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 is a rental subsidy program which 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.

NON- MEDICAID 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 CARE MANAGEMENT:
The Eating Disorder Care 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.

HEALTH HOME CARE MANAGEMENT:
Health Home care management services will assist adults with a serious mental illness, or chronic medical conditions, to access needed medical, social, psychosocial, educational, financial, housing and other services in order to support the consumer's maximum independent functioning in the community.

- **REFERRALS:** Please complete the Health Home referral. Consumer must have active Medicaid, two or more chronic medical or mental Health conditions (list is attached to referral), or HIV/AIDS, or one or more serious mental health illness.

Transitional Living Services of Northern New York

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

Date: _____

Referring Agent:_____Title:_____

Agency:_____Telephone#:_____

Referring to: **CIRCLE ONE**	
Apartment Program	**Community Residence**
Supported Housing	**Non-Medicaid Case Management**
Eating Disorder Care 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:

☐ PC Long Stay

☐ MRT

☐ 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**

_____ **Provider enrollment in Medicaid verified by OPRA search [ ] Yes [ ] No**
reviewed by (init/date)

Transitional Living Services of Northern New York
482 Black River Parkway
WATERTOWN, NEW YORK 13601
(315)782-1777
FAX (315)785-8628
E-mail: services@tlsnny.com

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