Catholic Charities
of the Roman Catholic Diocese of Syracuse
Broome County

MENTAL HEALTH SERVICES
SINGLE POINT OF ENTRY
290 Front Street • Binghamton, New York 13905
(607) 723-9991 • Fax (607) 773-7891

Dear Referral:

Enclosed please find a Catholic Charities Central Referral Form packet for Mental Health Services and Residential Programs. Three requirements for mental health services with Catholic Charities are:

1. A mental health diagnosis and
2. A signed and witnessed release of information
3. 18 years of age or older

Please take this Referral Form to your therapist and have him/her fill it out indicating which services are recommended for you. Instructions for filling out this form are on the first page of the packet. When completed, please send to:

Central Referral Office
Catholic Charities Mental Health
290 Front Street
Binghamton, NY 13905

If you or your therapist should have any questions regarding this form, please do not hesitate to contact the Single Entry Coordinator at 723-9991, extension 317.

CATHOLIC CHARITIES
ADULT MENTAL HEALTH AND RESIDENTIAL PROGRAMS
CENTRAL REFERRAL FORM

SEND TO: Catholic Charities
Central Referral Office
290 Front Street
Binghamton, New York 13905

Phone: (607) 723-9991
Fax: (607) 773-7891

Catholic Charities offers a wide range of Mental Health Services and Residential Services for adults with a mental health diagnosis requiring assistance to live successfully in the community. Use this referral form to refer an individual to one or more services.

This referral form and the consent for release of information will begin the initial screening process for all services requested on the form. Once received, referrals will be routed to all services checked.

- Acceptance into any Catholic Charities Adult Mental Health and Residential Programs will not be contingent upon participation in other Catholic Charities Services.
- Requesting a program does not assure acceptance in that program.

Incomplete referrals may not be routed until all information is received and may be returned to the referral source for completion for such items as an incorrect or missing release of information or if a program request is absent.

- Please include as much detail as possible to assist with best serving the consumer.
- Certain services will require additional information and assessments. You will be notified if that is necessary.
- Final disposition letters will be sent to each referral source and/or consumer.
- Specific questions regarding requested programs may be directed to the identified program at 723-9991, Residential Services at 723-1804 or Four Seasons Club at 773-1184.

Agency Name: _____ Referral date _____

***Referring Person** (Print):* _____ Title _____

Address: _____

Phone #: (____) _____ Ext _____

For Case Management and Residential referrals, Agency Referral Sources are welcome to attend the Single Entry Meeting when the case is presented. Do you wish to attend? ☐ Yes ☐ No Comments: _____

AOT Candidate: ☐ Yes ☐ No Current AOT Client: ☐ Yes ☐ No

To be completed by **State Psychiatric Center** only: **SPC Long Stay** ☐ Yes ☐ No Date _____

1. *Consumer Information*

Consumer Name: Last _____ First _____ MI _____

Current Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Phone #: (____) _____ Gender: ☐ Male ☐ Female DOB: _____

Social Security #: _____ Highest Level of Education Completed _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Veteran: ☐ No ☐ Yes

CSS Certified: ☐ No ☐ Yes Date _____ Number _____

Emergency Contact Person: _____ Telephone #: (____) _____

Relationship to Person: _____

Number of children living in the home under the age of 18: _____

CONSUMER NAME _____

2. *Please check the Box(es) for Program(s) Requested.*

Referral will not be processed unless a program is requested and all paperwork is included:

√	Programs	Referral Packet Pages 1 – 6	Releases of Information		Psychiatric Assessment/ Evaluation	Form OMH 143a	Community Support Services Functional Assessment Worksheet	CSS Transportation Program Form
			Single Entry Case Management/ Residential Services	Catholic Charities				
☐	**Single Entry (SE) Case Management Services**	X	X		X			
☐	**SE Residential Services Community Residence**	X	X		X			
☐	**SE Residential Services Certified Apartment Program**	X	X		X			
☐	**Supported Housing (IAP)**	X	X		X			
☐	**Four Seasons**	X		X	X	X	X	
☐	**CSS Transportation Program**	X		X		X	X	X
☐	**Portfolios Café** Community Employment	X		X	X			
☐	**Job Club**	X		X	X			

3. *DSM-IV Diagnosis:* (*Code **and** Description required. Include **current psychiatric and chemical addiction diagnoses.***)

	Code	Description
Axis I	___ . ___	_____
	___ . ___	_____
	___ . ___	_____
	___ . ___	_____
Axis II	___ . ___	_____
		_____
Axis III	___ . ___	_____
Axis IV	___ . ___	_____
	GAF Score	_____

4. *Financial Status:* *(Monthly)* ☐ SSI $_____ ☐ SSD $_____ ☐ TANF $_____ ☐ VA $_____

☐ Other $_____

Medicare #:_____ Medicaid #:_____

Private Ins.:_____ ***Attach copies*** *(Medicaid, Medicare, and third party insurance cards)*

Managed Care Insurance Provider: ☐ Excellus ☐ Fidelis ☐ GHI ☐ CDPHP ☐ Max

Rep-Payee Services Needed: ☐ Yes ☐ No ☐ Unknown

Current Rep-Payee: ☐ No ☐ Unknown ☐ Yes Name_____

CONSUMER NAME _____

5. *Health Care Providers:*

A. Primary Care Physician Name: _____

Address: _____ Telephone #: (____) _____

B. Outpatient Psychiatrist's Name: _____

Address: _____ Telephone #: (____) _____

C. Current Therapist Name: _____

Address: _____ Telephone #: (____) _____

D. Current Case Management Services: ☐ Yes ☐ No

(If yes, list agency): _____

6. *Psychiatric Treatment (Include Forensic):*

A. Inpatient History: (include dates and facility names)

_____

_____

B. Outpatient History: (include dates and facility names)

_____

_____

7. *Chemical Dependence* History of Substance/Alcohol Abuse: ☐ Yes ☐ No ☐ Unknown

A. Inpatient History: (include dates and facility names)

_____

_____

B. Outpatient History: (include dates and facility names)

_____

_____

Pattern/Frequency of Current Use (include drugs of choice): _____

_____

Current Treatment: _____

8. *Co-occurring Disabilities/Conditions:* *(Check all that apply)*

☐ None	☐ Blindness	☐ Impaired ability to walk
☐ Drug or alcohol abuse	☐ Visual impairment	☐ Wheelchair required
☐ Tobacco	☐ Deaf	☐ Amputee
☐ Mental retardation or developmental disorder	☐ Hearing impairment	☐ Bedridden
	☐ Speech impairment	☐ Incontinence
☐ Cognitive disorder	☐ Unable to read/write	☐ Gambling
☐ Seizure disorder	☐ Diabetes	☐ Other; specify _____

Medical conditions that require special services? ☐ Yes ☐ No

If yes, explain: _____

_____

CONSUMER NAME _____

9. *High Risk Alerts:* *(Check if history of the following)*

- ☐ Suicide /Attempts
- ☐ Suicidal Threats
- ☐ Fire Setting
- ☐ Violent
- ☐ Assault
- ☐ Medical Issues
- ☐ Inappropriate Sexual Behavior
- ☐ Self-Injurious Behaviors
- ☐ Frequent Crisis Requiring Readmission
- ☐ Non-compliance with Medication
- ☐ Non-compliance with Appointments
- ☐ Victim of Physical/Sexual Abuse
- ☐ Other (Specify) _____

If checked, provide dates and a brief explanation:

_____

_____

_____

_____

10. *Criminal Justice System.* *(Check if current or past history of the following - Provide name of Probation/Parole Officer if current.)*

- ☐ Conviction of a Crime
- ☐ Charges Pending
- ☐ Currently Incarcerated
- ☐ Probation, expires _____
- ☐ Parole, expires _____
- ☐ CPL Status, expires _____
- ☐ Order of Condition, expires _____
- ☐ Order of Protection, expires _____

Provide details; please include dates if known: _____

_____

_____

_____

11. *Community Living Needs*

- ☐ Advocacy
- ☐ Budgetary Support
- ☐ Connection to Psychiatrist
- ☐ Coordination of Services
- ☐ Crisis Intervention
- ☐ Daily Living Skills
- ☐ DSS (Medicaid, Food Stamps)
- ☐ Education
- ☐ Employment/Vocational
- ☐ Family Support
- ☐ Friend or Social Needs
- ☐ General Health Care
- ☐ Home Management
- ☐ Housing
- ☐ Legal Referrals
- ☐ Links to Self-Help
- ☐ Medication Compliance
- ☐ Outpatient Treatment
- ☐ Psychosocial Rehab
- ☐ Social Security (obtaining)
- ☐ Substance Abuse Services
- ☐ Symptom Management
- ☐ Transportation
- ☐ Trauma Treatment
- ☐ Volunteering
- ☐ Other _____

If checked, provide brief narrative:

_____

_____

_____

_____

12. *History Of Homelessness:* ☐ Yes ☐ No ☐ Currently Homeless

How long at current address _____

Number of residences in past 2 years _____

Brief explanation: _____

_____

CONSUMER NAME _____

13. Cultural Issues *(for example, Language, social interaction, dietary restrictions)*: _____

_____

_____

14. Ethnicity:

- ☐ White
- ☐ African-American/Black
- ☐ Asian/Asian American
- ☐ Native American
- ☐ Latino/Hispanic
- ☐ Pacific Islander
- ☐ Other; specify _____

15 Treatment Team Recommendation: _____

_____

_____

_____

_____

16. Reason for Referral: _____

_____

_____

_____

_____

17. Consumer's Statement (optional): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This statement completed by: ☐ Consumer ☐ Family Member ☐ Advocate ☐ Other _____

☐ I participated in completing this form.

☐ Consumer did not participate.
☐ Referral completed without consumer present.

_____	_____	_____
Consumer (Print)	Signature	Date
_____	_____	_____
Witness (Print)	Signature	Date

CONSUMER NAME _____

18. *Current Medications:* ☐ Yes *(please list)* ☐ No ☐ Unknown ☐ Copy Attached

Medication	Dosage	Frequency	Prescribing Physician

FOR OFFICE USE ONLY ☐ CC Privacy Practices Form Received

Copies Routed to:

☐ Case Management ☐ Transportation ☐ Residential ☐ Supported Housing

☐ Four Seasons ☐ Portfolios ☐ Job Club

DISPOSITION (for Single Entry use only)

Date(s) Reviewed: _____

Status: ☐ Assigned to Transitional Case Management: _____

☐ Program assigned: _____

☐ Approved for services/housing, put on wait list: _____

☐ Not eligible for services; Reason: _____

☐ Further information needed (By: _____)

☐ Other: _____

Date Referent Contacted: _____

(MHS Rev 2/12)

CONSENT FOR RELEASE OF INFORMATION
FOR SINGLE POINT OF ENTRY FOR CASE MANAGEMENT & RESIDENTIAL SERVICES
Sponsored By: Catholic Charities of Broome County
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____ F_____
I authorize an exchange of PHI between: **SINGLE ENTRY COMMITTEE** (Including Representatives from): Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, Project Uplift, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Monroe Plan for Medical Care, Catholic Charities of Broome County	AND: (Name, address, title of person/organization/facility/program): Catholic Charities Single Point of Entry 290 Front Street Binghamton NY 13905

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____Diagnosis	_____Inpatient/Outpatient History
_____Treatment Plan	_____Psychiatric Assessment
_____Financial Status	_____Psychosocial History & Assessment

Purpose or need for information:

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☐ **Other (describe)** _____

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I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
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- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Single Point of Entry ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

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Signature of Consumer or Personal Representative	Printed Name of Consumer	Date
_____	_____	
Printed Name of Personal Representative	Description of Authority of Personal Representative	

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____	_____	_____
Signature of Witness	Name/Title	Date

Form:ROISE:Rev11/11

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FOR SINGLE POINT OF ENTRY FOR CASE MANAGEMENT & RESIDENTIAL SERVICES
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Form:ROISE:Rev11/11

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Form:ROISE:Rev11/11

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290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____ F_____
I authorize an exchange of PHI between: **SINGLE ENTRY COMMITTEE** (Including Representatives from): Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, Project Uplift, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Monroe Plan for Medical Care, Catholic Charities of Broome County	AND: (Name, address, title of person/organization/facility/program):

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____Diagnosis	_____Inpatient/Outpatient History
_____Treatment Plan	_____Psychiatric Assessment
_____Financial Status	_____Psychosocial History & Assessment

Purpose or need for information:

☐ **By the individual or his/her personal representative to facilitate placement in Case Management and/or Residential Services; or**

☐ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Single Point of Entry ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
Signature of Consumer or Personal Representative | Printed Name of Consumer | Date

_____ _____
Printed Name of Personal Representative | Description of Authority of Personal Representative

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____ _____ _____
Signature of Witness | Name/Title | Date

Form:ROISE:Rev11/11

CONSENT FOR RELEASE OF INFORMATION
FOR CATHOLIC CHARITIES MENTAL HEALTH SERVICES
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____F_____
I authorize an exchange of PHI between: **Catholic Charities Mental Health Services** **290 Front Street** **Binghamton, New York 13905**	AND: (Name, address, title of person/organization/facility/program):

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____Medication/Past & Present
_____Psychological and Neurological Tests
_____Psychosocial History & Assessment
_____Discharge Summary/Treatment Plans
_____Other (Progress Notes)
_____Medical, Lab & Physical Exam Information
_____Functional Assessment & Employment History
_____Referral Packet
_____Psychiatric Assessment
_____Physicians Authorization For Restorative Services

Purpose or need for information:
☒ **By the individual or his/her personal representative to facilitate admission and appropriate psychiatric rehabilitation treatment planning; or**
☐ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Catholic Charities ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
Signature of Consumer or Personal Representative | Printed Name of Consumer | Date

_____ _____
Printed Name of Personal Representative | Description of Authority of Personal Representative

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____ _____ _____
Signature of Witness | Name/Title | Date