New York State Western Region Application for Community Residence (CR) Programs

Special Note: Thank you for your referral to the community-based programs of the New York State Western Region. All programs listed below are co-ed and licensed by the Office of Mental Health, whose regulations state that **a letter of support from the youth's county-of-origin Single Point of Access (SPOA) committee is required to accompany the referral to the program(s)**. Contact the youth's county-of-origin SPOA coordinator for instructions regarding the SPOA process, as some counties vary in their process.

Instructions: Place an X in the space provided next to the CR program(s) that you would like your child to be considered for. For referrals to multiple programs, rank your preference by putting a number "1" next to your first choice, "2" next to your second choice, and so on.
*Please note the age requirements of each individual program.

Community Residence Programs:

Child & Family Services _____Lee Randall Jones CR (ages 5-14) 51 Rossler Avenue Cheektowaga, NY 14206 Phone (716) 894-1981 Fax (716) 894- 0999 residentialreferrals@cfsbny.org	Villa of Hope _____Tuckahoe Road CR (ages 12-18) 6313 Tuckahoe Road Williamson, NY 14589 Phone (315) 589-2547 Fax (315) 589-8190 www.villaofhope.org	Community Missions _____Aurora House CR (ages 12-18) 5311 Ernest Road Lockport, NY 14094 Phone (716) 433-1905 Fax (716) 433-2081 www.communitymissions.org
Pathways, Inc. _____Conable House (ages 5-12) 5 Vargason Place Bath, NY 14810 Phone (607) 664-1128 Fax (607) 664-1196 www.pathwaysforyou.org	Pathways, Inc. _____Lake Breeze CR (ages 13-17) 3101 State Route 21 South Canandaigua, NY 14424 Phone (585) 394-0380 Fax (585) 394-0385 www.pathwaysforyou.org	Rochester Psychiatric Center _____Smith Road CR (ages 12-18) 446 Smith Road Webster, NY 14580 Phone (585) 241-1778 Fax (585) 787-1683
_____Glove House CR (ages 12-18) 380 Laurentian Place Elmira, NY 14904 Phone (607) 733-1335 Fax (607) 733-2862	_____Cattaraugus Rehabilitation Center (ages 12-18) 2399 N. Union Street Ext. Olean, NY 14760 Phone (716) 375-4601 Fax (716) 375-5190 centralintake@rehabcenter.org	

ADMISSION CRITERIA

Minimum Regulatory Requirements for Admission: According to the New York State Office of Mental Health regulations (Part 594.8), youth admitted to a Community Residence program must meet the following *minimum criteria*:

1. Age: Each program serves a specific age range. Refer to Page 1 (cover sheet) of this referral packet to determine which programs serve which age ranges.
2. Designated mental illness diagnosis.
3. Substantial problems in social functioning due to a serious emotional disturbance (SED) within the past year.
4. Serious problems in family relationships, peer/social interaction, or school performance.
5. Serious and persistent symptoms of cognitive, affective, and personality disorders.
6. A level of service need which requires multi-agency intervention and involvement.
7. Capability of self-preservation, as evidenced by successfully completing a Standard Capability of Self-Preservation Test at the specific program(s) facility.
8. Residency: applications are accepted from the 19 counties within the NYS OMH Western New York Regional Office catchment areas for children and youth.

Additional Considerations for Eligibility for Admission at the Discretion of Each Program: Each program may request additional information for youth with the following criteria, and the resulting determination regarding eligibility for admission is made at the discretion of each program:

- ✓ IQ: measured IQ of at least 70. An IQ below 70 requires additional referral information for consideration.
- ✓ Medication: acceptance of medication therapy, if prescribed
- ✓ Other Medical Needs: special medical needs which cannot be safely or adequately met by the program
- ✓ School: willing and able to participate in school or another type of day program.
- ✓ Physical Aggression: history of physical aggression toward others
- ✓ Suicidal Gestures: history of self-harm and/or suicidal gesture or attempt
- ✓ Homicidal Gestures: history of homicidal ideation, gestures, or attempt
- ✓ Fire Setting: history of fire-play or fire-setting
- ✓ Sexualized Behavior: history of sexualized behavior
- ✓ Adjudication: as a Juvenile Delinquent (JD) or as a Person In Need of Supervision (PINS)
- ✓ Other: as identified based on each individual referral

Note: Each program is empowered to make decisions regarding each youth's acceptance into the program in accordance with New York State Office of Mental Health regulations (Part 594.8). However, no individual will be discriminated against or excluded from the program on the basis of race, religion, gender, sexual orientation, or ethnic origin.

FINANCIAL INFORMATION

Community Residence (CR) Programs

General Information:

- Funding for the residential fees and services for a child in the Community Residence programs is paid by Supplemental Security Income (SSI) and Medicaid reimbursement.
- *Parent/guardian consent is required for these benefits to be paid directly to the placement agency as the "representative payee" during the youth's placement in the program.*
- If a youth does not have SSI, you are required to initiate the application process by obtaining, completing, and submitting the application to the Social Security Administration. You can obtain an SSI application by visiting the Social Security Website http://www.ssa.gov/online/ssa-3820.pdf or by calling the toll free number 1-800-772-1213 (TTY 1-800-325-0778).
- If a youth does not have Medicaid, you are required to initiate the application process by obtaining, completing, and submitting the application to your local county Medicaid office.

Important Exceptions & Examples of when a youth may not be eligible for SSI, or may receive a reduced or partial payment due to other funding he/she receives, include, but are not limited to:

- Adoption Subsidy: When an Adoption Subsidy is received by the youth's parent/guardian, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Child Support Payments: When Child Support Payments are received by the youth's parent/guardian, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Survivor Benefits or SSD: When Survivor Benefits or SSD are received for the youth, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Youth in the Guardianship of their County Department of Social Services: If a youth's guardianship is with their county Department of Social Services (DSS) receipt of federal Title 4E benefits should be discussed with the placement agency.

For all of the examples above, arrangements must be made by the parent/guardian with the placement agency for the parent/guardian to pay the agency for the difference not paid by SSI.

Private Payment Option: Arrangements can be arranged by the parent/guardian with the placement agency.

QUESTIONS? If you have questions, concerns, or circumstances that are not addressed above:

(1) Contact the placement agency directly.
(2) Contact your local Social Security Administration and/or Medicaid offices.

The youth's parent/guardian is ultimately responsible for payment.

HOW TO APPLY TO A COMMUNITY RESIDENCE (CR):

1. Complete the enclosed Referral Application and assemble a complete referral application packet, including the following:

Minimum Regulatory Requirements for Referral: According to the New York State Office of Mental Health regulations (Part 594.8), a referral for admission to a Community Residence program must include:

. _____ Completed Referral Application

. _____ Documentation of support of the referral from the youth's county-of-origin Single Point of Access (SPOA) committee

. _____ Updated medical report (within the past 90 days)

. _____ Psychosocial assessment (within the past 90 days)

. _____ Psychiatric evaluation (within the past 90 days)

. _____ Educational assessment (within the past year)

. _____ Signed parent/guardian consent for referral/admission consideration

. _____ Description of the child's current behaviors and significant strengths and problems

. _____ Documentation that potentially less restrictive community, home and/or extended nonresidential services have been reasonably explored and are either not available or have not been successful.

. _____ Physicians Authorization for Community-Based Residential Services (note: select agencies may also request a copy of the physician's progress note that verifies a face-to-face contact on the date of the physician's authorization)

Additional Requested Information:

. _____ Copy of Birth Certificate (if youth is in custody/guardianship of adult(s) other than listed, include official documentation of custody status)

. _____ Copy of Immunizations

. _____ Individualized Education Plan (IEP) if applicable (for current school year)

. _____ Treatment plan (most recent – from current provider as applicable)

. _____ Individualized crisis management plan (most recent – from current provider as applicable)

. _____ Psychological Evaluation (most recent - within the past 3 years)

. _____ Any information relevant to the Admission Criteria "Additional Considerations" described on the previous page of this packet.

2. Submit application to the youth's county-of-origin SPOA committee. Contact SPOA coordinator for further directions in this step, as the process varies by county. ***REMINDER:*** NYS OMH regulations require documentation of SPOA's support of the referral to CR.

3. **The CR program staff will call you to arrange an interview with the referred youth and to invite you, the youth, and their family to tour the program and learn more information about the program (if this has not already taken place prior to referral).**
4. **Each program has a committee that reviews the referred youth and family's ability to benefit from and take part in the program. You will be invited to come to this meeting, and you will be informed in writing of the committee's decision.**
5. **If appropriate, the youth will be scheduled for a pre-placement visit(s).**
6. **If appropriate, anticipated opening(s) and an admission date will be discussed with the family.**

REFERRAL APPLICATION
FOR COMMUNITY RESIDENCE (CR)

YOUTH INFORMATION:

Youth's Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Gender:_____ Ethnicity:_____

Youth Citizenship: ◯ U.S. citizen ◯ Other (specify:_____)

Youth is Currently: ◯ Home ◯ Hospital ◯ Residential Placement (specify:_____)

Current Address:_____

_____County of Origin:_____

Telephone Number:__(_____)_____-_____extension:_____

Legal Guardian:_____ Relationship to Youth:_____

Name of Party Holding Custody (ex: DSS, OCFS):_____

Custodian's Address:_____

Home Phone:__(_____)_____-_____ Business Phone:__(_____)_____-_____

REFERRAL SOURCE INFORMATION:

Name of Referral Agent:_____

Title/Relationship to Youth:_____

Referral Agency:_____

Address:_____
(Street) (City) (State) (Zip) (County)

Telephone Number:__(_____)_____-_____extension:_____

Reason for Referral:_____

_____

What is the anticipated permanency/discharge plan for this youth?_____

_____

FAMILY INFORMATION:

Mother's Name: _____ Date of Birth: _____

Race/Ethnicity (optional): _____ Religious/Spiritual Affiliation (optional): _____

Address: _____ Telephone: (____) ____-____

_____ County of Origin: _____

Place of employment: _____ Telephone: (____) ____-____

Work Address: _____

Marital Status: _____ If applicable, date and to whom: _____

Name of Spouse/Significant Other: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Race/Ethnicity (optional): _____ Religious/Spiritual Affiliation (optional): _____

Address: _____ Telephone: (____) ____-____

_____ County of Origin: _____

Place of employment: _____ Telephone: (____) ____-____

Work Address: _____

Marital Status: _____ If applicable, date and to whom: _____

Name of Spouse/Significant Other: _____ Date of Birth: _____

Siblings:

NAME	**AGE**	**ADDRESS**	full	half	step	other

Additional Significant Caring Adults in Referred Youth's Life:

NAME	RELATIONSHIP	PHONE
		( ) -
		( ) -
		( ) -
		( ) -
		( ) -

YOUTH'S PLACEMENT HISTORY:

Age/Onset of Psychiatric Problems (describe):_____

Age of First Psychiatric Treatment (describe):_____

Psychiatric Hospitalizations:

Facility	*Dates*	*Therapist/Psychiatrist*	*Reason for hospitalization*

Other placements (list previous placements including OMH and DSS/OCFS placements):

Facility/Program	*Dates*	*Therapist/Psychiatrist*	*Reason for placement*

YOUTH'S MENTAL HEALTH INFORMATION:

Most recent psychiatric diagnosis (DSM 5):

Primary Diagnosis: _____

Other Diagnoses: _____

_____

_____

_____

_____

Diagnosed by (name & title):_____Date of Diagnosis:_____

Current therapist:_____ Telephone: (_____) _____-_____

Agency/Facility Name:_____

Agency Address:_____
(Street) (City) (State) (Zip) (County)

Current psychiatrist:_____ License #:_____

Agency/Facility Name:_____ Telephone: (_____) _____-_____

Agency Address:_____
(Street) (City) (State) (Zip) (County)

Prescribed Psychotropic Medications:

Medication	Dosage	Schedule	PRN? Y/N

Does the referred youth have a history of:

	YES	Date & Description of Most Recent Incident	NO	UNKNOWN
Fire setting				
Sexual Perpetration				
Sexual Victimization				
Sexualized Behaviors				
Verbal Aggression				
Physical Aggression				
Suicidal: Ideation				
Gestures				
Attempts				
Other Self-Harm				
Homicidal: Threats				
Gestures				
Substance Abuse				
Criminal Activities				
Legal Adjudication(s)				

Additional Information:_____

Drug/Alcohol History:

Please list any substance abuse assessments or treatments received by the referred youth:

Facility/Program	*Dates*	*Discharge Recommendations*

Is ongoing/further treatment indicated at this time? _____Yes _____No

If yes, describe:_____

YOUTH'S MEDICAL INFORMATION:

Physician:_____ Telephone: (_____)_____-_____

Address:_____
(Street) (City) (State) (Zip) (County)

Date of last physical exam:_____

Does this youth have allergies? If yes, specify:_____

Describe any ongoing medical needs/concerns (i.e., asthma, seizures, acne):_____

_____

Dentist:_____ Telephone: (_____)_____-_____

Address:_____
(Street) (City) (State) (Zip) (County)

Date of last dental exam:_____

Other Medical Providers currently providing services to this youth:

Name of Provider	***Address & Phone***	***Reason for Services***

Prescribed NON-Psychotropic Medications:

Medication	Dosage	Schedule	PRN? Y/N

YOUTH'S EDUCATIONAL INFORMATION:

Current School:_____ Grade:_____

Address:_____
(Street) (City) (State) (Zip) (County)

School Counselor:_____ Telephone: (_____) _____-_____

Current Educational Placement: ◯ Regular ◯ CSE ◯ 504 Plan

CSE Classification (check all that apply):

◯ NONE ◯ Emotionally Disturbed ◯ Learning Disabled

◯ Intellectually Disabled ◯ Speech Impaired ◯ Visually Impaired

◯ Hearing Impaired ◯ Other Health Impaired ◯ Other:_____

Diploma Eligibility (grades 9-12 only): ◯ Regents ◯ Local ◯ IEP Year:_____

Home School District:_____ Telephone: (_____) _____-_____

Address:_____
(Street) (City) (State) (Zip) (County)

IQ Test Results (if available):

Date Tested:_____ Test Administered:_____

Test Results: Performance:_____ Verbal:_____ Full Scale:_____

Test Administered by:_____ Title:_____

Estimated Functioning Level: ◯ Above Average ◯ Average

◯ Borderline ◯ Intellectually Disabled

FINANCIAL INFORMATION:

Youth's Medicaid Number:_____ County:_____

Other Medical Insurance Provider:_____

Policy Holder's Name:_____ Policy Number:_____

Does youth currently receive an SSI benefit? ◯ Yes ◯ No

If no, date SSI application was filed:_____

Does youth currently receive a Social Security Survivor's Benefit? ◯ Yes ◯ No

Is child support currently paid for this youth? ◯ Yes ◯ No

If yes, who receives the child support payment?_____

Is an adoption subsidy currently paid for this youth? ◯ Yes ◯ No

If yes, who receives the adoption subsidy?_____

Special Note: Any income received by the youth or on behalf of the youth may reduce the amount SSI pays to the placement agency. In these cases, the income received is expected to go towards the cost of care for the youth while placed with the agency.

The youth's parent/guardian is ultimately responsible for payment.

Referral Application Completed By:_____ Date:_____

CONSENT & SIGNATURES (required):

I have reviewed this referral application, and I consent to being considered for admission to the program(s) indicated.

Youth Signature:_____ Date:_____

I have reviewed this referral application, and I consent to my child being considered for admission to the program(s) indicated.

Parent/Guardian Signature:_____ Date:_____

CKC 6/20/2011; revised 2/27/2015