East House
moving lives forward

Thank you for your interest in the East House Permanent Supportive Housing Program. For an applicant to be eligible for this program, he or she must meet all of the following criteria:

1. Single Adult (age 18 or older)
2. Have a primary diagnosis of a substance use disorder
3. Have active enrollment in Medicaid
4. Have a history of 2 inpatient hospitalizations *or* 5 emergency room visits within the past 12 months (or 1 inpatient *and* 4 emergency room visits) in the 12 months prior to entering treatment
5. Has limited income ($23,450.00 annually) eligible for rental subsidy;
6. Be a single adult planning on living alone
7. Have a history of, or is at risk of, homelessness

The following documents are needed for consideration for admission into the program:

- Medicaid Re-Design Team Permanent Supportive Housing Referral Form, attached
- Written documentation of hospitalizations and/or emergency room visits (discharge summaries)
- Current Psychosocial history including chemical dependency diagnosis from chemical dependency provider
- Written verification of history of homelessness from shelters or verification of imminent homelessness
- Permanent Supportive Housing Consent form (TRS 60), attached

- Addresses for the past 5 years
- RG&E print-out verifying that utilities can be turned on in the client's name
- Verification of financial resources
- Copy of Medicaid Card

To begin the referral process and to determine eligibility, please fax or mail complete referral to:

East House
Attn: Kaye Cunningham, Admissions Administrative Assistant
259 Monroe Avenue, Suite 200
Rochester NY 14607
Fax: (585) 238-8998

Office of Alcoholism and Substance Abuse Services
Medicaid Re-Design Team Permanent Supportive Housing Referral Form

REFERRAL AGENCY INFORMATION

Date of Referral ____/____/____ **Referring Agency:** _____

Contact Name: _____ **Phone Number:** (____)____-____

****

BASIC APPLICANT INFORMATION

First Name: _____ **Last Name:** _____

Sex: ____ **Marital Status:** _____ **DOB:** ____/____/____ **SSN#:** ____-____-____

Current address: _____

City: _____ **State:** ____ **ZIP:** _____

County of Residence: _____ **Phone Number:** (____)____-____

Marital Status: _____ **Number of Children:** _____ **Veteran:** ❒ *Yes* ❒ *No*

Medicaid CIN #: _____ **Medicaid Managed Care Organization:** _____

Highest Grade Completed: _____ **How many months employed in the past year:** _____

Current Legal Status: _____

Name and phone number of PO*(if applicable)*: _____

Homelessness Assessment

1. **For the past 30 days, have you been living in an inpatient facility or housing that you own, rent, or stay in as part of a household?** ❒ *Yes* ❒ *No* ***If yes,*** *skip the next question*
2. **How would you describe your most common housing situation over the past 30 days?**
   ❒ *Emergency or temporary housing (shelter)* ❒ *On street or abandoned building* ❒ *Other*_____
3. **When was the last time that you lived in the same apartment or house for 3 months or longer?**
   ❒ *In the past 6 months* ❒ *6 months-1 year ago* ❒ *1-3 years ago* ❒ *More than 3 years ago* ❒ *Don't know*

Risk of Homelessness Assessment (if tenant currently homeless, skip this section)

4. **Are you pending eviction within 30 days (with court papers/marshal's notice as back-up)?** ❒ Yes ❒ No
5. **Are there issues with the building in which you live (condemned, foreclosure, loss of physical accommodations, building damage)?** ❒ Yes ❒ No
6. **Are you living in an extreme overcrowded situation?** ❒ Yes ❒ No
7. **Are you living in an environment that may jeopardize your recovery?** ❒ Yes ❒ No
8. **Have you experienced sudden and significant loss of income?** ❒ Yes ❒ No
9. **Are you pending discharge from an inpatient facility (rehab, residential facility, hospital) within 30 days?**
   ❒ Yes ❒ No
10. **Do you have a residence identified or resources and support networks that can help you obtain access to housing?** ❒ Yes ❒ No

Substance Use

11. How many drinks containing alcohol do you have on a typical day when you are drinking?
❒ *Never* ❒ *1-2* ❒ *2-3* ❒ *3-4* ❒ *5-6* ❒ *7-9* ❒ *10 or more*

12. In the past 12 months, which substance, if any, has caused you the most serious problems?
❒ *None* ❒ *Alcohol* ❒ *Heroin* ❒ *Cocaine* ❒ *Marijuana/cannabis*
❒ *Stimulants* ❒ *Sedatives* ❒ *Prescription Drugs*

13. What is the qualifying substance use disorder? (*include DSM code*) _____

Health Service Use

14. Have you been in inpatient hospitalization 1 or more times in past 12 months?
❒ Yes ❒No If yes, how many? _____

15. Have you had 4 or more emergency room visits in past 12 months?
❒ Yes ❒No If yes, how many? _____

See page 3 of this form for a definition of the 12 month period

16. If currently inpatient, pending discharge date: _____/_____/_____

17. If currently in other residential setting (i.e., community residence, supportive living, transitional housing), what was admission date: _____/_____/_____ **pending discharge date:** _____/_____/_____

**** Referring agency should provide any supporting documentation that is available to support the above episodes ****

Physical and Mental Health

18. Secondary Diagnosis(es) (include MH): _____

19. Medical conditions: _____

20. Medications: _____

21. Name of Physician/Clinic: _____

22. How many days have you experienced medical problems in the past 30? _____

23. How many days have you experienced mental health problems in the past 30? _____

Certification of Program Eligibility

To be completed by MRT Housing Provider

ADMISSION REQUIREMENTS FOR HOUSING PROGRAM (please check):

- ☐ Applicant has a primary diagnosis of a substance use disorder
- ☐ Applicant is actively enrolled in Medicaid
- ☐ Applicant has a history of 2 inpatient hospitalizations, **or** 5 emergency room visits within the past 12 months (* **or** 1 inpatient **and** 4 emergency room visits)
- ☐ Applicant is a single adult living alone
- ☐ Applicant has history of or is at risk of homelessness *(see page 4 of this form for definition of at risk of homelessness)*

The 12 month period is defined as 12 months prior to the date of referral to the MRT Housing Program OR 12 months prior to the date of entry to a community residence, supportive living or other transitional housing program.

Certify the applicant has had 2 or more inpatient hospitalizations in past 12 months (*see above):

List facilities and dates:

_____

_____

_____

OR

Certify the applicant has had 5 or more emergency room visits in past 12 months (*see above):

List facilities and dates:

_____

_____

_____

_____

_____

_____

Housing Provider Staff First and Last Name: _____

Date: _____/_____/_____

At Risk of Homelessness – Definition

At risk of homelessness includes persons who are in imminent danger of losing their permanent housing due to a sudden change in the building, the ownership or the life situation of the resident such as:

- The household has received an eviction notice;
- Tenants in a building have been informed that a public safety condemnation is imminent;
- Foreclosure proceedings are pending on the household's rental housing;
- The household is in an extreme overcrowded situation (the number of persons exceeds health and/or safety standards for the unit's size);
- The person is living in an environment that may jeopardize their recovery (i.e., active substance use; drug sales) and has no financial means of immediately securing alternative permanent housing;
- Sudden and significant loss of income for the household;
- Sudden loss of existing physical accommodations (i.e., elevator no longer works);
- The building has sustained significant damage such as fire, loss of water, loss of heat; and
- The individual is pending a discharge from an inpatient facility (i.e., rehab, residential facility, state hospital) AND has no subsequent residence identified and lacks the resources and support networks needed to obtain access to housing due to their substance use disorder.

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING CHEMICAL DEPENDENCE TREATMENT FOR

PERMANENT SUPPORTIVE HOUSING

Applicant's Medicaid Identification Number

Applicant's Last Name, First, M.I.:
Housing Provider's Staff Member's Name:
Housing Provider's Name & Address:

INSTRUCTIONS: 1) PROVIDE A COPY OF THIS COMPLETED FORM TO THE APPLICANT;
2) ADD A COPY OF THIS COMPLETED FORM TO THE APPLICANT'S FILE; AND

1) I, the undersigned, Applicant, hereby **CONSENT** and authorize communication between and among the above named **Housing Provider**, New York State Office of Alcoholism and Substance Abuse Services (OASAS); New York State Department of Health (DOH); and National Center on Addiction and Substance Abuse at Columbia University (CASA).

I **CONSENT** to **DISCLOSURE OF INFORMATION** concerning my: first name; first initial of middle name; last name; maiden name; Medicaid Id number; date of birth; social security number; gender at birth, gender, date supportive housing began, date supportive housing ended, date of this consent and relevant information from the NYS Medicaid system and OASAS client data system.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to communicate as to my treatment needs, activities, history and evaluate my treatment for purposes of monitoring, case management purposes, and for carrying out other official duties;

AND

2) I further **CONSENT** and authorize communication between and among the above named **Housing Provider** and the New York State Office of Alcoholism and Substance Abuse Services (**OASAS**); and OASAS to **DISCLOSE** the above referenced **INFORMATION** to National Center on Addiction and Substance Abuse at Columbia University (**CASA**), for the **PURPOSE** of Medicaid utilization analysis and program evaluation activities. I understand that any reports or studies compiled from my records disclosed pursuant to this release will not include personally identifiable information which will remain confidential and protected from further re-disclosure.

I, the undersigned, have read the above and authorize the staff of the above named disclosing entities to disclose, obtain and share such information as herein specified. I understand that, unless otherwise specified, this consent will remain in effect for five years after I sign this consent OR leave my supportive housing unit, whichever is longer, unless this consent is revoked by me.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of such information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Print Name of Applicant)

(Signature of Applicant)

(Date)

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

- ☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
Signature of Patient or Patient's Legal Representative	Date	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
Signature of Witness	Print Name of Witness	