



Transitional Living Services of Northern New York

482 Black River Parkway
WATERTOWN, NEW YORK 13601
(315)782-1777
FAX (315)785-8628

Thank-you for your interest in Adult Mental Health Services provided by Transitional Living Services of Northern New York. Below you will find a brief description of each service along with a checklist of what is needed to make a referral to each program:

ADULT RESIDENTIAL PROGRAMS:

The residential programs provide a supportive, structured environment enabling individuals with a serious persistent mental illness to learn skills necessary for independent community living. As individuals increase their independence and acquire needed skills they can transition to a less structured, more independent setting.

- **REFERRALS:** Please complete the Adult Referral form; attach a copy of the most recent psychiatric assessments, history and physical, social assessments, and/or psychological reports. The referral must also include an **ORIGINAL** Initial Authorization for Restorative Services Form (**page 6 of referral packet**) signed by a permanently NY State licensed physician.

SUPPORTED HOUSING PROGRAM:

Supported housing enables individuals to live more independently in the community. Supported Housing recipients must be able to live in the community with a minimum of staff intervention. Supported Housing can provide start-up costs to include security deposit and rental assistance.

- **REFERRALS:** Please complete the Adult Referral form. In addition a Supported Housing Eligibility Form (**page 7 of packet**) signed by a qualified treatment provider must be attached.

CASE MANAGEMENT PROGRAM:

Adult case management services will assist adults with a serious mental illness to access needed medical, social, psychosocial, educational, financial, and other services in order to support the consumer's maximum independent functioning in the community. Consumers do not need to be receiving Medicaid in order to qualify.

- **REFERRALS:** Please complete the Adult Referral form and attach a copy of the most recent psychological/psychiatric evaluation with documentation of psychiatric diagnosis.

EATING DISORDER CASE MANAGEMENT:

The Eating Disorder Case Management focuses on providing assistance to adults and children with eating disorders achieve independent living skills and stability in their psychiatric symptoms by linking to service systems, coordinating services and monitoring the provision of services by all agencies involved.

- **REFERRALS:** Please complete the Adult Referral form and attach a copy of the most recent psychological/psychiatric evaluation or documentation verifying an eating disorder diagnosis.



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Date: _____

Referring Agent: _____ Title: _____

Agency: _____ Telephone#: _____

Referring to: CIRCLE ONE	
Apartment Program	Community Residence
Supported Housing	Case Management
Eating Disorder Case Management	

Indicate need for language/interpretation services; specify language spoken other than **English**: _____

Identifying Data:

NAME: _____

ALIAS/MAIDEN: _____

SEX: Male Female

STREET: _____

CITY: _____

ZIP: _____

SS NUMBER: _____

DOB: _____

TELEPHONE #: _____

MARITAL STATUS: S M W D Separated

INSURANCE TYPE: _____

POLICY NUMBER: _____

ISSUING COUNTY: _____

VETERAN: Yes No

Please indicate if applicable:
<input type="checkbox"/> PC Long Stay
<input type="checkbox"/> MRT
<input type="checkbox"/> RCE

Emergency Contact:

NAME: _____

RELATIONSHIP: _____

STREET: _____

CITY: _____

PHONE: _____

NEAREST RELATIVE: _____

ADVANCED DIRECTIVES: Yes No

AGENT: _____

Psychiatric Information:

Psychiatric Providers:

Therapist: _____

Clinic: _____

Psychiatrist: _____

Clinic: _____

Diagnosis:

AXIS I: _____

CODE: _____

AXIS I: _____

CODE: _____

AXIS II: _____

CODE: _____

AXIS III: _____

CODE: _____

AVIS V: Current GAF: _____

CODE: _____

Current Medications:

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Medical Information:

Physical Exam Yes No Comments: _____

Mantoux Test (within 1 yr.) PPD Yes No Comments: _____

Sleep Apnea Yes No Comments: _____

Cardiac/COPD Problems Yes No Comments: _____

If yes, do you require oxygen/breathing machine? Yes No

Diabetes Yes No Comments: _____

If yes, are you required to test blood sugar? Yes No

If yes, are you independent with management? Yes No

Seizure Disorder Yes No Date of last incident: _____

Allergies Yes No Comments: _____

Special Diet Yes No Comments: _____

Limited Ambulation Yes No Comments: _____

Any restrictions of activities Yes No Comments: _____

Medical Providers:

Medical Doctor: _____ Practice: _____

Dentist: _____ Practice: _____

Specialist: _____ Practice: _____

Other: _____ Practice: _____

Specific Problems:

Resistant to treatment and/or medications Yes No Comments: _____

Multiple psychiatric admissions Yes No Comments: _____

Long term psychiatric admission (over 1 year) Yes No Comments: _____

MICA Yes No Comments: _____

Alcohol abuse

Drug abuse

Substance abuse treatment

Suicidal Ideations Yes No Comments: _____

Suicidal Attempts Yes No Comments: _____

Trauma Yes No Comments: _____

Sexual Misconduct Yes No Comments: _____

Sexual Offender Yes No Comments: _____

Property Damage Yes No Comments: _____

History of Violence Yes No Comments: _____

Criminal History Yes No Probation/Parole Officer: _____

Arson Yes No Comments: _____

Management Problems:

Daily living skills (cooking, chores, budgeting, etc) Yes No Comments: _____

Nighttime agitation Yes No Comments: _____

Temper outbursts Yes No Comments: _____

Incontinence Yes No Comments: _____

Elopement Yes No Comments: _____

Smokes safely Yes No Comments: _____

Frequent crisis contacts (ER, police, etc) Yes No Comments: _____

Social or Family Yes No Comments: _____

Aware of basic fire safety Yes No Comments: _____

Are you able to self-preserve? Yes No Comments: _____

Social Data:

Highest level of education: _____

ACCES-VR Involvement: Yes No Comments: _____

Employment training history: _____

Social/Day programs: _____

History of homelessness: _____

Previous supervised living placements: _____

Describe previous living environment the individual cannot return to along with specific problems/reasons: _____

Financial Information:

Social Security:

SSI Yes No Amount: _____

SSDI Yes No Amount: _____

Survivors Yes No Amount: _____

Retirement Yes No Amount: _____

Disabled Child Yes No Amount: _____

Public Assistance/DSS Benefits

Yes No DSS Caseworker: _____

Phone: _____

V.A. Pension

Yes No Amount: _____

Payee Status

Self Rep Payee

Name: _____

Address: _____

Phone: _____

Are you employed

Yes No Where: _____

Checking Account: _____

Savings Account: _____

Property: _____

Other: _____

Statement of Need/ Reason for Referral:

Please stated the reason(s) the referred individual needs this level of housing:

Please have person who is applying for services sign.

I am requesting that my referral packet be submitted to Transitional Living Services of Northern New York and its Admission Committee to determine eligibility for their programs. I understand this committee will be made up of individuals from within the agency and may include representatives from the adult programs, the Director of Adult Services, Director of Quality Assurance and Corporate Compliance and the Intake Coordinator. I give my permission for this committee to give and receive information regarding myself.

I am applying for admission to _____ program/residence.

Applicant's Signature: _____

Date: _____

INITIAL Authorization
for
Restorative Services of Community Residences
in
Adult Apartment and Congregate Residences

Transitional Living Services of Northern New York
482 Black River Parkway
Watertown, NY 13601

Initial Authorization for the receipt of Restorative Services not to exceed:

- 6 months for Congregate Residences (**Check One Only**)
 12 months for Apartment Residences (**Check One Only**)

CLIENT'S NAME: _____

CLIENT'S MEDICAID #: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, and having conducted a face-to-face assessment with said client as required pursuant to Part 593 of Title 14 NYCRR, have determined that

_____ would benefit from the provision of
(Client's Name)
mental health restorative services as known to me and defined pursuant to Part 593 of
Title 14 NYCRR.

Month/Day/Year

Physician's Signature

License Number & State

Type or Print Physician's Name

NPI Number

reviewed by (init/date) Provider enrollment in Medicaid verified by OPRA search [] Yes [] No
#140b 01/09/2014 (IniAuthAdult:forms)



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SUPPORTED HOUSING PROGRAM ELIGIBILITY CRITERIA

The purpose of the Supported Housing Program is to provide one time rental assistance, security deposits, and/or household goods to individuals who are capable of living on their own, in the community, with minimal supports.

Please fill in the individual Psychiatric Diagnosis and Code in the space provided and check all applicable criteria.

Client MUST meet criteria A:

(Please note: Autism and Mental Retardation ARE NOT diagnoses that meet this criteria)

_____A. Designated Mental Illness Diagnosis: The individual must be 18 years of age and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or personality disorders. ICD-9-CM categories and codes that do not have an equivalent in DSM-IV are also NOT included as designated mental illness diagnoses.

Diagnosis: _____ **Code:** _____

Client must ALSO meet one or more of the following:

_____B. SSI or SSDI Enrollment due to Mental Illness: The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

_____C. Extended Impairment in Functioning due to Mental Illness: The individual must meet 1 or 2 below:

1. The individual must be functionally disabled due to mental illness for at least the past twelve months either continuously or intermittently in at least two of the following areas: Self Care; Social Functioning; Activities of Daily Living; Ability to Concentrate

2. The individual has met the criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

_____D. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows the individual at some point prior, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports.

I verify that this individual has a severe and persistent mental illness and meets the eligibility criteria.

Name of Individual: _____

DOB: _____

 Signature of Registered Nurse, LMSW
 LCSW, LMHC, Psychiatrist, or Psychologist

 License Number

 Print Name

 Date