STEL
SOUTHERN TIER ENVIRONMENTS FOR LIVING

715 Central Avenue • Dunkirk, NY 14048 • Phone (716) 366-3200 • Fax (716) 366-7840
Email: info@STEL.org

REFERRAL PACKET

LICENSED HOUSING

Supervised Community Residences
Treatment Apartment Programs

Revised April 2021

Mail, email, or fax completed referral to:

STEL, Inc.
Attn: Stacey Barron, Client Caseworker
715 Central Avenue
Dunkirk, NY 14048

Email: barrons@stel.org

Fax: (716) 366-7840

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Stacey Barron, Client Caseworker, STEL, Inc., 715 Central Avenue, Dunkirk, NY 14048

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____
INSERT START DATE INSERT EXPIRATION DATE OR EVENT

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

☐ Patient declined copy

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH2557 and/or OMH 11 or 11A and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information or mental health clinical records. However, this form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Southern Tier Environments for Living, Inc.
Licensed Housing Application

For Housing Provider Use Only

Date Received_____ Disposition _____

Please attach copies of the most recent Progress Notes, Service Plan Reviews, Psychiatric Evaluations (*within one year*) and Psychosocial History.

I. APPLICANT DATA

Name: _____ Social Security #: _____
(Last) (First) (Middle)

Current Address: _____ Telephone #: _____
(Street)

_____
(City) (State) (Zip Code)

Months in current living situation _____

Previous Address: _____ County of Origin: _____

Date of Birth: _____/_____/_____ Sex: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Religion (optional): _____ Race (optional): _____

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

Family Contact: _____ Relationship: _____

Address: _____ Telephone #: _____

_____

II. DIAGNOSIS (DSM 5 Code)

ICD.10 Diagnosis _____ Code _____

ICD.10 Diagnosis _____ Code _____

Intellectual Level: (IQ) _____ Below 70 _____ 70-84 _____ Above 84

III. REFERRED BY

Referral Agency _____

Contact Person _____ Phone # _____ Fax # _____

Email Address _____

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 below or include in a psychosocial history:

_____
_____
_____
_____
_____
_____
_____

Describe Signs of Decompensation and/or Prodromal Symptoms: _____
_____
_____
_____
_____

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	☐	☐	☐	☐

Applicant's Name: _____

VI. 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_____
Name Telephone
_____
Street 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 # _____ ☐ Medicare D# _____
☐ 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: _____

VII. PREVIOUS RESIDENTIAL SERVICES

AGENCY	ADMISSION DATE	DISCHARGE DATE

VIII. 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)	ADMISSION DATE	DISCHARGE DATE

ER VISITS (list dates over last 6 months) _____

IX. PREVIOUS OUTPATIENT TREATMENT / CASE MANAGEMENT SERVICES (within the past 6 months)

AGENCY	TYPE OF SERVICE	ADMISSION DATE	DISCHARGE DATE

X. CURRENT OUTPATIENT TREATMENT

Agency _____ Address _____ Contact _____

Telephone _____ Date Linkage Completed _____

Prescribing Psychiatrist _____ Telephone #: _____

XI. CURRENT CARE COORDINATION/CASE MANAGEMENT

☐ None ☐ ACT ☐ HHCM ☐ Other Case Manager

☐ Active Agency _____

Case Manager's Name _____ Telephone # _____

☐ Pending - Referral has been made.

☐ Assisted Outpatient Treatment (AOT)

Applicant's Name: _____

MEDICATION	DOSAGE	FREQUENCY

XII. CURRENT COMMUNITY REHABILITATION AND SUPPORTS

(If an activity or support is pending or recommended, please note under comments.)

☐ IPRT	Agency _____	Contact _____	Tel. # _____
☐ Work	Agency _____	Contact _____	Tel. # _____
☐ Volunteer	Agency _____	Contact _____	Tel. # _____
☐ P.R.O.S	Agency _____	Contact _____	Tel. # _____
☐ Peer Services	Agency _____	Contact _____	Tel. # _____
☐ Self-Help Groups	Agency _____	Contact _____	Tel. # _____
☐ Social Clubs	Agency _____	Contact _____	Tel. # _____
☐ Clubhouses	Agency _____	Contact _____	Tel. # _____
☐ School	Agency _____	Contact _____	Tel. # _____

Please note days and hours of activities below:

_____

_____

Comments:

Other Social Supports: ☐ Family ☐ Job ☐ Other _____

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

XIII. CURRENT HEALTH CARE PROVIDER

Clinic _____ Contact _____ Tel. # _____

Address _____

Primary Care Physician _____

Advanced Directive ☐ Yes ☐ No

Contact Person: _____ Phone number: _____

Applicant's Name: _____

XIV. MEDICAL EXAMINATION

Date of most recent medical examination: _____

(Completed by a Physician, Nurse Practitioner or Physician's 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 and title of person completing this form: _____

Date: _____

Applicant's Name: _____

XV. TUBERCULOSIS TEST RESULTS

(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

PHYSICIAN AUTHORIZATION FOR REHABILITATION SERVICES OF COMMUNITY RESIDENCES

APPLICANT'S NAME: _____

APPLICANT'S MEDICAID NUMBER: _____

ICD.10 DIAGNOSIS: _____ CODE: _____

I, the undersigned licensed physician, based on clinical information and my face to face assessment of this client, have determined that _____ meets one of the following criteria (A, B or C) for severe and persistent mental illness (SPMI).

(Client's Name)

_____ **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. Reliance on Psychiatric Treatment, Rehabilitation and Supports.**

A documented history shows that the individual at some prior time met the threshold for items B (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 next page). This determination is in effect for the period from _____ to _____ at which time there will be an evaluation for continued stay.

Month/Day/Year	MD Name (please print)	Licensure #
	MD Signature	National Provider Identification #

PER MEDICAID REGULATIONS, PLEASE RETURN COMPLETED ORIGINAL PHYSICIAN AUTHORIZATION TO STEL.

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.