

## **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)

Referring Agency:

Address (Street):

Contact Name:

Phone Number:

E-mail:

This referral is a:  NASSAU RESIDENT  SUFFOLK RESIDENT

### Individual Information

#### General Info

First name:

AKA:

Social security #:

Homeless status:

Last name:

Date of birth:  Age:

Gender:

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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Individual Information (Continued)**

**Entitlements and Income**

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

Type	Amt	ID# / Pending / None
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<input type="text"/>
<input type="text"/>
<input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arson / Firesetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal Activities / Arrests and Convictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highly disorganized thought processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal Ideas / attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate touching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual acting out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance / alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideas / attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Psychotropic Medications**

3. Current psychotropic medications:

Name
<input type="text"/>
<input type="text"/>

**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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<input type="text"/>
<input type="text"/>
<input type="text"/>

**Physical Functioning Level**

Physical functioning level (answer each of the following):

Physical Function Level	Yes	No
Amputee	<input type="checkbox"/>	<input type="checkbox"/>
Bedridden	<input type="checkbox"/>	<input type="checkbox"/>
Blind	<input type="checkbox"/>	<input type="checkbox"/>
Can dress self	<input type="checkbox"/>	<input type="checkbox"/>
Can feed self	<input type="checkbox"/>	<input type="checkbox"/>
Can fully bathe self	<input type="checkbox"/>	<input type="checkbox"/>
Climbs one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Fully Ambulatory	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>
Mute	<input type="checkbox"/>	<input type="checkbox"/>
Needs help with toileting	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair Required	<input type="checkbox"/>	<input type="checkbox"/>

**Medical Hospitalizations**

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

Hospital	Adm. Date	Dis. Date	Chief Complaint
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Additional Challenges**

Does applicant smoke?  Yes  No

Does applicant have any other needs to be considered?

**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:



## 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	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Summary (including current clinical assessment signed off by a licensed Physician/Psychiatrist)	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Physical Exam (including PPD within 1 year of application date signed off by licensed physician)	<input type="checkbox"/>	<input type="checkbox"/>	
Physician's Authorization Form signed off by a licensed Physician/Psychiatrist (Licensed programs only: Supervised and Apartment Treatment only)	<input type="checkbox"/>	<input type="checkbox"/>	
PPD if separate from the Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

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 #