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:

<table>
<thead>
<tr>
<th>Child &amp; Family Services</th>
<th>Villa of Hope</th>
<th>Community Missions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee Randall Jones CR (ages 5-14)</td>
<td>Tuckahoe Road CR (ages 12-18)</td>
<td>Aurora House CR (ages 12-18)</td>
</tr>
<tr>
<td>51 Rossler Avenue</td>
<td>6313 Tuckahoe Road</td>
<td>5311 Ernest Road</td>
</tr>
<tr>
<td>Cheektowaga, NY 14206</td>
<td>Williamson, NY 14589</td>
<td>Lockport, NY 14094</td>
</tr>
<tr>
<td>Phone (716) 894-1981</td>
<td>Phone (315) 589-2547</td>
<td>Phone (716) 433-1905</td>
</tr>
<tr>
<td>Fax (716) 894-0999</td>
<td>Fax (315) 589-8190</td>
<td>Fax (716) 433-2081</td>
</tr>
<tr>
<td><a href="mailto:residentialreferrals@cfsbny.org">residentialreferrals@cfsbny.org</a></td>
<td><a href="http://www.villaofhope.org">www.villaofhope.org</a></td>
<td><a href="http://www.communitymissions.org">www.communitymissions.org</a></td>
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<tr>
<td>Pathways, Inc.</td>
<td>Pathways, Inc.</td>
<td>Rochester Psychiatric Center</td>
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<tr>
<td>Conable House (ages 5-12)</td>
<td>Lake Breeze CR (ages 13-17)</td>
<td>Smith Road CR (ages 12-18)</td>
</tr>
<tr>
<td>5 Vargason Place</td>
<td>3101 State Route 21 South</td>
<td>446 Smith Road</td>
</tr>
<tr>
<td>Bath, NY 14810</td>
<td>Canandaigua, NY 14424</td>
<td>Webstyer, NY 14580</td>
</tr>
<tr>
<td>Phone (607) 664-1128</td>
<td>Phone (585) 394-0380</td>
<td>Phone (585) 241-1778</td>
</tr>
<tr>
<td>Fax (607) 664-1196</td>
<td>Fax (585) 394-0385</td>
<td>Fax (585) 787-1683</td>
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<tr>
<td><a href="http://www.pathwaysforyou.org">www.pathwaysforyou.org</a></td>
<td><a href="http://www.pathwaysforyou.org">www.pathwaysforyou.org</a></td>
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<tr>
<td>Glove House CR (ages 12-18)</td>
<td>Cattaraugus Rehabilitation Center (ages 12-18)</td>
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<tr>
<td>380 Laurentian Place</td>
<td>2399 N. Union Street Ext.</td>
<td></td>
</tr>
<tr>
<td>Elmira, NY 14904</td>
<td>Olean, NY 14760</td>
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<tr>
<td>Phone (607) 733-1335</td>
<td>Phone (716) 375-4601</td>
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<tr>
<td>Fax (607) 733-2862</td>
<td>Fax (716) 375-5190</td>
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<td><a href="mailto:centralintake@rehabcenter.org">centralintake@rehabcenter.org</a></td>
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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](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.

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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.

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

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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.

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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?________________________

______________________________________________________________________________
Referral Application - Page 2

**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:**

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>ADDRESS</th>
<th>full</th>
<th>half</th>
<th>step</th>
<th>other</th>
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Additional Significant Caring Adults in Referred Youth’s Life:

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<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
<th>PHONE</th>
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YOUTH’S PLACEMENT HISTORY:

Age/Onset of Psychiatric Problems (describe):

Age of First Psychiatric Treatment (describe):

Psychiatric Hospitalizations:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Dates</th>
<th>Therapist/Psychiatrist</th>
<th>Reason for hospitalization</th>
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<tbody>
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Other placements (list previous placements including OMH and DSS/OCFS placements):

<table>
<thead>
<tr>
<th>Facility/Program</th>
<th>Dates</th>
<th>Therapist/Psychiatrist</th>
<th>Reason for placement</th>
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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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Schedule</th>
<th>PRN? Y/N</th>
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</table>
## Does the referred youth have a history of:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>Date &amp; Description of Most Recent Incident</th>
<th>NO</th>
<th>UNKNOWN</th>
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</thead>
<tbody>
<tr>
<td>Fire setting</td>
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<tr>
<td>Sexual Perpetration</td>
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<tr>
<td>Sexual Victimization</td>
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<tr>
<td>Sexualized Behaviors</td>
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<tr>
<td>Verbal Aggression</td>
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<tr>
<td>Physical Aggression</td>
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<td>Suicidal: Ideation</td>
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<td>Gestures</td>
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<td>Attempts</td>
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<td>Other Self-Harm</td>
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<td>Homicidal: Threats</td>
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<td>Gestures</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Criminal Activities</td>
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<tr>
<td>Legal Adjudication(s)</td>
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</tbody>
</table>

Additional Information: ____________________________________________________________

### Drug/Alcohol History:

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

<table>
<thead>
<tr>
<th>Facility/Program</th>
<th>Dates</th>
<th>Discharge Recommendations</th>
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</table>

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:

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Address &amp; Phone</th>
<th>Reason for Services</th>
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Prescribed NON-Psychotropic Medications:

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Schedule</th>
<th>PRN? Y/N</th>
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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