NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

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 to apply for C-SPOA Coordination.

☐ Check this box if submitting this form with the C-SPOA Part 2 Application for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF) services.

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 Childhood 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**

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1

Youth Applicant's Identifying Information			
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Caregiver # 1 Contact 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 and Custody Status

- ☐ Both parents together
- ☐ Biological father only
- ☐ Biological mother only
- ☐ Joint custody
- ☐ Adoptive Parent(s)
- ☐ OCFS and Family Court Involvement. 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 yes, what is the mental health diagnosis?**
	When was the diagnosis made?

Has a Licensed Practitioner of the Healing Arts determined that the youth meets criteria for serious emotional disturbance? ☐ Yes ☐ No ☐ Unknown	**If so, when was determination made?**

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1

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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**

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 ☐ Not applicable
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

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

REQUIRED CONSENT FOR RELEASE OF INFORMATION
for Single Point of Access (SPOA), Monroe 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 (42 CFR Part 2) 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 5); **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
- ☐ Financial &/or Insurance Info
- ☐ Discharge Summary/Treatment Plan
- ☐ Pre-Sentence Investigation Report
- ☐ HIV/AIDS-related Information
- ☐ Inpatient/Outpatient Treatment
- ☐ Diagnosis
- ☐ Physical Health Medications (past and present)
- ☐ Other (specify): _____
- ☐ School Records (including testing)
- ☐ Substance Use Evaluation
- ☐ Substance Use Diagnosis
- ☐ Substance Use Treatment Plan
- ☐ Substance Use Medication(s)
- ☐ Substance Use Discharge

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 5; 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 5 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);
- I have been offered a copy of the Notice of Privacy Practices by my County Mental Health Department and I have the right to request and receive a copy at any time.

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

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 Committee is permitted to exchange information

See Attachment A

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Monroe County.

Anthony Jordan Health Center
Arc of Monroe
Aspire Hope
Baden Street
Baker Victory Services
Berkshire Farm
Catholic Charities Community Services
Catholic Charities of Livingston County;
Catholic Family Center
Cattaraugus Rehabilitation Center
Cayuga Children's Center
Center and Services for Youth
Children and Family Services
Children’s Health Home of Upstate New York (CHHUNY)
Children’s Home of Wyoming Conference (CHOWC)
Community Maternal Services
Community Missions
Compeer
CP Rochester
DayStar for Medically Fragile Children
Delphi
Elm and Oak Health
Epilepsy Pralid Inc.
Fingerlakes Therapy Works
Finger Lakes Area Counseling and Recovery Agency (FLACRA)
Genesee County Mental Health
Glove House
Greater Rochester Health Home Network (GRHHN)
Gustavus Adolphus Family Services
Happiness House / Finger Lakes Cerebal Palsy Association HCR Care Management LLC.
Heritage Christian Services Inc.
Hillside Family of Agencies
Housing Options Made Easy (HOME)
Huther Doyle
Innovative Care
Jefferson Family Medicine
Liberty Resources, Inc.
Lifetime Care
Livingston County Mental Health
Mary Cariola Children's Center
Mental Health Association;
New Directions Youth and Family Services Inc
North American Family Institute Inc.
Pathways Inc.
People Inc.
Rochester Psychiatric Center
Rochester Regional Health System
Salvation Army
Spectrum Human Services
St. Anne Institute
The Autism Council of Rochester Inc.
University of Rochester Medical Center/URMC
Vanderheyden Hall
Villa of Hope
Wayne Arc
Western New York Children's Psychiatric Center

Youth Applicant's Information			
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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 canceled 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**

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

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

Monroe County
Name of SPOA County

The SPOA team and Committee may get health information, including your youth's health records, through a computer system run by Rochester RHIO, 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, 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
- 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.

SIGNATURE of PARENT or LEGAL GUARDIAN	**Printed Name of Parent/Legal Guardian**	**Date**
SIGNATURE of WITNESS	**Printed Name of Witness**	**Date**

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

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 (585) 753-6346, 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 (585) 753-6346. 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.

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

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

Directions: To apply for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF), complete and submit the C-SPOA Part 1 and this Part 2 application to the applicant's C-SPOA of origin.

Note: If an update to the information provided in the application occurs within 90 days of the initial submission, updates can be provided by re-submitting the form, with updates to relevant section(s) and selecting "check this box if no information has changed" for all others.

Section 1: Referral Type ☐ If resubmitting within last 90 days, check this box if no information has changed.

Select the program type(s) to which the youth applicant/family is pursuing access:

☐ OMH Youth Assertive Community Treatment (ACT)

Not available statewide. Confirm applicant resides in one of the following catchment counties:

- ☐ Albany/Schenectady
- ☐ Bronx
- ☐ Brooklyn
- ☐ Broome
- ☐ Chemung/Steuben
- ☐ Cortland/Chenango
- ☐ Erie/Niagara
- ☐ Fulton/Montgomery
- ☐ Manhattan
- ☐ Monroe
- ☐ Nassau
- ☐ Oneida
- ☐ Onondaga
- ☐ Orange
- ☐ Queens
- ☐ Saratoga/Warren/Washington
- ☐ Staten Island
- ☐ Suffolk
- ☐ Westchester

☐ OMH Children's Community Residence (CCR)

☐ OMH Residential Treatment Facility (RTF)

For OPWDD use only: ☐ Referral for OLV ITP RTF

Section 2: Reason for Referral ☐ If resubmitting within last 90 days, check this box if no information has changed.

What are the current symptoms which require treatment and support? Describe the frequency, intensity, duration, and risk of harm for each symptom present.

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
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What are the youth applicant/family's presenting needs? How do these needs impair the youth applicant's ability to function in the home, school, and community?
What are youth applicant and family strengths?
Is the youth applicant/family currently connected to community-based services? If so, please describe the type of service(s), frequency, duration, and coordination of services.
What challenges have impacted the ability of home and community-based services to meet the youth applicant and their family's needs?

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

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

Section 3: Education Program Information
☐ If resubmitting within last 90 days, check this box if no information has changed.

Home School District	School Name	Grade

Has a CSE determined the applicant has a Special Education Disability or Condition? ☐ Yes ☐ No ☐ Pending

If yes, please list all that apply (e.g., Learning Disability, Emotional Disturbance, Multiple Disabilities, etc.):

Is there a current IEP or 504 Plan?	Has a CSE found the applicant eligible for New York State Alternate Assessment?	Date of Last CSE meeting
☐ No ☐ Yes, IEP ☐ Yes, 504	☐ No ☐ Yes	Date:_____ ☐ N/A

CSE Contact Name	CSE Phone	CSE Email

Section 4: System and Service Involvement ☐ If resubmitting within last 90 days, check this box if no information has changed.

System and Service Categories	Involvement	Describe Reason for Involvement and the Timeframe *If additional space is needed, please attach narrative to the application.*
Office for People with Developmental Disabilities (OPWDD)	NY START/CSIDD connected? ☐ Yes ☐ No ☐ Unknown	(*If applicable, indicate current status of pending eligibility or referrals.*)
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Child Protective Services (CPS) Involvement	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
DSS/ACS Custody	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

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

Family Court	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
PINS/PINS Diversion	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Probation	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Criminal Court	☐ Past ☐ Current ☐ Unknown	(*if applicable, indicate if charges pending*)
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
OCFS Division of Juvenile Justice (OCFS DJJOY Custody)	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	

Section 5: Residential or Inpatient Service Utilization (Over the past 2 years) If no history of residential or inpatient admission, indicate N/A. If additional space is needed, please attach narrative.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Name of Facility	Date of Admission	Date of Discharge (or Anticipated Date of Discharge)

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
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Section 6: Discharge Planning ☐ If resubmitting within last 90 days, check this box if no information has changed.

Detail a proposed plan for discharge. Include a discharge setting and the services that may be needed. Identify potential barriers.

Section 7: Discharge Planning Partner(s) Identify individuals, in addition to the parent/legal custodians and guardians, to be engaged in discharge planning discussions. If there is DSS, or an ACS Case Planning Agency involvement, the case worker and supervisor must be listed as discharge planning partners.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Name	Relationship to Youth Applicant/Family	Contact Information (Email and Phone Number)

Section 8: Primary Provider Contact For Clinical Updates. Complete if different than referrer.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Name	Agency Name
Phone Number	Fax Number
Relationship to Applicant (PCP, Therapist, Etc.)	Email Address
Signature	Date

Section 9: Supporting Documentation Guidelines and Checklist ☐ If resubmitting within last 90 days, check this box if no information has changed.

The following documentation is required to be completed and submitted with the C-SPOA Part 1 and this Part 2 application in order for the referral to be considered "complete" and processed by C-SPOA.

☐ **C-SPOA Application Part 1**
☐ **Required Consent For Release Of Information For C-SPOA** completed by parent/legal guardian
☐ **C-SPOA Application Part 2** (this form)
☐ **Verification of Serious Emotional Disturbance** completed by Licensed Behavioral Health Practitioner -OR- a psychiatric, psychosocial, or psychological evaluation which includes a SED determination

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

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

☐ **For referrals initiated in an inpatient setting**, **a current summary of the hospitalization is required**.
The summary of the hospitalization should address: course of treatment since time of admission (including use of increased observation (e.g.,1:1 5 min. observation), intramuscular medication for agitation, aggressive, or self-injurious behavior use of restraint) response to treatment, *current* status (e.g. overall behavior on unit, ADLs), and anticipated LOS.

☐ **For referrals initiated by Youth ACT, CCR or an RTF, submit**:
- ☐ Psychosocial which includes current course of treatment and response to treatment in the program.
- ☐ Current treatment plan

Subsection A: Required For Youth ACT Referrals Only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Any documentation to support the following ACT eligibility criteria**:

- Youth and/or family has not adequately engaged or responded to treatment in more traditional settings.
- High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year)
- High use of psychiatric emergency or crisis services
- Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues)
- Residing or being discharged from in an inpatient bed, residential treatment program, or in a CCR, or being deemed eligible for RTF, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. This may also include current or recent involvement (within the last six months) in another child-serving system such as juvenile justice, child welfare, foster care etc. wherein mental health services were provided.
- Home environment and/or community unable to provide necessary support for developmentally appropriate growth required to adequately address mental health needs.
- Clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., children's community residence, psychiatric hospital, or RTF) without intensive community services

Subsection B: Required For CCR and RTF Referrals Only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Psychiatric Evaluation**

- A full psychiatric evaluation must have been performed within the past 12 months, with an update within the past 90 days of the time of referral, verifying that the psychiatric evaluation accurately reflects the youth applicant's current level of functioning.
- The psychiatric evaluation may be signed by the treating Physician, or Nurse Practitioner.
- The psychiatric evaluation should address the following:
  - Current mental status
  - History of prior psychiatric care and treatment
  - Brief summary of past and present psychotropic medication, response to medications, reasons for changes/discontinuation, effectiveness, and side effects

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

- Diagnostic formulation with clear examples that substantiate clinical conceptualization
- DSM-5 diagnosis

☐ **Psychosocial Assessment**

- A psychosocial assessment must have been performed within the past 12 months.
- The psychosocial assessment must assess both youth applicant AND family and address the following:
  - Developmental History & Needs: Include pre-natal, peri-natal, and post-natal periods, developmental milestones and problems, any services and related progress, current status and needs across domains.
  - Treatment History: Indicate current and historical therapeutic interventions and response to the course of treatment. include treatment outcomes, engagement, problems with approaches, barriers to progress.
  - Family/Community History: Include family developmental/psychiatric/medical history and current status, constellation and dynamics of family members and other natural supports, past and current family problems, socioeconomic status, religious, cultural, ethnic, and other important youth and family affiliations. Note if there are visiting restrictions, loss of rights, or other special information.
  - Educational/Vocational History: Indicate current grade, academic, social, behavioral, and emotional functioning, special education needs and supports. Note employment history and vocational interests as appropriate. Note family's involvement in school/vocational interests and achievement.
  - Skills, Talents, Interests and Strengths: Describe youth applicant/family's special interests, skills/talents, recreational interests, and other assets.
  - Court involvement, if applicable: Indicate any involvement with family/criminal court, department of probation or any such mandated treatment and level of compliance. Include last court date with outcome and next court date.
  - Other co-morbid special needs: Please include any concurrent needs including substance abuse, sexual problematic behavior, etc. If applicable, be sure to include assessments indication risk to self and others, engagement in treatment and related progress.

☐ **Psychological Assessment (Required for RTF ONLY. For CCR, only required if youth has an IEP.)**

- The psychological assessment must have been performed within the last 3 years.
- The psychological assessment must be completed signed or co-signed by a Licensed Psychologist verifying that the psychological assessment accurately reflects the youth applicant's current level of functioning.
- The psychological assessment should address the following:
  - Mental status
  - Instruments used and dates of testing. Testing completed by JD/MHS licensed psychologist is acceptable. An ACTUAL copy of the testing administered should accompany the referral; it is not sufficient to reference someone's past psychological assessment in a new document without new testing.
  - Assessment of cognition (including FSIQ verbal and nonverbal/performance IQ). Standardized adaptive testing (e.g., Vineland, ABAS) is recommended if FSIQ is below 70.

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

- Evaluation of language, social-affective functioning, sensory-motor functioning, and adaptive behavior (may be based on standardized testing, interview, history, and observation, as appropriate)
- Where available and appropriate, personality assessment
- Case formulation with clear descriptive examples that substantiate clinical conceptualization

☐ **Physical/Medical Exam Documentation**

- Documentation of physical exam performed within last 12 months, unless there is an ongoing physical problem, in which case a summary within 90 days of referral is required
- Physical Exam documentation must include:
  - Statement regarding youth applicant's current health & medical history
  - Indicate any allergies, chronic and/or severe needs, potential risk factors that may interact with medications
  - Test results, prescribed treatment, and response to treatment.

☐ **If youth applicant has been reviewed by a CSE, attach**:

☐ CSE recommendations

☐ The IEP or 504, if established

☐ **If high risk behavior for sexualized behavior or fire-setting have occurred in the past two years, attach a risk assessment.** Contact C-SPOA for list of acceptable risk assessments.

☐ **If chronic/severe physical/medical needs are identified**, attach any relevant information (e.g., neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tine test report, nutritional assessment and any other physical findings.)

IF FOUND ELIGIBLE, the following documents will be requested for admission.

Please indicate which of the following are currently available

☐ **FOR CCR ONLY:** An authorization for Children's Community Residence rehabilitation services

☐ **Proof of US Residency as evidenced by:**

☐ Copy of Birth Certificate, and

☐ Copy of Social Security Card; **OR**

☐ Copy of Permanent Residency Card; **OR**

☐ Description of current U.S. residency status from Immigration Attorney

☐ **Copy of Immunization Record**

☐ **Copy of Health Insurance Card** (front and back)

☐ If the youth applicant is DSS/ACS involved or if in the youth is in DSS/ACS custody: Any restrictions to family contact (e.g., Order of Protection)

Subsection C: Required For RTF Referrals only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Statewide OMH RTF Authorization Review Process Consent** completed by parent/legal guardian

☐ **Statewide Request for Medicaid Childhood Disability Determination** completed by parent/legal guardian

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

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

Section 10: Be advised the following additional documents may be requested in order to determine eligibility for Youth ACT, CCR or RTF.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Please indicate which of the following are available upon request:

- ☐ If the youth applicant/family is DSS/ACS-involved or if in the youth applicant is in DSS/ACS custody: Family Court Order, Permanency Plan, Psycho-social
- ☐ Records related to involvement in other systems of care (e.g., juvenile justice, child welfare, disability services) that provide examples of functional impairment in home and community
- ☐ Other clinically relevant evaluations (psychiatric, psychological, neurological, occupational therapy, chemical dependency, etc.)
- ☐ Discharge summaries from previous inpatient, residential and outpatient treatment providers

Section 11: Referrer Attestation

☐ I attest that the information in this application, accurately reflects the youth's level of functioning at the time of application.

Referrer Signature	Date
Referrer Name	Title/ Agency

--------For C-SPOA Use Only----------

C-SPOA Name	Email	Phone	Date Received
Notes regarding application (e.g. completeness, resubmission, updates).			
Are less restrictive services documented to be insufficient to meet the individual's severe and persistent clinical needs? ☐ Yes ☐ No ☐ Unable to determine			
Provide additional information regarding the youth applicant's utilization of less restrictive treatment and support services and C-SPOA recommendation(s). If known and applicable, include any barriers encountered by the youth/family.			

Is referral for access to Youth ACT? ☐ Yes ☐ No	Date deemed complete for Youth ACT	Does the applicant meet eligibility criteria for Youth ACT? ☐ Yes ☐ No	Date youth/guardian agreed to proceed with Youth ACT referral
Is referral for access to CCR? ☐ Yes ☐ No	Date deemed complete for CCR	Is the applicant appropriate for CCR per the *CCR LOC Recommendation Guide*? ☐ Yes ☐ No	Date youth/guardian agreed to proceed with CCR referral
Is referral for access to RTF? ☐ Yes ☐ No	Date deemed complete for RTF	Date youth/guardian agreed to proceed with referral for RTF services	Date application for RTF services submitted to OMH
Is referral from OPWDD for the ITP? ☐ Yes ☐ No			

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

CONSENTIMIENTO INFORMADO PARA EL PROCESO DE REVISIÓN DE LA AUTORIZACIÓN DE CENTROS DE TRATAMIENTO RESIDENCIAL DE LA OFICINA DE SALUD MENTAL

Nombre del joven solicitante (apellido) (nombre) (segundo nombre)	Fecha de nacimiento del joven
Domicilio permanente del joven	
Nombre de la fuente de remisión	
Dirección de la fuente de remisión	

Yo, o mi representante autorizado, solicito que se divulgue la información médica relativa a la atención y el tratamiento del joven mencionado arriba, según lo establecido en este formulario. De conformidad con la Ley del Estado de Nueva York y la Regla de Privacidad de la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 (HIPAA), entiendo que:

- Se requiere una autorización específica para usar o divulgar diagnósticos o información sobre tratamientos por consumo de drogas o alcohol, o información confidencial relacionada con el VIH.
- Tengo derecho a saber qué información sobre el joven se ha compartido, por qué, cuándo y con quién se compartió.
- Tengo derecho a revocar mi autorización para divulgar información notificando por escrito a la agencia remitente o al Coordinador de Autorizaciones del Centro de Tratamiento Residencial (RTF) de la Oficina de Salud Mental (OMH) o a retirarme del Proceso de Revisión de Autorizaciones del RTF de la OMH en cualquier momento antes de que se divulgue la información. Esto impedirá que la OMH comparta información una vez que haya retirado mi consentimiento.
- Entiendo que el Proceso de Revisión de Autorización de la OMH para Centros de Tratamiento Residencial (RTF) puede estar compuesto por revisores del Punto Único de Acceso para Niños (C-SPOA) local del joven y de la Oficina de Salud Mental (OMH). Según corresponda, los revisores también pueden incluir representantes de la Oficina para Personas con Discapacidad de Desarrollo (OPWDD), la Oficina de Servicios para Niños y Familias (OCFS) y el Departamento de Educación del Estado (SED).
- Autorizo la divulgación de información clínica y educativa a la OMH sobre el joven mencionado arriba. Entiendo que el Proceso de Revisión de Autorización de la OMH para Centros de Tratamiento Residencial (RTF) revisará y evaluará esta información para determinar la elegibilidad del joven y la necesidad médica para obtener autorización para solicitar la admisión a los RTF, y que se mantendrá la confidencialidad de esta información. Entiendo que la información se compartirá por escrito, en reuniones, por teléfono o mediante datos informatizados.
- Autorizo a los Coordinadores de Autorización de la OMH para Centros de Tratamiento Residencial (RTF) a divulgar la información mencionada arriba a los RTF. Entiendo que esta información se utilizará para evaluar al joven para su posible admisión en los centros de rehabilitación y que dichos centros mantendrán ls confidencialidad de esta información.
- Este consentimiento para la divulgación de información caducará: a) un año después de la fecha de la firma si el joven no es admitido en un centro de rehabilitación o b) cuando el joven sea dado de alta de un centro de rehabilitación.

Esta autorización debe ser completada por el padre/madre o tutor legal para el uso y la divulgación de información médica protegida, de conformidad con las leyes y regulaciones estatales y federales. La información podrá divulgarse, conforme a esta autorización, a las partes aquí identificadas que tengan una necesidad demostrable de la misma, siempre que no se prevea razonablemente que la divulgación sea perjudicial para el paciente u otra persona.

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

CONSENTIMIENTO INFORMADO PARA EL PROCESO DE REVISIÓN DE LA AUTORIZACIÓN DE CENTROS DE TRATAMIENTO RESIDENCIAL DE LA OFICINA DE SALUD MENTAL

NOTA SOBRE LA INFORMACIÓN QUE ACOMPAÑA ESTE FORMULARIO DE DIVULGACIÓN: Esta información se le ha proporcionado a partir de registros protegidos por las normas federales de confidencialidad (42 CFR Parte 2 y HIPAA). Las normas federales le prohíben divulgar esta información a menos que la persona a la que se refiere la información lo autorice expresamente por escrito o según lo permita 42 CFR Parte 2 o HIPAA. **Una autorización general para la divulgación de información médica o de otro tipo NO es suficiente para este propósito.** Las normas federales restringen el uso de la información para investigar o procesar penalmente a pacientes con abuso de alcohol o drogas.

_____ _____ _____
Firma del padre/madre Parentesco

_____ _____
Nombre en petra imprenta del firmante Fecha de la firma

_____ _____
Firma del tutor legal * Título

_____ _____
Nombre en petra imprenta del firmante Fecha de la firma

*Se debe adjuntar a este formulario la documentación legal que acredite la autorización para firmar en nombre de los padres que figuran en el certificado de nacimiento.

_____ _____
Firma del testigo Título

_____ _____
Nombre en petra imprenta del firmante Fecha de la firma

PARA USO EXCLUSIVO DE LA OMH

EL CONSENTIMIENTO HA SIDO:

- ☐ Revocado en su totalidad
- ☐ Revocado parcialmente de la siguiente manera:
- ☐ Carta (adjunte copia)

FECHA DE RECEPCIÓN DE LA SOLICITUD:_____

REPRESENTANTE DE LA OMH QUE RECIBE LA SOLICITUD:

(NOMBRE COMPLETO Y CARGO DEL REPRESENTANTE DE LA OMH)

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

SOLICITUD DE DETERMINACIÓN DE DISCAPACIDAD

Nombre del joven solicitante: _____

Fecha de nacimiento del joven:_____

Por medio de la presente, solicito a la Oficina de Salud Mental (OMH) que determine si el joven solicitante mencionado arriba tiene una discapacidad para los fines del Programa de Asistencia Médica, según lo establecido por el Departamento de Servicios Sociales.

Autorizo a la OMH a revisar y evaluar cualquier información sobre salud mental, salud física o educación que haya recibido para determinar si el joven mencionado arriba tiene una discapacidad. Asimismo, autorizo a la OMH a solicitar aclaraciones u obtener documentación adicional necesaria para confirmar o verificar esta información y determinar si tiene una discapacidad.

Entiendo que este formulario no constituye una solicitud ni una solicitud de renovación de beneficios de Asistencia Médica, y que la OMH determinará si el joven mencionado arriba tiene una discapacidad, pero no si es elegible para recibir Asistencia Médica.

_____

Firma del padre/madre o tutor legal

_____

Relación con el solicitante

_____

Fecha de la firma

NEW YORK STATE | Office of Mental Health

Verification of Meeting Serious Emotional Disturbance Criteria for OMH Youth ACT, CCRs, and RTFs

Instructions:
A child or adolescent (under the age of 21) has Serious Emotional Disturbance (SED) if they have a designated mental illness diagnosis in the Diagnostic and Statistical Manual (DSM) categories below as defined by the most recent version of the DSM of Mental Health Disorders AND have experienced functional limitations listed below due to emotional disturbance over the past 12 months from the date of assessment on a continuous or intermittent basis as determined by the treating or assessing Licensed Practitioner of the Healing Arts (LPHA.) A child with verified SED may be eligible for intensive services offered by Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR) and Residential Treatment Facility (RTF.)

This verification form is to be filled-out by a LPHA who has the ability to diagnose within their scope of practice under New York State law. The LPHA must verify that the applicant meets SED criteria based on primary diagnosis and functional impairments. The form should be completed by a LPHA who has diagnosed or is actively treating the child. The LPHA verification is required component of a referral for access to Youth ACT, CCR, and RTF.

NOTE: This form is not required if verification of SED by an LPHA is present in the youth's clinical documentation.

Child's Information			
Last Name	First Name	MI	Date of birth

Verification of Meeting Serious Emotional Disturbance Criteria				
Diagnostic Criteria				
☐ As a Licensed Practitioner of the Healing Arts I verify that the child/youth has at least one primary DSM diagnosis in the following Qualifying Mental Health Categories				
Select at least one DSM Qualifying Mental Health Category	**Current Diagnosis**	**Select Primary Diagnosis**	**Select Severity Indicator**	**Date of Diagnosis**
Anxiety Disorders		○	Low ☐ Medium ☐ High ☐	
Bipolar and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Depressive Disorders		○	Low ☐ Medium ☐ High ☐	
Disruptive, Impulse-Control, and Conduct Disorders		○	Low ☐ Medium ☐ High ☐	
Dissociative Disorders		○	Low ☐ Medium ☐ High ☐	
Obsessive-Compulsive and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Feeding and Eating Disorders		○	Low ☐ Medium ☐ High ☐	
Gender Dysphoria		○	Low ☐ Medium ☐ High ☐	
Paraphilic Disorders		○	Low ☐ Medium ☐ High ☐	
Personality Disorders		○	Low ☐ Medium ☐ High ☐	
Schizophrenia Spectrum and Other Psychotic Disorders		○	Low ☐ Medium ☐ High ☐	
Somatic Symptom and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Trauma- and Stressor-Related Disorders		○	Low ☐ Medium ☐ High ☐	
Attention Deficit/Hyperactivity Disorder		○	Low ☐ Medium ☐ High ☐	

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Functional Criteria		
☐ **As a Licensed Practitioner of the Healing Arts I verify that the child/youth has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations have been moderate in at least two of the following areas or severe in at least one of the following areas:**		
Moderate	**Severe**	
☐	☐	Ability to care for self (e.g,. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
☐	☐	Family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
☐	☐	Social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
☐	☐	Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
☐	☐	Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
☐ Supporting documentation (psychosocial, psychological, psychiatric and education documentation) supports this verification.		
☐ I hereby verify, as a Licensed Practitioner of the Healing Arts that this child/youth meets the clinical standards for SED determination as indicated above.		

LPHA Name	LPHA Signature	Date

Credentials Of LPHA:

- ☐ Registered Professional Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Psychiatrist
- ☐ Licensed Psychologist
- ☐ Licensed Psychoanalyst
- ☐ Licensed Master Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage & Family Therapist
- ☐ Licensed Mental Health Counselor
- ☐ Licensed Creative Arts Therapist