Oswego County Opportunities Inc.
Helping People. Supporting Communities. Changing Lives

Application for Mental Health Transitional Living Residential Services

Thank you for your interest in our program. Enclosed, you will find the application for Mental Health Transitional Living Programs- all items are to be returned to the address below, marked 'Confidential'. To expedite the process, please complete the packet in its entirety.

The following 4 included forms, must be completed, signed and dated by the **New York State Licensed doctor** currently providing you services. Any initial form signed by a psychologist N.P. or P.A cannot be accepted.

1. Authorization for Restorative Services of Community Residences
2. Prescribed Medication Form
3. Over-the-Counter Medication Form (OTC)
4. Assessment of Ability to Self-Medicate

During the intake process, you will be asked to provide additional information; records from providers, current treatment plans from psychologist, psychiatrist, Substance Abuse Treatment Programs, parole/probation etc. in order to assess need and eligibility for the OCO Inc. Mental Health Transition Living services and the ability of our program to meet specific needs.

Please feel free to contact the office at the phone number below with any questions.

Thank you,

Ewelina Wojnowska, Mental Health Program Coordinator
e-mail: ewojnowska@oco.org
Phone: (315)598-9110
Fax: (315)598-6317
Oswego County Opportunities, Inc.
239 Oneida Street, Fulton, New York 13069

OSWEGO COUNTY OPPORTUNITIES, INC.
MENTAL HEALTH TRANSITIONAL LIVING PROGRAM
APPLICATION FOR RESIDENTIAL SERVICES

Please fill out clearly and completely
to expedite the referral process.
Please include all requested information.

Please mail to:
Oswego County Opportunities, Inc.
Ewelina Wojnowska, MH Services Program Coordinator
239 Oneida Street, Fulton, NY 13069
Phone: (315) 598-9110 Fax: (315) 598-6317

Referral To:

____ Supervised community Residence - 24 hour on site staff supervision
____ Treatment Apartments - Staff visits weekly/daily, and as needed

Applicant's Name: _____ DOB: _____

Applicant's SSN: _____ Sex: _____

Applicants Medicaid #: _____

Current Address: _____

Telephone #: _____

County of Residence: _____

County of Origin: _____

Primary SMI Diagnosis: _____

Prescribing MD: _____

Date and location of last hospitalization: _____

Date of last physical: _____ Physician: _____

Applicants Funding Source: _____

Any Legal charges pending? _____

Date and charges: _____

Why is referral being made at this time and what OCO staff assistance/services are necessary for transition into more independent living?

_____
_____
_____

Referring Agency: _____
Referring Worker/Title: _____
Telephone #: _____ Date: _____

Once the above referral is received by OCO Inc. MH Coordinator, the referring agent and the applicant will be contacted to set up an intake interview.

**** Please note that Mental Health Transitional Living is intended to be a transitional placement only with reintegration to the community anticipated to occur within approximately 24 months. ****

Please Complete and Return:

____ Consent for Release of Information for any provider or support in place for the applicant
____ Psyckes consent
____ Physician's Authorization for Restorative Services
____ Physician's Medication Order Form
____ Physician's Assessment of Ability to Self-Medicate
____ Functional Assessment

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PHYSICIAN AUTHORIZATION FOR RESTORATIVE SERVICES OF OMH CERTIFIED RESIDENTIAL HOUSING

□ **Initial Authorization**

Please note this authorization is effective for:

- □ **6 months at Supervised Residence level**
- □ **1 year at the Apartment Treatment Program level**

CLIENT'S NAME: _____ DOB: _____

CLIENT'S MEDICAID NUMBER: _____

AXIS I DIAGNOSIS & ICD.10 CODE: _____

I, the undersigned NYS licensed physician, based on my review of the assessments made available to me, have determined that _____, would benefit from the provision of
(Client's name)

mental health restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period from: _____ to: _____, at which time there will be an evaluation for continued stay.

_____(Initial here) signed during face to face appointment

__/__/__
Mo. Day Yr.

_____
Physician Name
(Please Print)

_____
Licensure #

_____
Physician Signature

_____
NPI #

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

_____
Managed Care Physician

_____
Managed Care Provider ID#

Residential Services Department
239 Oneida Street | Fulton, NY 13069
| ph: 315-598-9110 | fax: 315-598-6317
Mental Health Services / Family Care

MENTAL HEALTH TRANSITIONAL LIVING PROGRAM

ASSESSMENT OF ABILITY TO SELF-MEDICATE

Consumer's Name: _____

[] Initial Assessment

The Assessment found that she/he:

____ (1) is capable of self-administering medication
____ (2) is capable of self-administration of medication when reminded or supervised (See "comments" below)
____ (3) neither of the above, (See "comments" below)

The above recommendation was based on these factors:

		YES	NO	COMMENTS
1.	Can Correctly name all medications			
2.	Knows purpose of each drug			
3.	Knows correct time to take medication			
4.	Correctly states dosage			
5.	Correctly states special instructions			
6.	If appropriate, has awareness of possible side effects			
7.	Understands proper storage procedure.			
8.	Knows how to handle special circumstances such as:			
	a. Takes the wrong medication			
	b. Misses a dose			
	c. Takes too much			
	d. Feels medication looks different than usual			
	e. Wishes to combine over the counter drugs and/or alcohol with prescribed medication			
9.	Realizes the importance of telling <u>all</u> their doctors what medications have been prescribed for them			

COMMENTS:

Physician/NP/PA Signature: _____ **Date:** _____

Physician's Recommendation for Over-the-Counter Medications

NAME:_____ **AGE:**_____

ALLERGIES:_____

PHYSICIAN/NP/PA:_____

(Please make a check mark where applicable)

Medication	Dosage	Frequency / Special Instructions	Recommended	Not Recommended
Tylenol / Acetaminophen	325 mg tabs / caps	Per Label Directions		
Extra-Strength Tylenol / Acetaminophen	500 mg tabs / caps	Per Label Directions		
Ibuprofen / Motrin	200 mg 500 mg 600 mg	Per Label Directions		
Aspirin	81 mg 325 mg 500 mg	Per Label Directions		
Hydrocortisone / Benadryl / Caladryl creams / lotions	Topical Ointments	Per Label Directions		
Bactine / Neosporin First Aid Creams Bacitracin		Per Label Directions		
Hydrogen Peroxide		Per Label Directions		
Decongestants Cough Suppressants		Per Label Directions		
Stimulants: Diet Pills /Caffeine Pills		Per Label Directions		
Tums /Anti-Acid tabs / suspensions		Per Label Directions		

The above named consumer's current medication regime, diagnosis / health concerns and allergies have been reviewed. There are no known contradictions / interactions involving their regular medications and these OTC medications. If the consumer requires the use of two consecutive dosages, or if the consumer is not feeling better, you will be notified for further recommendations. Unless otherwise indicated, these orders are in effect for one year.

PHYSICIAN'S/NP/PA SIGNATURE:_____

DATE:_____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize:

Oswego County Opportunities, Inc, Mental Health Transitional Living
239 Oneida Street, Fulton, NY 13069 Phone: 315-598-9110 Fax: 315-598-631

to communicate and exchange information with:

_____
Name of Provider

_____
Address and Phone # of Provider

Regarding information from the record of:

Name: _____ **DOB:**_____

Information released will be limited to financial, psychiatric and medical. The purpose of disclosure of information is to be used in determining and verifying program and funding eligibility.

I understand that my records are protected under Federal Regulations governing Confidentiality and the Health Insurance Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164, and can not be disclosed without my written consent unless otherwise provided for in the regulations.
The duration of this authorization is 12 months. This authorization will expire 30 days after discharge, should I discharge from the OCO MHTL program during that time.
I understand that I may revoke this authorization at any time by notifying the program in writing, *except to the extent that action has been taken in reliance on my consent.*

_____ _____
Signature of Applicant/Consumer Date

_____ _____
Signature of Witness Date

_____
Printed Name of Witness/Title

Residential Services Department
239 Oneida Street | Fulton, NY 13069
| ph: 315-598-9110 | fax: 315-598-6317
Mental Health Services / Family Care

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_____ _____
Signature of Applicant/Consumer Date

_____ _____
Signature of Witness Date

_____
Printed Name of Witness/Title

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Signature of Applicant/Consumer Date

_____ _____
Signature of Witness Date

_____
Printed Name of Witness/Title

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Mental Health Services / Family Care

Oswego County Opportunities
Mental Health Transitional Living Program
Referral
Skills Assessment – Service Needs

Applicant Name:_____ DOB: _____

Please check 'strength' or 'need' in each item.
Strength indicates you may not need the service, 'need' indicates a service that would be helpful.

Strength	**Need**	
		ASSERTIVENESS/ SELF-ADVOCACY TRAINING:
_____	_____	Able to assess needs and advocate for self
_____	_____	Able to respond to medical and safety needs, and other personal problems
_____	_____	Able to make positive decisions/choices about daily life and goals
		COMMUNITY INTEGRATION:
_____	_____	Can Identify and accesses community resources – funding, transportation, doctors
_____	_____	Uses available community supports -
_____	_____	Has developed and maintained a community support system
_____	_____	Is in need of housing
_____	_____	Can independently secure own housing
		DAILY LIVING SKILLS:
_____	_____	Can complete household chores independently
_____	_____	Keeps a safe and sanitary home
_____	_____	Has knowledge of Fire Safety
_____	_____	Budget money appropriately
_____	_____	Pays all bills - Can pay bills
_____	_____	Maintain personal hygiene – showers regularly and dresses for weather
_____	_____	Knows how to use clothes washer and dryer, keeps clothes clean
_____	_____	Has adequate clothing
_____	_____	Can Shop and prepare simple meals
_____	_____	Knows how to use Public Transportation – bus, taxi
_____	_____	Has a Representative Payee for benefits
		HEALTH SERVICES:
_____	_____	Educated on proper nutrition & follows recommended diet
_____	_____	Has proper awareness of physical health
_____	_____	Attends all doctor appointments – sees Dr. when needed
_____	_____	Follows recommendations of all doctors
_____	_____	Has an understanding of basic First Aid
_____	_____	Knows how to use medical emergency services appropriately
_____	_____	Knowledge of HIV/AIDS and other highly contractible diseases

Strength	Need	
		MEDICATIONS:
_____	_____	Knows names, dosages and times for all prescribed medications
_____	_____	Educated about roles, desired effects and side effects of meds
_____	_____	Self Administers all prescribed medications properly and on time
_____	_____	Stores medications properly and safely
_____	_____	Take all prescribed medications on time
_____	_____	Independently pick up all prescriptions and refills
_____	_____	Advocates for med changes appropriately, discusses with Doctor
		PARENTING TRAINING:
_____	_____	Displays positive family functioning
_____	_____	Assumes all parental responsibilities safely and adequately
_____	_____	Ensures child's health and safety adequately
_____	_____	Provides for child's needs – clothing, food, activities
_____	_____	Participates in Parenting classes
_____	_____	Maintains contact with Child Protective Services
		REHAB COUNSELING:
_____	_____	Able to Identify behaviors which interfere with goal setting
_____	_____	Understands the influence of impact of external or social stress
_____	_____	Able to develop and follow goals and objectives
_____	_____	Able to research and secure treatment options
_____	_____	Attends and participates in selected options/treatment
_____	_____	Can apply new behavior to housing and other situations
		SKILL DEVELOPMENT:
_____	_____	Participates in a Day Program or day activities (school, employment, volunteers, psycho-social, day treatment)
_____	_____	Attends Day Program consistently
_____	_____	Maintains a daily schedule as structured
_____	_____	Able to dress properly for day program
_____	_____	Displays effective coping for work/school related symptom management
		SOCIALIZATION:
_____	_____	Has Social supports, friends in community
_____	_____	Displays proper social interaction with others (no aggressive, hostile behaviors)
_____	_____	Able to initiate social contact with others
_____	_____	Has positive/adequate social supports in community
_____	_____	Attends group social activities regularly
_____	_____	Attends community activities independently

Strength	Need	
		SUBSTANCE ABUSE SERVICES:
_____	_____	No alcohol or drug abuse history
_____	_____	Attends and participates in routine outpatient SAS program
_____	_____	Is aware and educated in relapse prevention
_____	_____	Recently Reduced or eliminated the use of substance(s)
_____	_____	Has at least 6 months of consistent sobriety
_____	_____	Has at least 12 months of sobriety
		_____ Date of last use

SYMPTOM MANAGEMENT:

_____	_____	Has an understanding of mental health diagnosis
_____	_____	Understands symptoms of mental illness
_____	_____	Can identify and understand symptoms
_____	_____	Can identify positive coping techniques
_____	_____	Can utilize coping techniques to secure stability
_____	_____	Utilize positive coping strategies to maintain stability
_____	_____	Has achieved a maximum reduction of psychiatric symptoms
_____	_____	Can utilize emergency services properly when in need of assistance

ADDITIONAL:

_____ In need of 24 hour staff support and/or supervision
Includes daily medication monitoring.

_____ In need of housing with limited staff supervision – consists of daily staff visits, And emergency on-call, but no 24 hour on site staff supervision.

Current Housing: (check those that apply)

_____ Homeless – no home,
_____ Hospitalized
_____ Independent Living/Own apartment or home
_____ Live w/ Parents or other relative
_____ Live w/ Spouse or Significant Other
_____ Live w/ Friends, In a friend's home
_____ Other (Specify) - _____

Applicant Signature:_____ Date: _____
OR
Referring Agent Signature:_____ Date: _____

Identified needs will be used in assessing need of offered Rehab services and assist to determine appropriate level of services. Services will be incorporated in to treatment plans as necessary.