SINGLE POINT OF ACCESS

Long Island Mental Health Housing
Pilgrim Psychiatric Center
998 Crooked Hill Road
Building #72
West Brentwood, NY 11717

Phone: 631-231-3562
Fax: 631-231-4568
## Long Island Mental Health Housing Application

### INSTRUCTIONS

- Completed applications MUST include:
  - Psycho-Social History (see attached sample)
  - Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)
  - Recent Physical Exam (including PPD exam within 1 year of application date signed off by licensed physician)
  - Physician’s Authorization Form (licensed: Supervised and Apartment Treatment only)
  - Completed Housing Preference Form.

Any omissions will delay potential placement.

Please indicate the program for which you would like to be considered (please see summary):

- A. Supervised Community Residence
- B. Apartment Treatment
- C. Supported Housing

Please check any specific program you would be appropriate for (see summary for details)

- M.I.
- M.I. / M.R.
- Senior Citizens / Geriatric (Nassau Only-Over 55)
- MICA
- SOCR
- RCCA
- CR-SRO (Single Room Occupancy) Suffolk Only
- Young Adult (Ages 18-24)
- Family Housing (Supported Housing Only)
- Couples (Supported Housing Only)

Specify other individual: _____________________________

(May require addition application for other individual)

- HUD – Homeless Housing
- HIV / AIDS Housing (requires additional consent)
- Other _____________________________

Agency Preference (if any): ____________________________________________

Geographic Preference (if any): ____________________________________________

☐ Please check here if the applicant is not interested in services of the Peer Specialist Team. In the event the above is not checked the Housing Preferences Form will be forwarded to the Peer Specialist Team.

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

### Summary

#### Program descriptions

Community Residence programs are operated by private, not-for-profit organizations licensed by the New York State Office of Mental Health. The programs are staffed by trained professionals who are available (via beeper or telephone) as needed in addition to regularly scheduled on-site hours. Residents are offered Restorative Services and are trained in the following areas:

- Assertiveness / Self-Advocacy Training
- Community Integration / Resource Development
- Daily Living Skills
- Meditation Management / Training
- Parent Training
- Rehabilitative Counseling
- Skill Development
- Socialization
- Substance Abuse Services
- Symptom Management

These programs are considered transitional housing. Individuals applying for Senior Citizen / Geriatric CRs (Nassau Only) must be 55 and over. Individuals applying for placement in MI/MR housing must fall between 65 – 85 IQ. There are four levels of care under the title Community Residence Program:

#### Supervised CR (Licensed):

These programs are supervised 24 hours per day. Overnight staff members are available. These residences typically house 8 – 12 individuals in one large house. Food is provided. Residents are offered all restorative services (listed above), generally with an emphasis on Daily Living Skills such as cooking, cleaning, personal hygiene, food shopping and money management. Medication is supervised as needed.

#### State Operated Community Residence (SOCR) (Licensed)

This level houses between 10-24 residents, staffed 24 hours a day, meals and social activities provided. Services are the same as above.

#### Residential Care Center for Adults (RCCA) (Licensed) Suffolk Only:

RCCA is a very structured environment. This level houses 130 residents, staffed 24 hours a day, meals and social activities provided. Medication is monitored by staff.

#### CR- Single Room Occupancy (Licensed):

This level offers individuals their own bedrooms usually in a large building with up to 50 residents. Staff supervision is present 24 hours per day. Residents must be able to cook their own breakfast and lunch and can purchase a meal plan for dinner. Medication is monitored.

#### Apartment Treatment:

These programs typically receive staff visits several times each week, depending on level of need. There are generally 2 – 3 residents per house or apartment. Residents are expected to have good daily living skills, and be able to hold their own medication. Food is not provided. Instead, residents receive an allowance, which is used to purchase food and cleaning supplies.

#### Supported Housing

Supported Housing programs vary. Programs may offer single or double apartments, houses for three individual adults, or families. Individuals residing in Supported Housing pay 30% of their monthly income toward their rent. The rest of their rent is subsidized. Residents of these programs live fairly independently, and may receive visits 1- 4 times monthly. Supported Housing is considered long term housing.

#### Homeless Housing

All homeless programs are subject to the HUD definition of homelessness as there are different regulations for homeless housing.
Section A: Identifying Information: (Please print clearly)

1. First Name: _______________________________________________ Last Name: ____________________________________________

2. AKA: ____________________________________________________

3. Date of Birth: __________________/__________/__________________ (age: ____________)

4. Social Security #: _________________ - ____________ - _______________

5. Gender: (  ) Male (  ) Female

6. Current Marital Status: (  ) Single (  ) Married (  ) Divorced (  ) Separated (  ) Widowed

7. Homeless? (  ) Yes (  ) No If Yes, check type: (  ) Currently (  ) at Risk (  ) other (Please use page 6 to explain)

8. Address: (if applicant is homeless, indicate location. If applicant is hospitalized, list address / location prior to hospitalization on A side. If applicant currently lives in a Mental Health Facility list address and info on B side.)

   (A) Street: ____________________________________________ Apt. # ______________
   City: ____________________________________________ State: _______________ Zip Code: _______________
   Phone #: (_______)____________________________________

   (B) Street: ____________________________________________ Apt. # ______________
   City: ____________________________________________ State: _______________ Zip Code: _______________
   Phone #: (_______)____________________________________

9. Emergency Contact Name: ________________________________
   Address: Street: ____________________________________________ Apt. # ______________
   City: ____________________________________________ State: _______________ Zip Code: _______________
   Phone #: (_______)____________________________________

10. Number of Children to be housed: _________ Age(s) and Sex: ______________________________

11. Special Conditions: ___________________________________________________________________________________

12. Applicant’s Ethnicity: __________________________________

   Citizenship: (  ) USA (  ) Other
   If other, specify: ___________________________________________

13. Is the applicant a Veteran? (  ) Yes (  ) No
   Type of Discharge?________________________________________

14. List all Entitlements and income which the applicant receives or which are pending:

   Monthly Dollar ($) Amount ID Number or “P” for Pending

   (  ) Social Security
   (  ) SSI
   (  ) SSD
   (  ) PA
   (  ) Veterans
   (  ) Medicare
   (  ) Medicaid
   (  ) Food Stamps
   (  ) Pension
   (  ) Wages
   (  ) Worker’s Comp
   (  ) Unemployment
   (  ) Other

   Does the applicant have a Representative Payee? (  ) Yes (  ) No
   If yes: Name:_____________________________________________________________________________________
   Phone:(______)____________________________________________________________________________________

   Is the applicant paying an overpayment? (  ) Yes (  ) No
   How much?_________________ To what agency?__________________________________________________________

15. Is the applicant currently have or eligible for any of the following?:

   SCM: (  ) Yes (  ) No
   Contact Person: _________________________________________ Phone :(_______)________________________

   ICM: (  ) Yes (  ) No
   Contact Person: _________________________________________ Phone: (_______)_________________________

   AOT: (  ) Yes (  ) No
   Contact Person: _________________________________________ Phone :(_______)________________________

   ACT: (  ) Yes (  ) No
   Contact Person: _________________________________________ Phone :(_______)________________________

**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.**
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Section B: Housing, Employment and Education 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):

<table>
<thead>
<tr>
<th>Dates</th>
<th>Location</th>
<th>Reason for Leaving</th>
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</tbody>
</table>

2. Has applicant been employed during the last five years?
   ( ) Yes ( ) No ( ) Unknown

   If yes, please list dates and positions:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Position / Title / Type of Employment</th>
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<tbody>
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3. Educational / Training History (check all relevant items):
   ( ) Special Education
   ( ) Some High School
   ( ) H.S. Diploma or GED
   ( ) Some College
   ( ) College Degree
   ( ) Master’s Degree or higher
   ( ) Vocational Training, Trade: __________________________
   ( ) VESID Sponsorship: __________________________

4. What is the reason this referral is being made at this time? (Please answer on page 5).

Section C: Skills / Supports Assessment

1. Rate the degree to which the applicant can accomplish the following: (1=Cannot accomplish, 2=Accomplish with assistance, 3=Can accomplish independently, U=Unknown):

<table>
<thead>
<tr>
<th>Program Name</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>U</th>
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</thead>
<tbody>
<tr>
<td>Paying Rent</td>
<td></td>
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<tr>
<td>Housekeeping</td>
<td></td>
<td></td>
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<tr>
<td>Money Management</td>
<td></td>
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<tr>
<td>Program Participation</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Use kitchen appliances safely</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Use of leisure time</td>
<td></td>
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<tr>
<td>Communicate in non-threatening manner</td>
<td></td>
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<tr>
<td>Travel</td>
<td></td>
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<tr>
<td>Access and use of medical services</td>
<td></td>
<td></td>
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<tr>
<td>Prepare or obtain meals</td>
<td></td>
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<tr>
<td>Obtain food</td>
<td></td>
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<tr>
<td>Securing / Maintaining Benefits</td>
<td></td>
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<tr>
<td>Manage medication regimen</td>
<td></td>
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<tr>
<td>Maintain personal hygiene</td>
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<tr>
<td>Smoke safely (if applicable)</td>
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<tr>
<td>Manage symptoms</td>
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<tr>
<td>Refrain from substance abuse</td>
<td></td>
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</table>

2. Indicate all services the applicant regularly utilizes:

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Contact</th>
<th>Phone</th>
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<tbody>
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3. Indicate all support services needed once the applicant is housed:
   Health ( )
   Educational Program ( )
   MICA (Dual Dx) Day Program ( )
   MIMR ( )
   Psychiatric Day Program ( )
   Therapy ( )
   Clubhouse ( )
   Psychiatric Clinic / Psychiatrist ( )
   Alcohol / Drug Treatment Services ( )
   Alcoholics / Narcotics Anonymous ( )
   Vocational Program ( )
   On-site Case Management Services ( )
   Probation / Parole ( )
   Cognitive Rehab ( )
   None ( )
   Other: __________________________ ( )
**Long Island Mental Health Housing Application**

Applicant Name (Please Print Clearly):  
SS#:  

### Section D: Psychiatric Information

1. **Current Diagnosis** *(Include ALL Axis I and Axis II diagnoses and Diagnostic and Statistical Manual (DSM-IV) Codes)*:
   - **Axis I:**  
   - **Axis II:**  
   - **Axis III:**  
   - **Axis IV:**  
   - **Axis V:**  

   If available IQ test used:
   - Score:  
   - Date:  

   Psychiatrist’s Name:  
   Address:  
   Phone: (____)  

2. **Does the applicant have a history of, or is the applicant currently exhibiting any of the following?** *(Fill in all items: C = Current, H = history, both C and H if appropriate, N = Neither, or U = Unknown.)*
   - Homicidal ideas / attempts:  
   - Delusions: C H N U  
   - Hallucinations: C H N U  
   - Disruptive Behavior: C H N U  
   - Severe Depression: C H N U  
   - Highly disorganized thought processes: C H N U  
   - Criminal Activities / Arrests: C H N U  
   - Cognitive Impairment: C H N U  
   - Aggressive / Assaultiveness: C H N U  
   - Suicidal ideas / attempts: C H N U  
   - Arson / Firesetting: C H N U  
   - Sexual acting out: C H N U  
   - Compulsive behaviors: C H N U  
   - Inappropriate touching: C H N U  
   - Substance / alcohol abuse: C H N U  

   **Total length of time hospitalized:**  

3. **Current Psychotropic Medications:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Schedule</th>
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4. **What level of support does the applicant require to achieve medication compliance?**
   - None, independent
   - Supervision
   - Refuses / Non-compliant
   - Reminders
   - Not Applicable

5. **Is the applicant currently hospitalized?** *( ) Yes  ( ) No*
   - If so, Date of admission:  
   - Hospital name and ward:  
   - Contact Person:  
   - Phone: (____)  

6. **To the degree known, list all psychiatric hospitalizations and psychiatric emergency room use:**

<table>
<thead>
<tr>
<th>Hospital / ER</th>
<th>Adm. Date</th>
<th>Dis. Date</th>
<th>Reason</th>
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   **Total length of time hospitalized:**  

7. **Does the applicant have a history of substance abuse?** *( ) Yes  Substance(s):  
   - Frequency of use:  
   - ( ) Daily  ( ) Less than once a week  
   - ( ) Several times / week  ( ) Not Applicable  
   - ( ) Once weekly  ( ) Unknown  
   - ( ) No

8. **Does the applicant have a history of substance abuse treatment?** *( ) Yes  ( ) No*

<table>
<thead>
<tr>
<th>Name of Treatment Program</th>
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   **Length of time the applicant has spent substance free:**
   - Alcohol: since /  ( ) Not applicable
   - Drugs: since /  ( ) Not applicable

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4
**Section E: 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. This is to be added as page 7.

1. **Medical Diagnosis:** *(Include ALL Axis III Diagnoses):*
   
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________

   **Allergies:**
   ________________________________________________________

2. **Current non-psychotropic medications:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Schedule</th>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Adm. Date</th>
<th>Dis. Date</th>
<th>Chief Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>__________</td>
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4. **Physical Functioning Level** *(Answer each of the following):*

   **Yes** | **No**
   | Fully Ambulatory | ( ) | ( ) |
   | Climbs one fight of stairs | ( ) | ( ) |
   | Bedridden | ( ) | ( ) |
   | Wheelchair Required | ( ) | ( ) |
   | Amputee | ( ) | ( ) |
   | Blind | ( ) | ( ) |
   | Deaf | ( ) | ( ) |
   | Mute | ( ) | ( ) |
   | Incontinent | ( ) | ( ) |
   | Needs help with toileting | ( ) | ( ) |
   | Can fully bathe self | ( ) | ( ) |
   | Can feel self | ( ) | ( ) |
   | Can dress self | ( ) | ( ) |

**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?

____________________________________________________________________
____________________________________________________________________

**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 applicant allergic to animals? *( ) Yes *( ) No

If yes, please specify ____________________________________________

**Does applicant smoke cigarettes?** *( ) Yes *( ) No

Does applicant have any additional challenges or issues that may impact placement into mental health housing?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Long Island Mental Health Housing Application

Applicant Name (Please print clearly):      SS#:      

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

Referring Agency: _____________________________________________________________

Address: (Street)_______________________________________    (City)______________________  (State)________  (Zip)__________

Facility / Agency Type:____________________________________________________________________________________________

Referring Worker
I also attest that all the information contained herein is accurate to the best of my knowledge and is reflective of the applicant’s current situation.

Worker Name (Please Print Clearly)_______________________________________________

Title: ________________________________________________________________________

Phone: (______)_______________________FAX: (_______)________________________

Please be certain the following information has been included with and in addition to this application before signing:  
☐ Signature of Applicant (Required)  
☐ Psycho-Social History  
☐ Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)  
☐ Recent Physical Exam (including PPD within 1 year of application date signed off by licensed physician)  
☐ Physician’s Authorization Form (Licensed programs only: Supervised and Apartment Treatment only)  
☐ Completed Housing Preference Form.

Referral Signature: _______________________________________________        Date:___________________________
AUTHORIZATION FOR RESTORATIVE SERVICES
OF COMMUNITY RESIDENCES

☐ Initial Authorization
☐ Semi – Annual Authorization
☐ Annual Authorization

Client’s Name: ____________________________________________________________

Client’s Medicaid Number: __________________________________________________

ICD. 9 Diagnosis: __________________________________________________________

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that ________________ 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 #

EES on Eadmin\Sys\Home\Forms\Physician’s Authorization
The applicant should fill out this form, with assistance if necessary. The questions are intended to clarify the applicant's housing preferences, and to highlight the areas where a substantial difference between types of housing supports exists. The applicant is to specify his/her preferences today. The applicant, with assistance if necessary, may find it helpful to identify long-term housing goals and the immediate steps that may help to reach these goals. It is assumed that these preferences may change over time.

This information will be shared with the SPA Team to help identify your interests, but it does not provide a guarantee that your preferences will be satisfied.

1. Do you have a particular town or area that you would like to live in?
   
   1\textsuperscript{st} Preference___________________________________
   
   2\textsuperscript{nd} Preference___________________________________

2. Please check Yes or No in response to the following questions.

   Would you like assistance with learning how to:

   A. Prepare your own meals?  
      - Yes  
      - No

   B. Manage your money?  
      - Yes  
      - No

   C. Take your medication as prescribed?  
      - Yes  
      - No

   D. Have good personal hygiene skills?  
      - Yes  
      - No

   E. Travel (use buses, trains, etc.)?  
      - Yes  
      - No

   F. Keeping your personal area clean?  
      - Yes  
      - No

   G. Do your own laundry?  
      - Yes  
      - No

   H. Is there anything else you need help with?  
      - Yes  
      - No

   (If yes, please be specific) __________________________________________

(Please turn over)
3. In addition to your Service Plan, are you interested in:

- A Community Based Alternative Treatment Program: __________
  (Clubhouse Model Program, Psycho-Social Program, School or Vocational Training)

- Employment or an Employment Readiness Program __________

- Participating in the Housing Agency’s Consumer Counsel __________

- Other? Please specify: ____________________________________________

4. Are you interested in participating in social or recreational activities sponsored by the housing agency?

  ☐ Yes    ☐ No

5. Do you require handicap accessible housing?

  ☐ Yes    ☐ No

6. What other services are you seeking? (Self-Help, AA, NA, EA, Double Trouble, Social, etc.,) Please be specific: ______________________________________________
  ____________________________________________________________
  ____________________________________________________________

7. Is there anything else you would like the committee to know? ________________
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________