to be considered for adult ICM services, an individual must fulfill the following general eligibility criteria:

- ☒ at least 18 years of age
- ☒ meet the OMH criteria for individuals with a serious mental illness

And ONE of the following specific conditions:

1. Have experienced 3 separate psychiatric admissions within the preceding 24 months (please attach consecutive history of psychiatric admissions).
2. Have utilized psychiatric emergency services (crisis team and/or emergency room) on at least 3 separate occasions within the preceding 12 months (please give facility and admission date).
3. Currently inpatient in state psychiatric facility for at least 90 days and in need of extensive assistance to return to the community (please give facility and admission date).
4. Currently living in homeless shelter, other non-permanent housing or on the street.

C. New York State Office of Mental Health Assertive Community Treatment (ACT) Eligibility Criteria

1. Person must be 18 years and older.
2. Person must have a severe and persistent mental illness that seriously impairs their functioning in the community.
3. Priority is given to people with schizophrenia, other psychotic disorders, bipolar disorder and/or major chronic depression.
4. Priority is given to individuals with continuous high service needs that are not being met in more traditional settings.