Children's Single Point of Access Application Part 1

Instructions

Thank you for completing this application for the Children's Single Point of Access. When a child in our community is in need of assistance, we are always grateful to find out so that we can make sure that s/he is connected to the care and support that they and their family need.

The Children's Single Point of Access (C-SPOA) is operated by Columbia County government to enable families easy, streamlined access to the mental health service system regardless of their financial resources or insurance status. While C-SPOA does not provide any direct services, it can help a family to access the complete continuum of mental health services for a child. If you are in doubt as to whether the child about whom you are concerned should be referred to the C-SPOA, please make the referral.

The attached form requests information that will enable us to ascertain how best to begin serving this family.

- **Please complete this form no matter what kind of insurance the child has, or if the child has no insurance. C-SPOA services are available for all children in NYS, regardless of their insurance or immigration status.**
- **Please complete the form to the best of your ability – fields can remain incomplete if information is unavailable.**
  - **If you have documentation of the child's diagnosis, please provide it, but we do not want you to delay the application gathering documentation.**
  - **The C-SPOA will be able to help capture any missing information once you submit this form to them.**
  - **If you need help with this form, please call Natasha Robinson, SPOA Coordinator at (518) 828-9446 ext. 1280.**
- **There are two consent forms attached to this application.**
  - **The Consent for Release of Information is <u>REQUIRED</u> in order for us to access the information we need to process this application. Therefore, we cannot process this application without appropriate consent signatures.**
  - **The Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent is highly recommended. This information is <u>NOT required</u>, but will help us to coordinate services for the child, so we strongly encourage the patient/guardian signs it.**

When you have completed this form, please submit it by encrypted email to natasha.robinson@columbiacountyny.com, by fax to 518-828-9450, or by mail to 325 Columbia Street Hudson, NY 12534 (attention to SPOA Coordinator).

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Today's date _____

Child's Information

Full Name (Last, First MI)	Primary Language(s)
Date of Birth / SSN	Gender Identity
Home Address	Fluent in English? ☐ YES ☐ NO
Mailing Address (if different from home)	Does the child have health insurance? ☐ YES ☐ NO

**** Please note that some services require Medicaid enrollment. Immigration status may impact a child's ability to apply for and receive Medicaid coverage ****

Insurance Plan	Insurance Policy Number	Medicaid/CIN#
Is this child enrolled in Health Home Care Management? ☐ YES ☐ NO ☐ UNKNOWN	If yes, please indicate which Health Home/Care Management Agency	

Referral Information

Date of Referral	Name/Title of Referrer	Referring Organization/Program
Address of Referrer		
Referrer Phone	Referrer Fax	Referrer Email
Reason for Referral (attach additional sheet if needed)		
Referrer Signature		

Caregiver Contact #1 Information		Caregiver Contact #2 Information	
Full Name		Full Name	
Address		Address	
Phone	Email	Phone	Email
Relationship to Child	Legal Guardian? ☐ YES ☐ NO	Relationship to Child	Legal Guardian? ☐ YES ☐ NO
Caregiver Primary Language	Fluent in English? ☐ YES ☐ NO	Caregiver Primary Language	Fluent in English? ☐ YES ☐ NO
Is this caregiver the primary contact? ☐ YES ☐ NO		Is this caregiver the primary contact? ☐ YES ☐ NO	
Is this caregiver enrolled in Health Home Care Management? ☐ YES ☐ NO ☐ UNKNOWN		Is this caregiver enrolled in Health Home Care Management? ☐ YES ☐ NO ☐ UNKNOWN	
If yes, please indicate which Health Home/Care Management Agency		If yes, please indicate which Health Home/Care Management Agency	

Legal Custody Status	
Both parents together	Joint custody
Biological mother only	DSS
Biological father only	Adult Sibling
Other Legal Guardian (describe):	Emancipated Minor
	Adoptive Parent

Current Providers	
School and grade	Therapist/Therapist's agency
Psychiatrist/Psychiatrist's agency	Other service provider/agency

IQ Testing Scores (if available)		
Verbal	Full Scale	Test date

Additional Information	
Is child/youth currently admitted to an inpatient facility? ☐ YES ☐ NO	Number of hospitalizations in the previous 12 months
If yes, name of facility and expected discharge date	Number of Emergency Department visits in the previous 12 months
Is child/youth currently receiving DSS preventive services? ☐ YES ☐ NO ☐ UNKNOWN	Other systems involvement (e.g. CPS, MST, etc.) – Please specify
If yes, name of provider	

Mental Health Diagnosis (if known)	
Does the child have a diagnosed serious emotional disturbance? ☐ YES ☐ NO	If so, what is it?
If yes, by whom was the diagnosis made?	If yes, when was the diagnosis made?

Preliminary Eligibility Screening	
Does the child have two or more chronic medical conditions (i.e. asthma, diabetes, substance use disorder)?	☐ YES ☐ NO ☐ UNKNOWN
Does the child have HIV/AIDS?	☐ YES ☐ NO ☐ UNKNOWN
Do you believe the child has a Serious Emotional Disturbance? (child 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 child's behavior creates a risk of removal from the household	☐ YES ☐ NO ☐ UNKNOWN
Has the child been exposed to multiple traumatic events that have left a long-term and wide-ranging impact?	☐ YES ☐ NO ☐ UNKNOWN

If you have supporting documentation related to one of the above diagnoses/conditions, please attach it.

Please complete attached REQUIRED consent for release of information to process this SPOA application.

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Child's Name _____

REQUIRED CONSENT FOR RELEASE OF INFORMATION for Single Point of Access (SPOA) for Children's Services

This authorization must be completed by the referred individual or his/her legal guardian to use/disclose 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. A separate authorization is required to use or disclose confidential HIV information.

CHILD'S NAME: _____ **Child's DOB:** _____

COUNTY(IES): _____

I authorize an exchange of PHI between the Single Point of Access (SPOA) Committee AND OTHER AGENCY/PERSON providing information to the committee (Please see attached list of agencies from which the SPOA Committee is permitted to request information):

AND: Referral Source (Person / Title / Agency or School):

_____

Description of information to be used / disclosed is as follows: (Please check ALL that apply) ☐ **All**

- ☐ Referral Packet
- ☐ Diagnosis
- ☐ Financial Status
- ☐ Physical Exam History
- ☐ School Records
- ☐ Physician's Authorization for Restorative Services
- ☐ Psychological & Neurological Tests
- ☐ Discharge Summary / Treatment Plans
- ☐ Psychosocial History & Assessment
- ☐ Inpatient/Outpatient History
- ☐ Psychiatric Assessment
- ☐ Other (progress notes)

Purpose or need for information:

By the individual or his/her personal representative to facilitate participation in services through SPOA, and through Health Homes Serving Children.

Note: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed on the attached list.

Thereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or re-disclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by the County government. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified as often as necessary to fulfill the purpose identified above, and this authorization will expire: **(Initial ONE)**

☐ When the child named herein is no longer receiving Services through the Single Point of Access Process in *(fill in county(ies))*
_____ Counties

☐ One Year from the date below

☐ Other: _____

I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire:

☐ When acted upon ☐ Other: _____

I certify that I authorize the use of the health information 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 PARENT or LEGAL GUARDIAN	**Printed Name of Parent/Legal Guardian**	**Date**
_____	_____	_____
SIGNATURE of WITNESS "I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION."	**Printed Name of Witness**	**Date**

Child's Name _____

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

C-YES

Children's Single Point of Access Application Part 1

Child's Name _____

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

Columbia
Name of SPOA County

By signing this form, you agree to have your child's health information shared with the SPOA Committee. The goals of the SPOA Committee are to improve the integration of medical and behavioral health and to help healthcare providers improve quality of care. To support coordination of your child's care, health care providers and other people involved in such care need to be able to talk to each other about your child's care and share health information with each other to give your child better care. Your child will still be able to get health care and health insurance even if you do not sign this form.

The SPOA Committee may get health information, including your child's health records, through a computer system run by HIXNY, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store health information, including medical records, from your child's doctors and health care providers who are part of the RHIO. The RHIO can only share your child's health information with people who you say can see or get such health information. PSYCKES is a computer system to collect and store health information from doctors and health care providers to help them plan and coordinate care.

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

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions;
6. Sexually-transmitted diseases (diseases you can get from having sex);
7. Social needs information (housing, food, clothing, etc..) and/or
8. Assessment results, care plans, or other information you or your treatment provider enter into PSYCKES.

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 child's health information must obey all these laws. They cannot give your child'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 child'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 AGREE** that the SPOA Committee can get ALL my child's health information through the RHIO and/or through PSYCKES to give my child care or manage my child's care, to check if my child is in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the SPOA Committee and the health provider agencies may share my child's health information with each other. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the SPOA participating providers.

_____ _____
Print Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____