



Saratoga County Single Point of Access SPOA Referral Form for EMS and Law Enforcement

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Client Information

Name:	Gender:	Date of Birth:	Phone:	
Home Address:	City:		State:	Zip Code:
Parent or Guardian if minor child:				

Eligibility

Medicaid Eligible: Yes No Unknown

Documented history of Mental Health Disorder: Yes No Unknown

Documented history of Substance Use Disorder: Yes No Unknown

Documented history of two Chronic Medical Conditions: Yes No Unknown

I understand that by signing form that I am voluntarily requesting access to mental health support services.

Applicant Signature: _____ Date: _____

Parent or Guardian signature if minor child: _____ Date: _____

Additional Comments