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,

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

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

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.
Jessica Hotaling, MH Services Program Coordinator
239 Oneida Street, Fulton, NY 13069
Phone: (315) 598-9110 Fax: (315) 598-6317

Referral To:

☐ Family Care – In home residential setting
☐ 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: _____

_____

Date: _____

Referring Worker/Title:
Telephone #: _____

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#

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MENTAL HEALTH TRANSITIONAL LIVING PROGRAM ASSESSMENT OF ABILITY TO SELF-MEDICATE

Consumer's Name: _____ [X] Initial Assessment

The Assessment found that she/he: Please circle one below.

(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 all 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: _____

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

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

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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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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 goa
		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

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:

Strength	**Need**	
_____	_____	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.

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_____	_____	_____
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

_____	_____
Signature of Patient or Patient's Legal Representative	Date

_____	_____
Print Name of Legal Representative (if applicable) to Patient (if applicable)	Relationship of Legal Representative

_____	_____
Signature of Witness	Print Name of Witness

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health information can only be used by your treatment provider to:
   - Provide you with medical treatment, care coordination, and related services
   - Evaluate and improve the quality of medical care provided to all patients
   - Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. **What Types of Information About You Are Included?** If you give consent, _____ can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: _____'s doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for _____ and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call _____ at _____ or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by _____; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any services from _____ or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to _____. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling _____ at _____. Note: Organizations that access your health information through _____ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.