Broome County Adult Single Point of Access (A-SPOA)

Physician's Authorization Form

Level of Care: Certified Apartment Program (1 yr.)

Applicant's NAME: ____ Applicant's DOB: ____________________

PURPOSE	Pursuant to NYCRR Mental Hygiene Law §593.6(a), for the provision of community rehabilitation services [MHY §593.4(b) and (c)] offered under the oversight of the New York State Office of Mental Health, providers must seek authorization from a physician, in writing, prior to admission.
INSTRUCTIONS	Complete Page One (1) of the ***Physician's Authorization Form***. Please refer to Page (2) for additional instructions and references for each requested entry.
SUBMISSION	Submit completed ***Physician's Authorization Form*** to: AdultSPOA@BroomeCounty.us **Questions:** Contact Adult SPOA Coordinator at: Phone: (607) 778-1119 · Fax: (607) 778-6189

SECTION 1 – Applicant Information

1. **Diagnosis(es):** ***(Demonstrating eligibility for Severe and Persistent Mental Illness)***

2. ICD 10 Code:	**3. Medicaid #:**

4. **Eligibility:** ***(Please check both boxes if applicant is qualified for services)***

☐ The above-named applicant is in need of community rehabilitation, as defined by Mental Hygiene Law 593.4(b)

☐ The above-named individual has been, based on assessments provided and/or face-to-face evaluation, determined to meet the eligibility criteria for severe and persistent mental illness.

SECTION 2 – Eligibility Timeframe

5. **Enter the timeframe for which services are authorized:**
(Initial approvals are for One (1) Year. Example: 2/1/2022 to 1/31/2023)

This authorization shall be in effect for the period of _________ to __________at which time an evaluation for continued services at this level will be completed.

SECTION 3 - Attestation

6. **Attestation**

Pursuant of NYCRR Mental Hygiene Law §593.5(b), I, the undersigned licensed health care provider, have determined, based on my review of the assessments made available to me and face-to-face contacts with the above-named applicant, recommend the provision of mental health community rehabilitation services at Catholic Charities of Broome County's ***Certified Apartment Program***.

Print Name	**Licensure Number**	**NPI Number**

Signature ***(Per MHY § 593.6(a), the signing provider must be a physician)***	**Date**

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Applicant's NAME: ____ Applicant's DOB: ___________________

INSTRUCTIONS

Section 1- Applicant Information

1. **Diagnosis(es):**
   a. **<u>Definition of Serious and Persistent Mental Illness</u>**
   (For full explanation of definitions visit: https://omh.ny.gov/omhweb/guidance/serious_persistent_mental_illness.html)
      i. Individual must be 18 years of age and currently meet criteria for a DSM-IV psychiatric diagnosis
      ii. Meet criteria for one of the following:
         a. SSI or SSD due to mental illness
         b. Extended impairment in functioning due to mental illness
         c. Reliance on psychiatric treatment, rehabilitation and supports

   b. **Instructions:** Write or Type the diagnosis or diagnoses that meet the criteria as listed in the definition to demonstrate eligibility for community rehabilitation services.

2. **ICD 10 Code:**
   a. **Definition of ICD 10:** International Classification of Diseases, 10th Revision
   b. **Instructions:** Write or type the ICD 10 code associated with the diagnosis(es) entered in Box One (1).

3. **Medicaid #:**
   a. **Definition of Medicaid #:** The Medicaid #, or Client Identification Number (CIN), is the first nine characters of the identification number located on the front of the member's Benefits Identification Card (BIC).
   b. **Instructions:** Write or Type the CIN for the individual seeking services into Box 3. This will be two (2) letters, five (5) numbers, and one (1) number.

4. **Eligibility**
   a. **Definition:** Pursuant to NYCRR MHY §595.4(a)(1): admission criteria which are identified for use in determining an individual's eligibility for admission to a residential services program.
   b. **Instructions:** Check or Click each box located in Box Four (4) that are applicable to the individuals seeking services. Both boxes must be checked for an individual to be eligible for services.

Section 2 – Eligibility Timeframe

5. **Enter timeframe for which services are authorized**
   a. **Definition:** Pursuant to NYCRR MHY §593.6(b)(2), individuals admitted to community rehabilitation services are required to have service authorization renewals every twelve months.
   b. **Instructions:** Enter the timeframe in which the authorization is approved for the individual seeking services to remain eligible for community rehabilitation services. Initial approvals are for one year. Enter the initiated date on the first line, and the expiration date on the second line in Box five (5).

Section 3 - Attestation

6. **Attestation**
   a. **Definition**: The authorization of the signing provider that the individual seeking services meets the eligibility criteria and is authorized for consideration for admission to community rehabilitation services.
   b. **Instructions**: Write or Type printed name, licensure number, and NPI number. Sign and date in designated areas.

END OF DOCUMENT