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 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 Female Male Nonbinary/Genderqueer X Other: _______________

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

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

7UfY[]jYf 7cbhUWh %=bZcfaUh]cb		7UfY[]jYf 7cbhUWh &=bZcfaUh]cb	
: i ``BUaY Primary Contact?		: i ``BUaY Primary Contact?	
5XXfYgg		5XXfYgg	
D\cbY	9aU]`	D\cbY	9aU]`
FYUh]cbg\]d hc Mci h\	@Y[U ; i UfX]Ub3 Yes No	FYUh]cbg\]d hc Mci h\	@Y[U ; i UfX]Ub3 Yes No
7UfY[]jYf Df]aUfm@Ub[i U[Y	: `i Ybh]b 9b[`]g\ 3 Yes No	7UfY[]jYf Df]aUfm@Ub[i U[Y	: `i Ybh]b 9b[`]g\ 3 Yes No

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- 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):

FYUgcb Zcf C-SPOA Coordination FYZYffU

FYUgcb Zcf rYZYffU f=XYbh]Zm gYfj]WY bYYXg UbX]bhYfYghg"5 HUW UXX]h]cbU g\ YYh]ZbYYXYX'L

AYbhU <YUh\ 8]U[bcg]g f]Z_bck bL

8cYg h\ Y W]`X\ Uj Y U a YbhU \ YUh\ X]U[bcg]g? Yes No Unknown	=Zgcžk\ Uh]g h\ Y df]aUfmX]U[bcg]g3
	K\ Yb k Ug h\ Y X]U[bcg]g a UXY3

<Ug U @]WYbgYX DfUWh]h]cbYf cZh\ Y <YU]b[5fhg XYhYfa]bYX h\ Uh h\ Y mci h\ a YYhg W]hYf]U Zcf gYf]ci g Ya ch]cbU X]ghi fVUbWY3 Yes No Unknown	=Zgcžk\ Yb k Ug h\ Y XYhYfa]bUh]cb a UXY3

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

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

Broome County Child Single Point of Access (C-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME:____ **Individual's DOB:** ____________________

This authorization must be completed by the referred individual or their 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, Part 2 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 Protected Health Information (PHI) between, *Broome County Single Point of Access (SPOA) Team* (comprised of Broome County Mental Health Department staff), ***Other Providers*** (see attached list of Providers on page 2) which comprise the ***SPOA Committee***; **AND** the ***Referral Source*** listed here (e.g.: Person & Title / Agency / School or Correctional Facility) .

Name & Address of Referral Source:____

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

☐ ***ALL listed below***
☐ Mental Health/Psychosocial Assessment
☐ Psychiatric Evaluation/Assessment/ Consultation
☐ Discharge Summary/Treatment Plan
☐ Psychological &/or Neurological Tests
☐ Documentation of Medical Necessity

X ***Referral (including contact info) - required***
☐ Inpatient/Outpatient Treatment
☐ Financial &/or Insurance Info
☐ Medications (past & present)
☐ Pre-Sentence Investigation Report
☐ Physical Health (including family planning if applicable)
☐ Other (specify): __________________

Diagnosis(es)
☐ HIV/AIDS-related Information
☐ 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: consult with and make referrals to appropriate providers, collect and provide documentation (e.g.: discharge planning information) and coordinate care among providers (listed on page 2 of this document); and facilitate participation in services accessed through SPOA.

- I am applying for services and programs, appropriate to my wants and needs, accessible via the SPOA process.
- 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.
- I authorize the re-disclosure and digital storage, including Cloud-based services, of the above-described information to the providers identified on page 2 of this document 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 Broome 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 medical treatment nor access to benefits to which I may be eligible.
- 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* and/or notified that a copy can be located at www.gobroomecounty.com/mh/requestforrecords and I have the right to request and receive a copy at any time.

I HEREBY PERMIT the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified in this *Universal Consent for Release of Information* 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 accessed through Broome County SPOA.
One Year from the date of signature. Other: ______________________________________

I CERTIFY THAT BY SIGNING THIS AUTHORIZATION I acknowledge I have read, understand, and consent to use of the PII and PHI as set forth in this document. 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 or Personal Representative	**Printed Name of Individual**	**Date**
Printed Name of Personal Representative *(if applicable)*	**Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*	
SIGNATURE of WITNESS	**Printed Name of Witness/Title**	**Date**

Broome County Child Single Point of Access (C-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME: ____ **Individual's DOB:** ____________________

List of PROVIDERS with which Child Single Point of Access (C-SPOA) is permitted to exchange information.

Addiction Center of Broome County
Berkshire Farm Center & Services for Youth
Broome County Department of Social Services
Broome County Health Department
Broome County Mental Health Department
Broome County Probation Department
Broome Tioga BOCES
Capital District Physicians' Health Plan
Catholic Charities of Broome County
Children's Home of Wyoming Conference
Crime Victim's Assistance Center
Elmcrest Children's Center
Encompass Health Home
Excellus Blue Cross Blue Shield
Family & Children's Counseling Services
Family Enrichment Network
Fidelis Care
Greater Binghamton Health Center
Hillside Family of Agencies
-Hillside Residential Treatment Facility
- Stillwater Children's Center/Care Management
House of the Good Shepherd
LIFEPlan CCO-NY
Lourdes Center for Mental Health *(Ascension Health)*
Mental Health Association of the Southern Tier
Molina Healthcare of New York
Monroe Plan for Medical Care
NYS Office for People with Developmental Disabilities
NYS Office of Addiction Services and Supports
NYS Office of Mental Health
Our Lady of Lourdes Memorial Hospital *(Ascension Health)*
Parsons Child & Family Center
Pathways
Prime Care Coordination
Salvation Army of Binghamton
Social Security Administration
Southern Tier Connect
Southern Tier Independence Center
United Healthcare Community Plan
United Health Services Hospitals *(Hospitals, Medical Groups,Outpatient Services, Primary Care Practices)*

School District/Building *(specify)*:

If not listed above - include* AGENCY NAME, ADDRESS AND PHONE NUMBER *for:

Mental Health Treatment/Psychiatric Records:

____

Substance Use Treatment/Records:

____

Primary Care Practitioner:

____

Other:

Individual's NAME:____ **Individual's DOB:** ____________________

Broome County Child Single Point of Access (C-SPOA) Patient Information Retrieval Consent

The SPOA Team and Committee may get health information, including the youth's health records, through a computer system operated by *HealtheConnections,* 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 Team and Committee may also get health information through a NYS Office of Mental Health database called *PSYCKES* (Psychiatric Services and Clinical Knowledge Enhancement System). It can contain 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.

If you agree and sign this form, SPOA Team and Committee members can access, read, and copy your youth'shealth information - including health information obtained from the RHIO and/or from *PSYCKES* –needed to arrange your youth's care, manage such care, or study such care to make health care better for patients. The health information they see, read and copy may be from before and after the date you sign this form. The 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 pertaining to:

- 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 summaries
- 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 you r youth's health information must obey all these laws. They cannot give you your 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 Team and Committee must obey these laws and rules.

Please read all of the information on this form before signing 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 youth's information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_______________________________ _______________________________ ____________

SIGNATURE of Individual or Personal Representative | **Printed Name of Individual** | **Date**

_______________________________ _______________________________

Printed Name of Personal Representative *(if applicable)* | **Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*

_______________________________ _______________________________ ____________

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

Individual's NAME: ____ **Individual's DOB:** ____________________

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**
By signing the *Universal Consent for Release of Information*, SPOA providers can use your health information to coordinate and manage your health care; check if you have health insurance and what it pays for; and study and make health care better for patients. The choice you make does not let health insurers see your information, 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. An example of where this information is accessed is Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). If you have any questions, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider.

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 the HIPAA Privacy Rule – or - "HIPAA" – *Health Information Portability and Accountability Act*).

4. **How does SPOA protect health information?**
The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose Protected Health Information (PHI) about them, as well as their rights and the covered entity's obligations with respect to that information.
    - The *Notice of Privacy Practices* of the Broome County Mental Health Department can be found on the department's website, located here: https://www.gobroomecounty.com/mh/requestforrecords

5. **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. For the purposes of SPOA, this may include treatment and services providers who work for SPOA or for a SPOA provider.

6. **What if a person uses my information and I didn't agree to let them use it?**
If you think someone used your information, and you did not agree to give the person your information, you can contact: the Broome County SPOA at (607) 778-2351; the NYS Office of Mental Health Customer Relations at (800) 597-8481; or the United States Attorney's Office at (212) 637-2800.

7. **How long does the *Universal Consent for Release of Information* last?**
The *Universal Consent for Release of Information* is valid until you revoke (take back) permission or when SPOA Team or SPOA service providers discontinue/complete working with you.

8. **What if I change my mind later and want to take back my consent?**
You have the right to revoke (take back) the written consent at any time. The revocation must be in writing on a form provided by Broome County located here: https://www.gobroomecounty.com/mh/requestforrecords. The revocation of consent does not affect information disclosed while the authorization was in effect. 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.

9. **How do I get a copy of this form?**
You can request to have a copy of this form after you sign it from: ChildSPOA@BroomeCountyNY.gov