COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

GREGSON H. PIGOTT, MD, MPH
COMMISSIONER

Children's Single Point of Access for Enhanced Mental Health Services

If your child needs more intensive mental health services than outpatient therapy alone, Children's Single Point of Access (SPOA) can help. Preventive, intensive, and residential services are available through a network of agencies in Suffolk County.

Referral Process

Provide a completed Children's SPOA Application, signed Authorization for Release of Information and required clinical materials. Send documentation to:

Children's SPOA Services
Suffolk County Division of Community Mental Hygiene Services
William J. Lindsay County Complex, Building C-016
725 Veterans Memorial Hwy. – P.O. Box 6100
Hauppauge, NY 11788
or Fax completed application to*: (631) 853-8518*

Please call (631) 853-8513 for assistance.*

Please select one of the service categories below:

☐ **Preventive In-Home Services:**

Parent to Parent; Family Connect; Youth and Family Integration (Y-FI); Services, Supports, Transitions, Advocacy, and Access for Youth (SSTAAY)

- **Psychosocial Assessment within 1 year signed by a Masters Level Mental Health Professional, SED Criteria Checklist (p. 3) AND one of the following:**
  - **Psychiatric/Diagnostic Assessment**
  - **IEP or 504 plan with mental health diagnosis**
  - **Psychological Assessment, Neurological Evaluation or Physician's statement with mental health diagnosis**

☐ **Intensive In-Home Services:**

Children's Care Coordination; Children's Health Home Care Management; Coordinated Children's Services Initiative; High Fidelity Wraparound; Mobile Early Intervention Program (MEIP)

- **Psychosocial Assessment within 1 year signed by a Masters Level Mental Health Professional**
- **Psychiatric Evaluation signed by a MD/DO or Nurse Practitioner within 1 year**

☐ **Residential Services:**

Community Residences; Residential Treatment Facilities

- **Psychosocial Assessment within 90 days signed by a Masters Level Mental Health Professional**
- **Psychiatric Assessment within 90 days signed by a MD/DO**
- **Physical Assessment within 90 days signed by a MD/DO or Nurse Practitioner**

Additional information may be requested to determine eligibility

Public Health
Prevent. Promote. Protect.

DIVISION OF COMMUNITY MENTAL HYGIENE Child SPOA
William J. Lindsay Complex, Building C016
725 Veterans Memorial Highway, P.O. Box 6100, Hauppauge, NY 11788
(631) 853-8500 FAX: (631) 853-3117

Children's Single Point of Access Application

Today's date_____

Child's Information

Full Name (Last, First MI)

Gender	Date of Birth	SSN

Race/Ethnicity	Primary Language(s)	Fluent in English? ☐ Yes ☐ No

Home Address

Mailing Address (if different from home)

Child's Insurance Plan	Child's Insurance Policy Number	Child's Medicaid/CIN #

If Medicaid recipient, please note: Many CSPOA services are now Health Home Services and require Health Home Consent. Not consenting may limit program option.

Do you consent to your child being referred to a Health Home?

☐ YES ☐ NO

Is this child enrolled in Health Home Care Management?

☐ YES ☐ NO ☐ UNKNOWN

If yes, please indicate which HH/CMA: _____

Caregiver Contact Information

Full Name	Primary Phone Alt. Phone

Address	Relationship to Child _____ Is this caregiver the primary contact? ☐ YES ☐ NO

Does the child reside at this address? ☐ YES ☐ NO

Caregiver Primary Language	Fluent in English? ☐ YES ☐ NO

Legal Guardian? ☐ YES ☐ NO If no, name and phone number of legal guardian? _____

Is this caregiver enrolled in Health Home Care Management?

☐ YES If yes, please indicate which HH/CMA: _____ ☐ NO ☐ UNKNOWN

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 **Date**

Legal Guardian Signature **Date**

I agree to be contacted by a Family Peer Support Specialist ☐ YES ☐ NO

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

Current Providers	
Name of School District, School Attending, and Grade	Therapist/Therapist's Agency
Psychiatrist/Psychiatrist's Agency	Other Service Provider/Agency

IQ Testing Scores (if available)		
Full Scale	Verbal	Name of Test and Test Date

Additional Information	
Is child/youth currently admitted to an inpatient facility? ☐ YES ☐ NO	Previous Hospitalizations/ER Visits Dates _____ _____ _____ _____ _____ _____ _____ _____
If yes, name of facility and expected discharge date	
Is child/youth currently receiving DSS preventive services? ☐ YES ☐ NO ☐ UNKNOWN	
If yes, name of provider	Other systems involvement (e.g. CPS, AFY, PINS, etc.) – Please specify

Preliminary Eligibility Screening	
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
Does the child have a diagnosed serious emotional disturbance? If yes, what is it? _____ By whom was the diagnosis made? _____ Date of diagnosis _____	☐ 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
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

Criteria Checklist: At Risk of Serious Emotional Disturbance (SED)

Complete this form if you are referring the youth to Preventive Services.

In order to qualify, the following 5 areas must be met. Check All That Apply:

☐ 1. **Age:**

- ☐ be a person under the age of 18 years **OR**
- ☐ be a person between the ages of 18 and 21, who received services prior to their 18th birthday, was diagnosed with an emotional disturbance and demonstrates a continued need for services

☐ 2. **Diagnosis of Emotional Disturbance:** A DSMV Diagnosis **OTHER** than**:**

- Substance Related and Addictive Disorders
- Neurocognitive Disorders and Disorders Due to Another Medical Condition
- Neurodevelopmental Disorders (with the exception of ADHD)

☐ 3. **Impairment in Functioning due to Emotional Disturbance:** Over the last 6+ months, the person has experienced functional limitations due to emotional disturbance. ***Check all that apply.***

Limitations	Mild	Moderate	Severe
Ability to Care for Self	☐	☐	☐
Family Life	☐	☐	☐
Social Relationships	☐	☐	☐
Self-Direction/Self-Control	☐	☐	☐
Ability to Learn	☐	☐	☐

☐ 4. **Meets Criteria for At Risk of SED:**

☐ **Meets Criteria for At Risk of Serious Emotional Disturbance:** At least one must be selected

- ☐ Failed adoptions
- ☐ Parent with serious/persistent mental illness
- ☐ Parent with history of chronic alcohol and/or drug abuse
- ☐ Death of a caregiver/loved one
- ☐ Has been a victim of physical, emotional, sexual abuse, or severe neglect
- ☐ Has been a victim of or witness to serious violent crime or domestic violence
- ☐ Has been a victim of bullying
- ☐ Out of home placement due to emotional disturbance
- ☐ Multiple family separations
- ☐ Extended period of homelessness
- ☐ Youth is at risk of out of home placement or inpatient hospitalization
- ☐ Psychiatric ER visit without admission
- ☐ Involvement with the juvenile justice/child welfare systems

☐ 5. **Required Documentation:** Psychosocial assessment within 1 year AND one of the following:

☐ Psychiatric/Diagnostic Assessment ☐ IEP or 504 Plan with mental health diagnosis
☐ Psychological Assessment, Neurological Evaluation, or Physician's Statement with mental health diagnosis

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This youth meets the criteria for the designation of At Risk of Serious Emotional Disturbance as documented by the individual below, a **qualified licensed/certified Masters Level Mental Health professional.**

Print Name/Credentials: _____ Phone: _____

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) "C" No.

……

Sex……Date of Birth……

Facility Name

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purpose), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Part I – Authorization to Release Information

Description of Information to be Used/Disclosed:

Telephone contact and/or written summary for the following: Universal Referral Form, Psychiatric, Psychosocial, Psychological, Neurological, and Physical Assessments, Educational Records, Treatment Plans, Discharge Summaries, All relevant clinical data

I, *(insert Parent/Legal Guardian)* _____ consent to release personal health information to the Children's Single Point of Access (CSPOA) Committee. I understand that the CSPOA will review and evaluate the information to determine eligibility for services in Family Connect; Youth and Family Integration; Services, Supports, Transitions, Advocacy, and Access for Youth; Children's Care Coordination; Health Home Care Management; Coordinated Children's Services Initiative; High Fidelity Wraparound; Mobile Early Intervention Program; Parent to Parent; Community Residence; and/or Residential Treatment Facility.

Purpose or Need for Information:

1. This information is being requested:
   - ☐ by the individual or his/her personal representative; or
   - ☐ Other (please describe)_____
2. The purpose of the disclosure is: To facilitate program determination and placement

From/To: Name, Address and Title of Person/Organization/ Facility Program Disclosing Information.	To/From: Name, Address and Title of Person/Organization/Facility Program to which Disclosure is to be made.
	CSPOA: Children's Services Suffolk County Department of Health Div. of Community Mental Hygiene Services William J. Lindsay Complex, Bldg. C-016 725 Veterans Memorial Hwy. P.O. Box 6100 Hauppauge, New York 11788

A. I authorize the CSPOA to release clinical information and make recommendations for the appropriate program for possible enrollment. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. 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.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) **CSPOA** shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health and Suffolk County Dept. of Health Services, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524.

B-1. **Periodic Use/Disclosure:** I hereby authorize the periodic use/disclosure of this information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ☐ When I am no longer receiving services from (insert name of facility/program) **CSPOA**
- ☐ Other _____

B-2. **One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above.

My authorization will expire:

- ☐ When acted upon;
- ☐ 90 Days from this Date;
- ☐ Other_____

AUTHORIZATION FOR RELEASE OF INFORMATION

State of New York
OFFICE OF MENTAL HEALTH

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C" Wd. No.

C. **Patient Signature:** I certify that I authorize the use of my health information as set forth in this document.
I understand that I will be offered a copy of this completed form and/or that a copy will be maintained by the facility for me.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization)

D. **Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____ _____
Staff person's name and title Date

Authorization Provided To: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

Title _____

Date Released _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

Name: _____

Address: _____

City: _____ Zip _____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

Name: _____

Address: _____

City: _____ Zip _____

Patient Signature

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name (Printed) Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization)

AUTHORIZATION FOR RELEASE OF INFORMATION

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C" Wd. No.

I understand that I have the right to attend all meetings held to determine what services my child will receive, along with a full explanation of those services.

I understand that my input will be considered in any decisions made regarding services offered to my child and family. I understand that I am entitled to have a Family Peer Support Specialist designated to assist me through the application review process, and I will be given information about other family support services available to me.

I understand information about my child and family will be handled in a confidential manner, will be reviewed solely for the purpose of determining services, and will not be released to any other parties without my express permission.

I understand that if I disagree with what services are offered to my child, and it cannot be resolved with the Children's SPOA Coordinator, I can appeal to the County Director of Children's Mental Health Services.

I have read and give my consent for the Children's SPOA to review my child's application.

Children's SPOA Services

Suffolk County

In Home Programs

Parent to Parent
Family Connect
Youth and Family Integration
Services, Supports, Transitions, Advocacy, and Access for Youth Children's Care Coordination
Children's Health Home Care Management
Coordinated Children's Services Initiative
High Fidelity Wraparound
Mobile Early Intervention Program

Out of Home Programs

Community Residence
Residential Treatment Facility

Provider list includes:

Association for Mental Health and Wellness,
Family and Children's Association,
Family Service League, Mercy First,
Northwell Health, SCO Family of Services,
Suffolk Co. Division of Community Mental Hygiene Services,
Sun River Health & WellLife Network

Please contact CSPOA at *(631) 853-8513
if you have any questions or need assistance with this form
***The completed CSPOA Application may be faxed to**
(631) 853-8518

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

SUFFOLK COUNTY CHILDREN'S SINGLE POINT OF ACCESS

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 HealtheConnection, 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 allow to access such 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
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient
Signature of Witness	Print Name of Witness

Child's Name _____

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

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my child's information?**

   If you agree, SPOA providers will use your child's health information to:

   - Coordinate your child's health care and manage your child's care;
   - Check if your child has 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 your child health insurance or pay your bills.

2. **Where does my child's health information come from?**

   Your child's health information comes from places and people that gave your child 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 child's 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 child's information?**

   The only people who can see your child's health information are those who you agree can access it, like doctors, professionals who work for the SPOA and SPOA providers who are involved in your child's health care. The information will help them check your child's health insurance or to study and make health care better for all patients.

5. **What if a person uses my child's information and I didn't agree to let them use it?**

   If you think a person used your child's information, and you did not agree to give the person your child's information, call one of the providers you have said can see your child's records, the Suffolk County Children's SPOA at 631-853-8513, 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 Suffolk County Children's SPOA at 631-853-8513. 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.