Saratoga County Single Point of Access

Children's SPOA Universal Referral Form

135 South Broadway
Saratoga Springs, New York 12866
Telephone: (518) 584-9030
Fax: (518) 581-1709

Child's Name (Last, First, M.I.)**:**

Sex:	**Date of Birth:**	**Social Security #** :

Parent/Guardian's Name:	**Telephone:**

Relationship to Child/Custody Status:

Address:	**City:**	**State:**	**Zip Code:**

Type of health coverage (for this child)**:**	**Youth Meets NYS DOH Eligibility Criteria** (attach documentation)**:**
☐ Medicaid: **CIN # required** _____ (ex. DF10447A)	☐ Two Chronic Health Conditions *or*
☐ Commercial _____	☐ HIV / AIDS *or*
	☐ Serious Emotional Disturbance *or*
	☐ Complex Trauma (please include complex trauma screen) *and*
☐ Other/None _____	☐ Significant Behavioral, Medical or Social Risk Factors

Diagnoses (list Primary Mental Health ICD.10 Diagnosis first)**:**	**Psychiatric Hospitalizations** (include hospital names, dates of service)**:**

Past and/or Present Service Providers:		**Education:**		
☐ Care Management	☐ Probation PINS/Diversion	Home School District:		
☐ HCBS/Waiver	☐ DSS Child Protection/Prevention			
☐ HBCI	☐ Foster Care	Grade Level:	Educational Placement**:**	
☐ Mobile Crisis	☐ Residential CR/RTC/RTF			
☐ Family Support	☐ OPWDD	☐ 504 Plan ☐ IEP	Classification:	Full Scale IQ:
☐ Counseling/Med Mgmt.	☐ Other: _____			

Summary of Concerns or Needs:

Request for Services (please note if there is a provider agency preference for requested services)**:** _____

☐ **Health Home Care Management** ☐ **CFTSS:** OLP, CPST, YPST, PSR, FPSS, CI ☐ **HCBS:** CFSS, CSATS, PR, CR, Pre-Voc, SE

Items to include with referral if available/applicable:

Psychiatric Assessment, Psychosocial History, Psychological Evaluation, Hospital Admission/Discharge Summaries, Medical Necessity Form.

Saratoga County Children's SPOA Consent for Release of Information

Child's Name: _____ Gender: _____ DOB: _____

The Saratoga County Single Point of Access Committee (SPOA) is composed of representatives of community agencies including, but not limited to, the Saratoga County Department of Mental Health and Addiction Services, Saratoga Hospital (to include Mental Health Unit), RISE Healthy Housing and Support Services, Parsons Home and Community Based Services Waiver, Saratoga County Department of Social Services (to include Children's Services, Probation, Public Health and Early Intervention), Saratoga County Alcoholism Services,Community Human Services, Saratoga County PROS, Parsons Home Based Crisis Intervention, Four Winds Hospital, Shelters of Saratoga, Captain Youth and Family Services, Unlimited Potential, Capital District Psychiatric Center, Northeast Parent and Child Society, AIDS Council of Northeastern NY, Conifer Park, Wellspring, Legal Aid Society of Northeastern NY, Saratoga County Options for Independent Living, Saratoga County Rural Preservation, Saratoga County Treatment Court, Saratoga Springs Housing Authority, Saratoga Supreme & County Courts, St. Peter's Addiction and Recovery, Regional Adult Mobile Program, Youth Mobile Crisis,Building Blocks, Capital District Office for People with Developmental Disabilities, Department of Health Children and Youth Evaluation Service and Children's Health of Upstate NY. In order to determine the most appropriate level of service based on strengths,needs and availability of program openings, I give my permission for members of the SPOA Committee to exchange information between the agencies listed above and to obtain information from and/or release information to the following Person, Organization,Facility or Program:

_____	_____
Referring Agent (if different from Outpatient Mental Health provider)	**Outpatient Mental Health Treatment Provider** (name, title, agency)
_____	_____
Address	Address
_____	_____
Phone Fax	Phone Fax

The extent or nature of information to be disclosed includes:

☐ Clinical summaries (i.e. psychiatric evaluations) ☐ Treatment plans and treatment plan reviews
☐ Admission and/or discharge summaries ☐ Notes of psychiatric or other clinic visits
☐ Medication records and laboratory results ☐ Other: _____

Affirmation of Release: I understand that treatment will not be refused, but clinical decisions may be affected, if I do not sign any authorizations to release information. I have the right to revoke (take back) in writing this authorization at any time except to the extent that action has been taken in reliance on it and unless receiving services from Alcoholism and Substance Abuse Service as a result of criminal justice involvement, in which case consent for disclosure to the criminal justice system cannot be revoked. The revocation will take effect on the day it is received. Alcohol and drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records as well as the Health Insurance Portability and Accountability Act of 1996. Confidential information cannot be disclosed without my written consent unless otherwise provided for (i.e. suspected child abuse, health or mental health emergency under the above noted regulations). If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may no longer be protected. Alcohol and drug program treatment records are protected.

Expiration: This authorization will expire, ☐ when acted upon (one time disclosure), ☐ 90 days from this date, ☐ when I am no longer receiving services from _____, or ☐ other _____.

_____	_____
Parent/Guardian (Print Name)	Parent/Guardian (Signature)
_____	_____
Referring Agent (Signature and Title)	Date

Summary of Services	
Health Home Care Management (HHCM) –referral available upon request or accessed through SPOA referral Enrolled in a Medicaid Managed Care Plan, under age 21 and meet SED criteria	
HHCM	**Core Services** • Comprehensive Care Management • Care Coordination and Health Promotion Services • Comprehensive and Transitional Care Services • Child and Family Support Services • Referral to Community and Social Support Services
Children and Family Treatment and Support Services (CFTSS) –referral available upon request or accessed through SPOA referral Enrolled in a Medicaid Managed Care Plan, under age 21 and meet medical necessity criteria	
OLP	**Other Licensed Practitioner** • Licensed Evaluation/Assessment, including Treatment Planning • Psychotherapy • Crisis Intervention Activities
CPST	**Community Psychiatric Support and Treatment** (Intensive In-Home) • Intensive Interventions (counseling) • Crisis Avoidance (counseling) • Intermediate Term Crisis Management (counseling) • Rehabilitative Psychoeducation (not involving counseling) • Strengths Based Service Planning (not involving counseling) • Rehabilitative Supports (not involving counseling)
PSR	**Psychosocial Rehabilitation** (Skill Building) • Social and Interpersonal Skills • Daily Living Skills • Community Integration
FPSS	**Family Peer Support Services** • Provided by a Credentialed Family Peer Advocate/Certified Recovery Peer Advocate who has similar experiences • Get support and assistance with locating information and resources available to meet the youth/family's needs • Making informed decisions, building and strengthening natural supports and resources
CI	**Crisis Intervention**
YPS	**Youth Peer Support**
Home and Community Based Services (HCBS) –referral available upon request or accessed through SPOA referral Enrolled in a Medicaid Managed Care Plan (or meet Medicaid eligibility as a family of one), under age 21, meet SED, risk factors and functional criteria.	
CFSS	**Caregiver Family Support Services** • Enhance the child's ability to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child in the home and/or community
CSATS	**Community Self Advocacy Training and Support** • Provide family/caregiver with techniques and information to better respond to the needs of the child • Provided to prevent problems in the community settings as well as when the child is experiencing difficulties
PR	**Planned Respite** • Short-term relief for the child or family/primary caregivers to support the child's behavioral health needs
CR	**Crisis Respite** • Short-term care and intervention strategy to alleviate the risk for an escalation of symptoms, loss of functioning, and/or a disruption in a stable living environment • Delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community based sites or in allowable facilities
Pre-Voc	**Prevocational Services** (age 14 -21)
SE	**Supported Employment** (age 14 - 21)