Saratoga County Children's SPOA Referral

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

Child's Name:	**Date of Birth:**	**Gender:**	
Telephone:	**Social Security #** :		
Parent/Guardian's Name:			
Relationship to Child/Custody Status:			
Address:	**City:**	**State:**	**Zip Code:**

Child's type of health coverage:	**Education:**		
☐ Medicaid: **CIN # required** _____ (ex. DF10447A)	Home School District:		
	Grade Level:	Educational Placement**:**	
☐ Other Insurance: _____	☐ 504 Plan ☐ IEP	Classification:	Full Scale IQ:

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

Child meets Serious Emotional Disturbance (SED) Criteria Attach Supporting Documentation

☐ Designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders **AND**

☐ Experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis **OR**

☐ Functional limitations must be moderate in at least two of the following areas:

- ☐ Ability to care for self (personal hygiene, dressing, avoiding self-injury, etc.); or
- ☐ Family life (capacity to live in a family environment, relationships/behaviors in family setting, etc.); or
- ☐ Social relationships (establishing/maintaining friendships, interpersonal interactions with others, social skills, etc.); or
- ☐ Self-direction/self-control (ability to sustain focused attention, behavioral self-control, decision making ability, etc.); or
- ☐ Ability to learn (school achievement and attendance, behavior in school, etc.)

Reason for referral (identify service needs and interests / attach additional sheet if needed)

Saratoga County SPOA Consent for Release of Information

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Client Name: _____ Gender: _____ DOB: _____

The Saratoga County Single Point of Access Committee (SPOA) is composed of representatives of community agencies including, but not limited to, Saratoga County (Mental Health, Addiction Services, PROS, Social Services, Adult/Child Protective, Child Preventive, Probation, Aging and Youth Services), Saratoga Hospital, Four Winds Hospital, Ellis Hospital, Glens Falls Hospital, Mohawk Valley Psychiatric Center, Capital District Psychiatric Center, Office of Mental Health, RISE Housing and Support Services, Rehabilitative Support Services, Northern Rivers Family of Services, Captain Community Human Services, Adirondack Health Institute Health Home, Children's Health Home of Upstate NY, Health Home Care Management Agencies serving Saratoga County, Saratoga County School Districts, Shelters of Saratoga, Code Blue, Unlimited Potential, Wellspring, Saratoga County Options for Independent Living, Saratoga County Rural Preservation, Saratoga Springs Housing Authority, Saratoga County Sheriff, Ballston Spa, Mechanicville and Saratoga Springs Police Department and Office for People with Developmental Disabilities. 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 Agency (if different from Outpatient Mental Health Provider)	**Outpatient Mental Health Treatment Provider** (Agency Name)
_____	_____
Referring Agent Name, title	Outpatient Provider Name, title
_____	_____
Address	Address
_____	_____
Phone Fax	Phone Fax

The extent or nature of information to be disclosed includes:

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

_____	_____
Applicant (Print Name)	Applicant (Signature)
_____	_____
Referring Agent (Signature and Title)	Date