

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

Applicant's Name (Please Print clearly): _____

SS#: _____

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, Health Services, Medication 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.

Long Island Mental Health Housing Application

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. # _____ (B) Street: _____ Apt. # _____
 City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____

- Phone #: (____) _____
 9. Emergency Contact Name: _____
 Address: Street: _____ Apt. # _____
 City: _____ State: _____ Zip Code: _____
 Phone #: (____) _____

Number of Children to be housed: _____ Age(s) and Sex: _____
 Special Conditions: _____

**10. Applicant's Ethnicity: _____
 Citizenship: USA Other

If other, specify: _____
 11. Is the applicant a Veteran? Yes No
 Type of Discharge? _____

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

Monthly Dollar (\$) Amount	ID Number or "P" for Pending
<input type="checkbox"/> Social Security	_____
<input type="checkbox"/> SSI	_____
<input type="checkbox"/> SSD	_____
<input type="checkbox"/> PA	_____
<input type="checkbox"/> Veterans	_____
<input type="checkbox"/> Medicare	_____
<input type="checkbox"/> Medicaid	_____
<input type="checkbox"/> Food Stamps	_____
<input type="checkbox"/> Pension	_____
<input type="checkbox"/> Wages	_____
<input type="checkbox"/> Worker's Comp	_____
<input type="checkbox"/> Unemployment	_____
<input type="checkbox"/> 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? _____

13. 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	Section C: Skills / Supports Assessment																																																																																																																																																																																							
<p>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):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Dates</th> <th style="width: 40%;">Location</th> <th style="width: 45%;">Reason for Leaving</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>2. 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<p>3. Educational / Training History (<i>check all relevant items</i>):</p> <p><input type="checkbox"/> Special Education</p> <p><input type="checkbox"/> Some High School</p> <p><input type="checkbox"/> H.S. Diploma or GED</p> <p><input type="checkbox"/> Some College</p> <p><input type="checkbox"/> College Degree</p> <p><input type="checkbox"/> Master's Degree or higher</p> <p><input type="checkbox"/> Vocational Training, Trade: _____</p> <p><input type="checkbox"/> VESID Sponsorship: _____</p> <p>4. What is the reason this referral is being made at this time? (Please answer on page 5).</p>																																																																																																																																																																																								

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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.)

	<u>C</u>	<u>H</u>	<u>N</u>	<u>U</u>
Homicidal ideas / attempts	()	()	()	()
Delusions	()	()	()	()
Hallucinations	()	()	()	()
Disruptive Behavior	()	()	()	()
Severe Depression	()	()	()	()
Highly disorganized thought processes	()	()	()	()
Criminal Activities / Arrests	()	()	()	()
Cognitive Impairment	()	()	()	()
Aggressive / Assaultiveness	()	()	()	()
Suicidal ideas / attempts	()	()	()	()
Arson / Firesetting	()	()	()	()
Sexual acting out	()	()	()	()
Compulsive behaviors	()	()	()	()
Inappropriate touching	()	()	()	()
Substance / alcohol abuse	()	()	()	()

3. Current Psychotropic Medications:

Name	Dosage	Schedule

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:

Hospital / ER	Adm. Date	Dis. Date	Reason

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

Name of Treatment Program	Date

Length of time the applicant has spent substance free:

Alcohol: since ____ / ____ () Not applicable
 Drugs: since ____ / ____ () Not applicable

Long Island Mental Health Housing Application

Applicant Name (Please print clearly): _____ SS#: _____

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.

<p>1. Medical Diagnosis: <i>(Include ALL Axis III Diagnoses)</i>:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Allergies: _____</p> <p>2. Current non-psychotropic medications:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 20%;">Dosage</th> <th style="width: 20%;">Schedule</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>3. To the degree known, list all medical hospitalizations during the past <i>three</i> years:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Hospital</th> <th style="width: 15%;">Adm. Date</th> <th style="width: 15%;">Dis. Date</th> <th style="width: 50%;">Chief Complaint</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>4. Physical Functioning Level <i>(Answer each of the following)</i>:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Yes</th> <th style="width: 15%; text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>Fully Ambulatory</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Climbs one flight of stairs</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Bedridden</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Wheelchair Required</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Amputee</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Blind</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Deaf</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Mute</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Incontinent</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Needs help with toileting</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Can fully bathe self</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Can feel self</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> <tr><td>Can dress self</td><td style="text-align: center;">()</td><td style="text-align: center;">()</td></tr> </tbody> </table>	Name	Dosage	Schedule																Hospital	Adm. Date	Dis. Date	Chief Complaint																		Yes	No	Fully Ambulatory	()	()	Climbs one flight of stairs	()	()	Bedridden	()	()	Wheelchair Required	()	()	Amputee	()	()	Blind	()	()	Deaf	()	()	Mute	()	()	Incontinent	()	()	Needs help with toileting	()	()	Can fully bathe self	()	()	Can feel self	()	()	Can dress self	()	()	<p>Does the applicant have a medical condition that requires special services? () Yes () No</p> <p>If so, indicate which services:</p> <p>() Special medical equipment Please Specify: _____</p> <p>() Medical supplies Please Specify: _____</p> <p>() Ongoing physician support</p> <p>() Nursing services</p> <p>() Home Care</p> <p>() Therapeutic diet</p> <p>() Injectable medication</p> <p>() Other _____</p> <p>What medical services is the applicant currently receiving?</p> <p>_____</p> <p>Name, address, and telephone number of treating physician:</p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p>Does applicant have pets? ** () Yes () No</p> <p>If yes, please specify _____</p> <p><small>**Please be aware that different programs have varying policies regarding pet ownership. In addition, pets may affect your entry into mental health housing.</small></p> <p>Is the applicant allergic to animals? () Yes () No</p> <p>If yes, please specify _____</p> <p>Does applicant smoke cigarettes? () Yes () No</p> <p>Does applicant have any additional challenges or issues that may impact placement into mental health housing?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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HOUSING PREFERENCES FORM

Applicant's Name: _____

SS#: _____

The applicant should fill out this form, with assistance if necessary. The questions are intended to clarify the applicants 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?

1st Preference _____

2nd 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Manage your money? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Take your medication as prescribed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Have good personal hygiene skills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Travel (use buses, trains, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Keeping your personal area clean? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Do your own laundry? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Is there anything else you need help with? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? _____
