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

NON-LICENSED HOUSING

Supportive Housing SRO Program

Revised April 2021

Mail, email, or fax completed referral to:

STEL, Inc.
Janine Tomczak, Client Caseworker
715 Central Avenue
Dunkirk, NY 14048

Email: tomczakj@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:
Janine Tomczak, 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.

SUPPORTIVE HOUSING / SRO REFERRAL FORM

Homeless and Non-Homeless Programs (Non-licensed Housing)

Applicant Name _____ Referral Date _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Telephone _____ Length of Residence _____

DOB _____ Age _____ Marital Status _____ Veteran Y / N

SS#: _____ Medicaid #: _____ Other Ins.: _____

Referral Agency _____

Contact Person _____ Phone # _____ Fax # _____

Email Address _____

Primary Therapist _____ Agency _____

Phone # _____ Fax # _____ Email _____

Psychiatrist _____ Agency _____

Phone # _____ Fax #_____

Will applicant be living ☐ Alone ☐ With Spouse ☐ With Children ☐ With Others

Has applicant applied for Section 8 Assistance? ☐ Yes ☐ No If Yes, when? _____

Where does the applicant prefer to live? Specify neighborhood, village, town, etc. _____

☐ **A Recent Psychiatric Evaluation and Psycho-Social Assessment is Included to Complete the Referral.**

THE APPLICANT

	YES	NO	DON'T KNOW	
1.	☐	☐	☐	Is at least 18 years old.
2.	☐	☐	☐	Has a primary diagnosis of psychiatric illness. Other than alcohol or substance abuse.
				ICD.10 Diagnosis _____ Code _____
				ICD.10 Diagnosis _____ Code _____
3.	☐	☐	☐	Is medically stable.
4.	☐	☐	☐	Is psychiatrically stable.
5.	☐	☐	☐	Has no immediate potential or likelihood of harm to self or others.

	YES	NO	DON'T KNOW	
6.	☐	☐	☐	Is approved for or receiving :

- ☐ SSD Amount _____
- ☐ SSI Amount _____
- ☐ Public Assistance Amount _____
- ☐ VA Benefits Amount _____
- ☐ Other Income Amount _____

7. ☐ ☐ ☐ Meets the criteria for SPMI as defined by NYSOMH (checklist p.3)

8. ☐ ☐ ☐ At the time of referral lacks a fixed, regular, and adequate night time residence or lives in one of the following:

- ☐ A supervised public or private temporary shelter.
- ☐ An inpatient or rehabilitation facility for 28 days, homeless prior to admission and does not have resources to obtain housing at discharge.
- ☐ A public or private place not designed or used for sleeping accommodations for human beings.
- ☐ Facing eviction within one week (provide copy of eviction notice).
- ☐ A transitional housing program for homeless individuals.
- ☐ A welfare hotel.
- ☐ Other homeless situation, describe:

_____

9. ☐ ☐ ☐ Is capable of maintaining a household and managing independent living (paying rent, meeting nutritional, medical and mental health needs) with housing case management and support provided.

- ☐ Monthly
- ☐ Bi-Weekly
- ☐ Weekly
- ☐ More than once a week

10. Does the applicant have a history of any of the following: (Check all that apply.)

- ☐ Suicide Attempts
- ☐ Self-Abuse or Injury
- ☐ Assault
- ☐ Sex Offense / Child Molestation
- ☐ Homicide
- ☐ Fire Setting
- ☐ Arrest
- ☐ Substance Abuse
- ☐ Chronic Medical Condition

Provide explanation for items checked in # 10.

_____

_____

_____

_____

_____

_____

VERIFICATION OF HOMELESSNESS

Applicant's Name: _____ Date of Referral: _____

Section A: For Applicants to HUD Supportive Housing Programs

(At a minimum, one of the criteria in Section A must be met at the time of admission)

☐ Yes ☐ No At the time of the referral and admission, lacks a fixed, regular, and adequate night time residence and lives in one of the following:

☐ Yes ☐ No In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or the streets

☐ Yes ☐ No A supervised public or private emergency/temporary shelter (not transitional housing)

☐ Yes ☐ No Transitional/supportive housing program for homeless individuals or welfare hotel

☐ Yes ☐ No Hospital or other institution for thirty (30) days or less and was homeless upon admission to the hospital or other institution

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Section B: For Applicants to Single Room Occupancy Programs (SRO)

(At a minimum, one of the criteria under Nature of Homelessness must be met at the time of admission)

- Nature of Homelessness:

☐ Currently in emergency shelter
☐ Currently in hotel/motel
☐ Currently in transitional facility
☐ Current residence is condemned/dangerous
☐ Homeless
☐ At risk of becoming homeless
☐ Family violence
☐ Documented history of frequent evictions
☐ Temporarily doubled up in another person's residence
☐ Family has been separated legally/physically; may now be unified
☐ Unable to live independently without support services
☐ Other: _____

- Applicant would benefit from the SRO Program because (check all that apply):

☐ Can't afford market rent
☐ Current apartment is substandard
☐ Frequent moves
☐ Overcrowded
☐ Would benefit from supportive environment
☐ Physically handicapped
☐ Other disability: _____
☐ Other: _____

Person Completing Form: _____ **Date:** _____

CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMOUNG ADULTS
As defined by NYSOMH

Applicant _____ Completed By _____

Date _____

To be considered an adult with severe and persistent mental illness **A** must be met. In addition, **B** or **C** or **D** must be met.

A. Designated Mental Illness Diagnosis

☐ Yes ☐ No The individual is 18 hears of age or older and has a primary DSM-5 psychiatric diagnosis other than alcohol disorders, drug disorders, organic brain syndromes, or developmental disabilities.

AND

B. SSI or SSDI Enrollment due to Mental Illness

☐ Yes ☐ No The individual is currently enrolled in SSI / SSDI due to a designated mental illness.

OR

C. Extended Impairment in Functioning due to Mental Illness

1. The individual has experienced *two of the following four* functional limitations *due to a designated mental illness over the past 12 months* on a continuous or intermittent basis.

☐ Yes ☐ No a. Marked difficulties in self-care

☐ Yes ☐ No b. Marked restriction of activities of daily living

☐ Yes ☐ No c. Marked difficulties in maintaining social functioning

☐ Yes ☐ No d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.

OR

D. Reliance on Psychiatric Treatment, Rehabilitation, and Supports

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabil-itation and supports. Medication refers to psychotropic medications, which may control certain primary manifestations of 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 underlying mental disorder.

Professional Staff Signature: _____ Date: _____
(To be signed by a licensed/credentialed psychiatric or medical professional)

FUNCTIONAL ASSESSMENT WORKSHEET

Applicant _____ Completed By _____

Date _____

A. Self Care

- ☐ Needs assistance in maintaining personal hygiene.
- ☐ Needs assistance in gathering information regarding proper health care.
- ☐ Puts self at continual risk of injury.
- ☐ Needs assistance in securing proper health care, or complying with prescriptions or other medical procedures.
- ☐ Needs assistance in learning about medication and its administration.
- ☐ Needs assistance in learning about and maintaining proper nutrition.
- ☐ Needs assistance in making own appointments for doctors, services, etc.

B. Activities of Daily Living

- ☐ Needs assistance in utilizing public transportation on familiar or unfamiliar routes.
- ☐ Needs assistance with basic housekeeping chores.
- ☐ Needs assistance with day-to-day meal planning and preparation.
- ☐ Needs assistance with day-to-day money management.
- ☐ Needs assistance in fully accessing community resources, i.e. senior services, libraries, recreational activities, etc.
- ☐ Needs assistance in developing and maintaining social and recreational activities outside the home.
- ☐ Needs assistance in day-to-day self-administration of medications.
- ☐ Needs assistance in organizing and scheduling personal activities.
- ☐ Needs assistance in taking initiative/seeking out others for assistance with problems.
- ☐ Needs assistance from others to obtain and or retain entitlements, i.e. SSI, food stamps, Medicaid, etc.
- ☐ Needs assistance in budgeting and paying for recurring monthly expenses, occasionally runs out of money before the end of the month.

C. Social Functioning

- ☐ Lacks the skills to effectively and appropriately communicate with family and friends.
- ☐ Does not respond appropriately to individuals in authority.
- ☐ Repeatedly violates rules at home, work, or school.
- ☐ Is not fully aware of the array of legal rights available, including Constitutional and relevant resident/tenant rights and regulations.
- ☐ Does not willingly participate in social or recreational activities.
- ☐ Does not organize group activities with friends.
- ☐ Needs assistance in forming contacts with potential friends or interacting with strangers.
- ☐ Needs assistance in confronting criticism or other stressful situations.
- ☐ Needs assistance in advocating for own interests with landlords, homeowners, doctors, and/or service providers.

D. Ability to Concentrate

- ☐ Medication and/or mental illness interferes with the person's ability to focus and concentrate.
- ☐ Needs assistance in completing tasks and following through on personal goals and social activities.
- ☐ Lacks stability and proper support groups in his/her environment which would otherwise support clear thinking and concentration.
- ☐ Needs assistance in establishing and maintaining personal goals.

COMMENTS

_____

_____

_____

_____

MEDICAL & HEALTH INFORMATION
(Please Provide as Available)

Date of most recent physical examination _____ (attach copy if available)

Examining Physician / Nurse Practitioner / Physician Assistant _____

Location _____ Telephone # _____ Fax # _____

List all medical conditions as specific care instructions to be followed by the applicant.

Describe any physical conditions that will limit the applicant's mobility or their ability to live independently.

List any medications to which the applicant is sensitive.

Date of last dental exam _____ Performed by _____

Describe the applicant's dental needs

Other health / medical information