Children's Single Point of Access Application Part 1

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Directions: Complete this form and submit to the youth applicant's C-SPOA of origin to apply for C-SPOA Coordination.
Note: To apply for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF), submit this completed form and the C-SPOA Application Part 2 to C-SPOA.

☐ Check this box if submitting this application with the C-SPOA Part 2 Application for Youth ACT, CCR and RTF.

Youth Applicant Information

Youth's Name in Use

Pronouns in Use

Sex assigned on youth's birth certificate
☐ Male
☐ Female

Gender Identity
☐ Agender ☐ Nonbinary/Genderqueer
☐ Female ☐ X
☐ Male ☐ Other: _____

Youth's Race – select all that apply
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American

Primary Language/Means of Communication:

Is the youth fluent in English? ☐ Yes ☐ No

Youth's Ethnicity ☐ Hispanic ☐ Non-Hispanic

SSN

County of Origin

Permanent Home Address, if applicable

Current Location (if different from home)

Does the youth have Medicaid coverage? ☐ Yes ☐ No

Medicaid/CIN#

Check if the youth is eligible for any of the following:
☐ Title IV-E ☐ SSI ☐ SSDI

People with the following immigration status may be eligible for Medicaid:
- Citizen
- Permanent resident (green card holder)
- Refugee or asylee
- U or T visa holder (for victims of crime or trafficking)
- Employment authorization card holder
- Deferred Action for Youthhood Arrivals (DACA) recipient

Does the youth's immigration status fall into one of the above categories? ☐ Yes ☐ No

Is documentation available to confirm the youth's immigration status falls into one of the above categories? ☐ Yes ☐ No

Does youth have private health insurance? ☐ Yes ☐ No

Insurance Plan

Insurance Policy Number

Is youth enrolled in Health Home Care Management/Coordination?
☐ Yes ☐ No ☐ Unknown

If the child is enrolled in Health Homes Serving Children or Health Homes Serving Individuals with ID and/or DD, provide contact info.:
Agency & HHCM/CCO Name:_____
Phone Number:_____ Email:_____

Referrer Contact information (if other than caregiver)

Name/Title of Referrer

Referring Organization/Program

Address of Referrer

Referrer Phone

Referrer Fax

Referrer Email

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Caregiver Contact #1 Information		Caregiver Contact #2 Information	
Full Name Primary Contact? ☐		**Full Name** Primary Contact? ☐	
Address		**Address**	
Phone	**Email**	**Phone**	**Email**
Relationship to Youth	**Legal Guardian?** ☐ Yes ☐ No	**Relationship to Youth**	**Legal Guardian?** ☐ Yes ☐ No
Caregiver Primary Language	**Fluent in English?** ☐ Yes ☐ No	**Caregiver Primary Language**	**Fluent in English?** ☐ Yes ☐ No

Legal /Custody Status

- ☐ Both parents together
- ☐ Biological father only
- ☐ Biological mother only
- ☐ Joint custody
- ☐ Adoptive Parent(s)
- ☐ OCFS and Family Court. Identify Status
  - ☐ Case Pending
  - ☐ Person In Need of Supervision (PINS)
  - ☐ Youthful Offender
  - ☐ Juvenile Offender
  - ☐ Juvenile Delinquent
  - ☐ Restrictive Placement
- ☐ Other, Relative
- ☐ Emancipated Minor
- ☐ DSS. Identify locality:
- ☐ ACS. Identify Case Planning agency:

Please note any details about custody status (e.g. restricted access):

Reason for C-SPOA Coordination Referral

Reason for referral (Identify service needs and interests. Attach additional sheet if needed.)

Mental Health Diagnosis (if known)

Does the child have a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown	**If so, what is the primary diagnosis?**
	When was the diagnosis made?
Has a Licensed Practitioner of the Healing Arts determined that the youth meet criteria for serious emotional disturbance? ☐ Yes ☐ No ☐ Unknown	**If so, when was the determination made?**

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

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Intellectual and Developmental Disability Diagnosis (if known)	
Does the child have an intellectual and/ or developmental disability diagnosis? ☐ Yes ☐ No ☐ Unknown	**If so, what is the diagnosis?**
	When was the diagnosis made?

IQ Testing Scores (if available)			
Full Scale	**Verbal Subscale** as applicable	**Non-Verbal Subscale,** as applicable	**Test date**

Current Providers	
School and grade	**Therapist/Therapist's agency**
Psychiatric Medication Prescriber/agency	**Other service provider/agency**

Additional Service Information	
Number of psychiatric hospitalizations in the previous 12 months	**Number of Emergency Department visits in the previous 12 months**
Is the youth currently eligible for Home and Community Based Services? ☐ Yes ☐ No ☐ Application Pending ☐ Unknown	
Is youth currently receiving preventive services through DSS or ACS? ☐ Yes ☐ No ☐ Unknown	**If yes, name of Prevention provider**
Is the youth currently in foster care? ☐ Yes ☐ No ☐ Unknown	**Is the youth freed for adoption?** ☐ Yes ☐ No ☐ Unknown
Is the youth currently OPWDD eligible? ☐ Yes ☐ No ☐ Application Pending	**Is the youth currently eligible for OPWDD Home and Community Based Services?** ☐ Yes ☐ No ☐ Application Pending
Other systems involvement (e.g., child welfare, etc.) – Please specify	

Preliminary Eligibility for Health Home Case Management	check here if the youth has HHCM		
Does the youth have two or more chronic conditions (e.g., asthma, diabetes, substance use disorder)?	☐ Yes	☐ No	☐ Unknown
Does the youth have HIV/AIDS?	☐ Yes	☐ No	☐ Unknown
Do you believe the youth has a Serious Emotional Disturbance? (Youth meets one of the below criteria) • Difficulty with self-care, family life, social relationships, self-control, or learning • Suicidal symptoms • Psychotic symptoms (hallucinations, delusions, etc.) • Is at risk of causing personal injury or property damage • The youth's behavior creates a risk of removal from the household	☐ Yes	☐ No	☐ Unknown
Has the youth been exposed to multiple traumatic events that have left a long-term and wide- ranging impact?	☐ Yes	☐ No	☐ Unknown

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REQUIRED CONSENT FOR RELEASE OF INFORMATION
for Single Point of Access (SPOA), _____County ("County")

This authorization must be completed by the referred individual or his/her legal guardian/personal representative. This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and PHI between, the County Single Point of Access (SPOA) team (comprised of County and state employees as well as representatives of local service providers), Other Provider(s) (see attached list of Providers on page 3); **AND** the Referral Source (Person / Title / Agency / School or Correctional Facility): _____

DESCRIPTION OF INFORMATION to be used / disclosed and re-disclosed *(check ALL that apply):* ☐ **ALL listed below**

- ☐ Referral (including contact info)
- ☐ Psychiatric Evaluation/Assessment
- ☐ Mental Health/Psychosocial Assessment
- ☐ Psychological &/or Neurological Tests
- ☐ Documentation of Medical Necessity
- ☐ Psychosocial History and Assessment
- ☐ Family Planning Information
- ☐ Inpatient/Outpatient Treatment
- ☐ Financial &/or Insurance Info
- ☐ Discharge Summary/Treatment Plan
- ☐ Pre-Sentence Investigation Report
- ☐ HIV/AIDS-related Information
- ☐ Other (specify): _____
- ☐ Diagnosis
- ☐ Physical Health
- ☐ Medications (past & present)
- ☐ Substance Use
- ☐ School Records (including testing)

PURPOSE OR NEED FOR INFORMATION:
Allow SPOA to: make referrals to appropriate providers; consult regarding care; participate in care management services; provide discharge planning information to the providers listed on page 2; coordinate care among providers and through Health Homes; and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization;
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law or regulation;
- I am authorizing the re-disclosure of above-described information to the providers identified on page 2 of this form for the purposes identified on this form;
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on a form provided by **County.** I am aware that my revocation does not affect information disclosed while the authorization was in effect;
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain treatment, nor my eligibility for benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524);

Youth Applicant's Information			
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I HEREBY AUTHORIZE the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified on this release as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire: (check one)

☐ When the individual named herein is no longer receiving services from County SPOA;

☐ One Year from the date of signature; ☐ Other: _____

I CERTIFY THAT I AUTHORIZE the use of the PHI as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____

SIGNATURE of Individual, Parent or Legal Guardian **Printed Name of Individual signing** **Date**

_____

Description of Authority of Personal Representative

_____ _____ _____

SIGNATURE of WITNESS **Printed Name of Witness/Title** **Date**

List of agencies with which the SPOA Comittee is permitted to exchange information

Adirondack Health Institute Health Home Care Management
Berkshire Farm Center
Building Blocks Health Home Care Management
Captain Community Human Services
Children's Health Home of Upstate New York
Ellis Hospital
Four Winds Hospital
Northern Rivers Youth ACT Team
Northern Rivers Health Home Care Management
Northern Rivers Home Based Crisis Intervention
Northern Rivers Mobile Crisis
RISE Health Home Care Management
Saratoga County Children's Services
Saratoga County Department of Mental Health
Saratoga County Probation
Saratoga Hospital
School District:_____
Outpatient Mental Health Provider:_____
Other:_____

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COMMUNICATION PREFERENCES

County SPOA wants to respect your wishes regarding communication. Please indicate your preferences below.

US Mail

Can we send mail to your address with our return address on the envelope? ☐ Yes ☐ No

Telephone:

When calling, can we say we are County SPOA (Single Point of Access)? ☐ Yes ☐ No

Are we able to leave a voicemail at the telephone number(s) provided? ☐ Yes ☐ No

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PERMISSION FOR ELECTRONIC COMMUNICATION

I understand the transmission of electronic information may not be secure. E-mails and cell phone communications are unencrypted, and other concerns may exist including but not limited to: email and faxes may accidently be sent to the wrong person; content may be changed without knowledge; copies may exist; some e-mails may contain harmful viruses; cell phone communications may be intercepted or heard by others; texting leaves a record of communication; and there is a risk of loss of device with information on it.

BY SIGNING BELOW, I HEREBY AUTHORIZE County Mental Health SPOA Team permission to correspond ***with me*** via *(check all that apply)*:

☐ FAX Fax Number: _____

☐ E-MAIL Email Address: _____

☐ CELL PHONE Phone Number: _____

☐ TEXT MESSAGE Phone Number: _____

I understand this permission may be cancelled by me at any time but cannot apply retroactively to communication that has already been sent.

_____ _____ _____

SIGNATURE of Individual, Parent or Legal Guardian **Printed Name of Individual signing** **Date**

_____

Description of Authority of Personal Representative

_____ _____ _____

SIGNATURE of WITNESS **Printed Name of Witness/Title** **Date**

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Optional Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent

_____
Name of SPOA County

The SPOA Committee may get health information, including your youth's health records, through a computer system run by_____, a Regional Health Information Organization (RHIO) A RHIO uses a computer system to collect and store health information, including medical records, from your youth's doctors and health care providers who are part of the RHIO. The RHIO can only share your youth's health information with people who you say can see or get such health information.

The SPOA Committee may also get health information, including your youth's history of services reimbursed by Medicaid through a computer system called PSYCKES, which is run by the New York State Office of Mental Health. PSYCKES is a computer system maintained by the New York State Office of Mental Health that 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."

If you agree and sign this form, SPOA Committee members are allowed to get, see, read and copy ALL of your youth's health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your youth's care, manage such care or study such care to make health care better for patients. The health information they may get, see, read and copy may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries your youth had or may have had before; test results, like X-rays or blood tests; and the medicines your youth is now taking or has taken before. Your youth's health records may also have information on:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and Dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summary
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data
- Lab Tests

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your youth's health information must obey all these laws. They cannot give your youth's information to other people unless an appropriate guardian agrees or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your youth's health information and the SPOA Committee must obey these laws and rules.

Please read all the information on this form before you sign it:

☐ **I GIVE CONSENT** for the SPOA Committee to access ALL of my youth's health information through the RHIO and/or through PSYCKES to provide my youth care or manage my youth's care, to check if my youth is in a health plan and what the plan covers.

☐ **I DENY CONSENT** for the SPOA Committee to access ALL of my youth's health information through the RHIO and/or through 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.

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Patient Information Sharing Consent

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**

   If you agree, SPOA providers will use your health information to:
   - Coordinate your health care and manage your care;
   - Check if you have health insurance and what it pays for; and
   - Study and make health care for patients better.

   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. **Where does my health information come from?**

   Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

3. **What laws and rules cover how my health information can be shared?**

   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I agree, who can get and see my information?**

   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients.

5. **What if a person uses my information and I didn't agree to let them use it?**

   If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at 518.584.9030, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **How long does my consent last?**

   Your consent will last until the day you take back your consent, or if the SPOA stops working, or three years after the last date of service from the SPOA, whichever comes first.

7. **What if I change my mind later and want to take back my consent?**

   You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the SPOA. You can get this form by calling 518.584.9030. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

8. **How do I get a copy of this form?**

   You can have a copy of this form after you sign it.