COUNTY of NASSAU
DEPARTMENT OF HUMAN SERVICES

Office of Mental Health, Chemical Dependency and Developmental Disabilities Services
60 Charles Lindbergh Boulevard, Suite 200, Uniondale, New York 11553-3687
Phone: (516) 227-7057 Fax: (516) 227-7076

SPOA CARE COORDINATION COMMUNITY REFERRAL

(To be used for any referral within Nassau County for medical, behavioral health and substance abuse care management services)

Services Referred to *(check all that apply:)* ☐ **Care Coordination** ☐ **ACT** ☐ **AOT**

Date:		
Last Name	**First Name**	**SSN**
Address: Street / Apt. / Town / State / Zip		
Alt. Address: Street / Apt. / Town / State / Zip		
AKA (also known as):		
Home Phone:	Mobile Phone:	Alt. Phone:
E-mail address:		

DEMOGRAPHIC INFORMATION

DOB:	Age:	Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Asian ☐ Alaskan Native ☐ American Indian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other, specify:

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Primary Language (spoken at home): ☐ English ☐ Spanish ☐ Other (specify):

Primary Language During Service Provision: ☐ English ☐ Spanish ☐ Other (specify):

If necessary, who will interpret?

ENTITLEMENTS

☐ Medicaid	Medicaid Number:
☐ Medicaid Managed Care	Medicaid Number: Managed Care Provider:
☐ Medicare	Medicare number:
☐ Private Insurance	Insurance Provider:
☐ No Insurance	

REFERRAL SOURCE

☐ Self, family or friend	☐ MR/DD Facility	☐ Family Court	☐ BHO
☐ Mental Health outpatient	☐ General Hospital ER	☐ Criminal Court	☐ Other Health Home:
☐ Mental Health inpatient	☐ General Hospital (inpatient)	☐ Parole	specify:
☐ Mental Health residential	☐ Other medical provider	☐ Probation	
☐ Substance Abuse Program		☐ Jail, penitentiary, etc.	

Applicant:	Medicaid #

REFERRAL INFORMATION		
Name		
Title:		
Agency:		
Phone #:		Ext:

PSYCHIATRIC DIAGNOSIS (including substance abuse)		
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V	**Current:**	**Past Year:**

ALL MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS MUST INCLUDE PSYCHOSOCIAL AND PSYCHIATRIC EVALUATIONS.

MEDICAL DIAGNOSIS (check all that apply)	
☐ Asthma	☐ Hypertension
☐ Diabetes	☐ Obesity (BMI >25)
☐ Heart Disease	☐ HIV/AIDS
☐ Other, please specify:	

ATTACH AVAILABLE SUPPORTING DOCUMENTATION OF MEDICAL DIAGNOSIS

MENTAL HEALTH/SUBSTANCE ABUSE/MEDICAL PROVIDERS, *if known*	
Outpatient MH Treatment Provider	Name
	Phone
Outpatient Substance Abuse Provider	Name
	Phone
Primary Health Care Provider	Name
	Phone
Other Medical Provider	Name
Specialty:	Phone
Other Medical Provider	Name
Specialty:	Phone

APPROPRIATENESS FOR HEALTH HOME *(Significant behavioral, medical or social risk factors that can be addressed through care coordination)* **CHECK ALL THAT APPLY AND EXPLAIN BELOW**

☐ Probable risk for adverse event, e.g., death, disability, inpatient or nursing home admission
☐ Lack of or inadequate social/family/housing support
☐ Lack of or inadequate connectivity with healthcare system
☐ Non-adherence to treatments or medication(s) or difficulty managing medications
☐ Recent release from incarceration or psychiatric hospitalization
☐ Deficits in activities of daily living such as dressing, eating, etc.
☐ Learning or cognitive issues

Applicant:	Medicaid #

Rationale (provide explanation/information/examples of items checked above, e.g., client is a BOCES graduate with cognitive impairments and diabetes who has lost his support network and is having difficulty keeping appointments):

_____

_____

_____

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_____

AOT REFERRALS CONTINUE ON PAGE 4

THIS SECTION FOR SPOA & HEALTH HOME USE ONLY

TO BE COMPLETED BY SPOA

Client meets eligibility for SMI Legacy Slot ☐ Yes ☐ No,
If Yes, assigned to: ☐ CNGC ☐ F·E·G·S ☐ MHA
OR
Client meets criteria for COBRA Legacy Slot ☐ Yes ☐ No,
If Yes, assigned to: ☐ EOC Suffolk ☐ OPTIONS ☐ TRI-CARE
OR
Does not meet Legacy criteria, refer to Health Home: ☐ F·E·G·S ☐ NS/LIJ
☐ Other, specify:

SPOA Reviewer (Print Name):	**SPOA Reviewer Signature:**	**Date**

TO BE COMPLETED BY HEALTH HOME

Medicaid Eligible *(confirmed through E-Paces)*: ☐ Yes ☐ No
Health Home eligibility *(confirmed through HCS Portal)* ☐ Yes ☐ No

☐ The supporting documentation has been reviewed and this client meets eligibility and appropriateness for a health home. Assigned for Initial Screening to:
OR
☐ The supporting documentation has been reviewed and this client does not meet eligibility and appropriateness for a health home. Referral source has been notified.

HH Reviewer Print Name	**HH Reviewer Signature**	**Date**

Applicant:	Medicaid #

AOT REFERRALS ONLY

Completion of additional information is required

Hospitalization history resulting from non-adherence with medication:		
Name of Hospital	**Date from**	**To**

Note: if exact date is unknown, the year of hospitalization MUST be listed.

Act(s) or threat(s) of violence: ☐ **YES** ☐ **NO**

If yes, provide the date(s):

Describe the incident(s) or threat(s):

Currently adherent with medication: ☐ **YES** ☐ **NO**

Please provide a brief narrative as to why this individual would benefit from an AOT Order: