Broome County

Adult Single Point of Access

(A-SPOA)

Instructions

for

APPLICATION

This document provides item-by-item descriptions of information needed to successfully complete the A-SPOA *Application.*

This document is best suited for *Adobe Acrobat Reader*.

Download here: https://get.adobe.com/reader/

Use *TAB* button to toggle forward through Application. Use *SHIFT + TAB* to toggle backwards.

PURPOSE:

Broome County Adult Single Point of Access (A-SPOA) provides access to high-intensity mental health services, to better integrate medical and behavioral health, and improve overall quality of care.

To ensure timely processing of referrals, this document provides itemized guidance to assist referral sources to complete the *A-SPOA Application*.

SECTION 1 – APPLICANT INFORMATION

Item No.	Item	Description
1.	Full Name	Enter the full, legal name of the applicant. *[LAST Name, FIRST Name]*
2.	Date of Birth	Enter the applicant's Date of Birth *[MM/DD/YYYY]*
3.	Gender Identity	Gender Identity refers to the gender the applicant identifies as currently, *not* the sex assigned at birth.
4.	Currently Homeless	Select either Yes or No. If "yes", continue to 7. If "no", continue to 6.
5.	Current Residence	Select which type of residence best describes the applicant's current living situation.
6.	Physical Address	Enter street address where the applicant primarily resides.
7.	Mailing Address	If different from the physical address, enter the mailing address where applicant receives mail.
8.	Phone	Enter the current and active phone number for the applicant to be contacted *[(area code) xxx-xxxx]*
9.	Primary Language	Enter the primary language the applicant uses to communicate. *[Enter text]* of Primary Language.
10.	Veteran	Click to indicate if the applicant is a veteran. *[☐ Yes or ☐ No]*
11.	Financial Status/Income Status	Check the box to indicate the amount and type of income the applicant currently is receiving. Check all that apply.
12.	Health Insurance	Check the box to indicate the type of health insurance the applicant currently receives. Enter the Medicaid CIN number and/or the Medicare identification number in the text box to the right of the selection(s), if applicable. Check all that apply.
13.	Ethnicity	Check the box of the ethnicity of the applicant by checking the box to the left of the selection(s) that apply. You may make more than one selection.
14.	Current Rep Payee	Click the box next to the *[☐ Yes or ☐ No]* selection. If yes, please enter the first and last name of the rep payee in the text box. *[If so, who?]*
15.	Emergency Contact	Enter the *[Last Name, First Name]* and phone number *[(area code) xxx-xxxx]* of the person who may be contacted in the event of a medical or mental health emergency.
16.	Applicant's Reason for Referral	Enter a brief description stating the reason the applicant is seeking the requested services.

SECTION 2 – REFERRER'S INFORMATION		
Item No.	**Item**	**Description**
17.	Referrer Name	Enter the name of the person making the referral. *[LAST Name, FIRST Name]*
18.	Title	Enter the title of the person making the referral. *[Title] – i.e. Case Manager*
19.	Agency/Program	Enter the agency the referral source works for, including the specific program as applicable. [*Name of Agency/Program*] *- i.e. Broome County Mental Health Department/SPOA Program*
20.	Referrer Mailing Address	Enter the mailing address of the referral source.
21.	Referrer Email	Enter the email address of the referral source.
22.	Referrer Phone	Enter the phone number where the referral source can be reached. *[(xxx) xxx – xxxx]*
23.	Referrer Fax	Enter the fax number where the referral source can receive a fax. *[(xxx) xxx – xxxx]*
24.	Reason for Referral	Enter a brief description as to why the referral source is making this referral for the applicant.
SECTION 3 – DIAGNOSTIC AND CURRENT TREATMENT INFORMATION		
Item No.	**Item**	**Description**
Be advised this section repeats itself to capture information for different caregivers who may have different contact information.		
25.	Diagnosis (es) (Mental Health, Substance Use Disorder, Medical, Intellectual)	Enter the current and historic diagnosis (es) of the applicant including: Mental Health, Substance Use Disorder(s), Medical and/or Intellectual. *[i.e. Major Depressive Disorder, Schizophrenia, Alcohol Use Disorder, etc.]*
26.	Current Mental Health Treatment Provider(s)	Enter the name and contact information of the provider currently providing mental health treatment to the applicant. If not applicable, choose *[None/Not Applicable]*
27.	Current Substance Use Treatment Provider(s)	Enter the name and contact information of the provider currently providing treatment for substance use disorder(s) to the applicant. If not applicable, choose *[None/Not Applicable]*
SECTION 4 – OTHER SERVICE PROVIDERS		
Item No.	**Item**	**Description**
28.	Primary Care Physician	Enter the name and contact information for the primary care provider for the applicant. If not applicable, choose *[None/Not Applicable]*
29.	Current Care Management Services	Enter the name and contact information for the current care management provider for the applicant. If not applicable, choose *[None/Not Applicable]*
SECTION 5 – HIGH RISK ALERTS		
Item No.	**Item**	**Description**
30.	Check all that apply	Choose all current and historic items that apply. For any items checked, please provide details *(dates, brief explanation, etc.).*
31.	Assisted Outpatient Treatment (AOT) Status	Check the box to indicate if the applicant is a Current AOT Order Recipient. Check the box to indicate if the applicant is an AOT Candidate *(in process)*. *[☐ Yes or ☐ No ☐ Unknown]*

SECTION 6 – CRIMINAL JUSTICE STATUS		
Item No.	**Item**	**Description**
32.	Indicate any current - or past - history	Check the box next to the response that describes the applicant's current and/or past criminal justice status. Please indicate both past and present history in your selections. For any items checked, please provide details *(dates, brief explanation, etc.).*
SECTION 7 – TREATMENT HISTORY		
Item No.	**Item**	**Description**
33.	Mental Health Treatment	Enter any inpatient and/or outpatient mental health treatment history including dates and facility names. If not applicable, click the box next to *[None/Not Applicable]*
34.	Substance Use Treatment	Enter any inpatient and/or outpatient substance use treatment history including dates and facility names If not applicable, click the box next to [None/*Not Applicable]*
35.	Number of Emergency Department visits in 12 months prior to referral	Enter the number of instances the applicant has been to the Emergency Department for either medical or psychiatric reasons in the 12 months prior to the referral.
SECTION 8 – ADDITIONAL INFORMATION		
Item No.	**Item**	**Description**
36.	Please include any additional information not otherwise requested	Enter any additional information that should be included in this application that was not otherwise requested.
SECTION 9 – CARE MANAGEMENT SERVICE SELECTION ❖ Medicaid Health Home & Health Home Plus ❖ Non-Medicaid Care Management		
Item No.	**Item**	**Description**
37.	What does Care Management do for you?	A brief description of Care Management services is provided.
38.	Do I qualify?	A brief description of Care Management eligibility is provided along with a link for more detailed information regarding eligibility.
39.	Medicaid Care Management Options	*Select ONE, if Applicable* – select the circle next to the Non-Medicaid Care Management Agency the applicant would prefer to enroll. *Please note:* this is not a guarantee of placement with a chosen agency. Factors such as capacity and waitlist may alter this selection.
40.	Non-Medicaid Care Management Options	*Select ONE, if Applicable* – select the circle next to the Non-Medicaid Care Management Agency the applicant would prefer to enroll. *Please note:* this is not a guarantee of placement with a chosen agency. Factors such as capacity and waitlist may alter this selection. If not applicable, click the box next to *[None/Not Applicable]*

SUBMISSION & REVIEW

- Submit completed *Application* and *Universal Consent for Release of Information* to: AdultSPOA@BroomeCountyNY.gov

- To ensure timely access to SPOA services, the *Application* should be submitted as completely and correctly as practicable. A-SPOA will contact the referral source for clarification and/or corrections as necessary.

For questions, please contact:

Broome County Adult SPOA
Broome County Mental Health Department
501 Reynolds Road
Johnson City, NY 13790
Phone: (607) 778-1119
Fax: (607) 778-6189
Email: AdultSPOA@BroomeCountyNY.gov
Website: www.gobroomecounty.com/mh/SPOA

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