YATES COUNTY SPOA/Community Services
417 Liberty St., Ste. 2033
Penn Yan, NY 14527
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PHONE: 315-536-5115 SPOA Coordinator: 585-721-8316

REFERRAL TO THE SPOA COMMITTEE

(Single Point of Access for Adults, Children and Youth)

RELEASE OF INFORMATION

I,_____,(Parent/Guardian) of_____ consent to the release of clinical information to SPOA. I understand that SPOA will review and evaluate the information to determine eligibility for services, which could include a variety of formal and informal community resources. See Single Point of Access Information Summary for Specific list of Team Members.

I authorize SPOA to release clinical information and make recommendations for possible enrollment in the appropriate program, i.e, Home and Community Based Waiver, Case Management Services, Community Residence or Residential Treatment, as well as formal and informal community resources.

I hereby permit the use or disclosure of the 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. I am aware that 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 ability to obtain treatment from the New York State Office of Mental Health, 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).

____ I have been given a copy the signed release ____ I have declined a copy of the signed release

Signed: _____ Date Signed**:** _____
Parent / Guardian

Witness: _____ Date Signed: _____

I hereby revoke my authorization given above to submit my child's name or to provide information to the SPOA Committee so that s/he might be considered for involvement in SPOA for services. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and / or disclose my protected health information have acted in reliance upon this authorization.

Signed: _____ Date Signed: _____
Parent / Guardian

Witness: _____ Date Signed: _____

Children SPOA Referral
Yates County Single Point of Access (SPOA)
Enrollment Referral Application
REFERRAL SOURCE

Client Information

Child's First Name:	**Middle initial**:	**Last Name**
Current Address:		**Phone**:
Date of Birth:	**Gender:** **Male** ☐ **Female** ☐	**Child's SSN:**
Medicaid ID 1:		**Primary Language:**
Ethnicity:		
English proficiency: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Does not understand** **Family's primary language:** ☐ **English** ☐ **Spanish** ☐ **Other, please specify**		
County of SPOA (Fiscal) Responsibility		**County of Residence** Yates

Are Parents legal guardians? ☐ Yes ☐ No	If NO, please list guardian below in "Other Significant Contacts	
Primary Contact's Name	Relationship	
Address	Home phone	Work Phone
Father's Name	Address	Phone Number
Mother's Name	Address	Phone Number

Other Significant Contacts-

First Names, MI, Last Name	Primary contact? ☐ Yes ☐ No	County
Address, City, State, zip	Home phone	Work Phone
First Names, MI, Last Name	Primary contact? ☐ Yes ☐ No	County
Address, City, State, zip	Home phone	Work Phone

Current Therapist

NAME:	
Agency:	Phone Number:

Current Providers

Agency	Name	County
Address	Home Phone	Work Phone
Agency	Name	County
Address	Home Phone	Work Phone

Background Information

Child's living situation: (Check one box only)

- ☐ Independent living
- ☐ Two parent family
- ☐ One parent family
- ☐ 2 parent adoptive family
- ☐ 1 parent adoptive family
- ☐ Grandparent (s)
- ☐ Other relative's home
- ☐ Crisis Residence
- ☐ Family Base Treatment
- ☐ Teaching family home
- ☐ OMH CY community Residence
- ☐ Residential Treatment Facility (OMH)
- ☐ OCFS family foster care
- ☐ Psychiatric inpatient care-unspecified
- ☐ OCFS group home
- ☐ OCFS/ DRS facility
- ☐ OCFS therapeutic foster care
- ☐ DFY Community Group home
- ☐ Residential treatment center (OCFS)
- ☐ Residential School In State(SED)
- ☐ General hospital psychiatric inpatient
- ☐ Private psychiatric inpatient
- ☐ State psychiatric inpatient
- ☐ Runaway shelter
- ☐ Jail
- ☐ Homeless/ streets
- ☐ SED Out of State Placement
- ☐ DSS/OCFS Out of State Placement
- ☐ Unknown
- ☐ other specify

Highest level of education (check one box only)

- ☐ Kindergarten
- ☐ First
- ☐ Second
- ☐ Third
- ☐ Fourth
- ☐ Fifth
- ☐ Sixth
- ☐ Seventh
- ☐ Eighth
- ☐ Ninth
- ☐ Tenth
- ☐ Eleventh
- ☐ Twelfth

School District:

Child's custody status: (check one box only)

- ☐ Adoptive Father
- ☐ Adoptive Mother
- ☐ Adoptive Parents
- ☐ Biological Father
- ☐ Biological Mother
- ☐ Biological Parent & Adoptive Parent
- ☐ Biological Parents
- ☐ DFY
- ☐ Emancipated Minor
- ☐ Grandparent(s)
- ☐ Legal Guardian (non-kin)
- ☐ Local DSS
- ☐ Local DSS - FREED
- ☐ OCFS/DRS
- ☐ Other

Child's Educational Placement: (Check one box only)

- ☐ Regular class in age-appropriate grade
- ☐ Regular class, above grade level
- ☐ Regular class, but behind at least one grade
- ☐ Special class for students with handicapping conditions
- ☐ Residential school for the educationally (emotionally) handicapped
- ☐ Vocational training only
- ☐ Part time vocational/educational
- ☐ High School graduated/GED
- ☐ Day Treatment
- ☐ Home instruction
- ☐ BOCES
- ☐ College
- ☐ Not enrolled in school
- ☐ Other Specify
- ☐ Unknown

Committee on Special Education Status:

- ☐ Emotionally disturbed
- ☐ Learning disabled
- ☐ Sensory impaired
- ☐ Physically disabled
- ☐ Other health impaired
- ☐ Multiply handicapped
- ☐ None
- ☐ Unknown

Child's Legal Status: (Check one box only)

- ☐ PINS
- ☐ PINS Diversion
- ☐ Juvenile delinquent
- ☐ Juvenile delinquent - restricted
- ☐ Juvenile offender
- ☐ None
- ☐ Unknown
- ☐ Other specify

Income or benefits child is currently receiving: (check all that apply)

- ☐ Social Security retirement, survivor's or dependent's (SSA)
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Income (SSDI)
- ☐ Any public assistance cash program: Family Assistance(TANF), Safety Net, Temporary Disability
- ☐ Medicare
- ☐ Medicaid
- ☐ Private insurance, employer coverage, no third party insurance
- ☐ VA/Military benefits
- ☐ None
- ☐ Unknown
- ☐ Other benefits(please specify)

SCALE

0. NOT EVIDENT Child does not display this symptom/ behavior
1. MILD This symptom/behavior exists, but there is no impairment (loss of effectiveness) in carrying out daily activities or in meeting major role requirements.
2. MODERATE This symptom/behavior exists. This child maintains an appropriate level of functioning in daily activities and major roles only with difficulty and increased effort and support.
3. MARGINALLY SEVERE This symptom/behavior exists. There is definite impairment in carrying out daily activities and/or performing major roles. Major roles are able to be performed.
4. SEVERE This symptom/behavior exists. Definite impairment exists in daily activities. The child is unable to perform one or more major role at any level. The child may not be allowed to remain in one or more major roles due to severity of symptom/behavior.
5 UNKNOWN

Functioning

	Not Evident 0	Mild 1	Moderate 2	Marginally Severe 3	Severe 4	Unknown 5
Self Care	☐	☐	☐	☐	☐	☐
Social Relationships/Functioning	☐	☐	☐	☐	☐	☐
Cognitive Functioning/Communication	☐	☐	☐	☐	☐	☐
Self Direction	☐	☐	☐	☐	☐	☐
Motor Functioning	☐	☐	☐	☐	☐	☐

Symptoms and Behavior

Currently	Not Evident 0	Mild 1	Moderate 2	Marginally Severe 3	Severe 4	Unknown 5	**PAST HISTORY**		
							Y	**N**	**U**
Suicidal Ideation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychotic Symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phobia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Danger to self	☐	☐	☐	☐	☐	☐	☐	☐	☐
Danger to others	☐	☐	☐	☐	☐	☐	☐	☐	☐
Temper Tantrums	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Enuresis/Encopresis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical Complaints	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Developmental Delays	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexually inappropriate	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexually Aggressive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Verbally Aggressive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physically Aggressive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Interactions	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hyperactive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Impulsive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-injury	☐	☐	☐	☐	☐	☐	☐	☐	☐
Runaway	☐	☐	☐	☐	☐	☐	☐	☐	☐
Destruction of Property	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fire setting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cruelty to Animals	☐	☐	☐	☐	☐	☐	☐	☐	☐

Child's Treatment and Services History

History of Past and Present Services: (Check all that apply)

	Prior			Current				Prior			Current		
	Y	N	U	Y	N	U		Y	N	U	Y	N	U
Individualized Care Coordination (HCBS-Waiver)	☐	☐	☐	☐	☐	☐	Intensive in home	☐	☐	☐	☐	☐	☐
Intensive Case Management	☐	☐	☐	☐	☐	☐	Specialized summer program	☐	☐	☐	☐	☐	☐
Supportive Case Management	☐	☐	☐	☐	☐	☐	Specialized educational services	☐	☐	☐	☐	☐	☐
Blended Case Management	☐	☐	☐	☐	☐	☐	Mentoring	☐	☐	☐	☐	☐	☐
Service coordination/case management	☐	☐	☐	☐	☐	☐	Flexible funding	☐	☐	☐	☐	☐	☐
Family Based Treatment	☐	☐	☐	☐	☐	☐	Foster Care	☐	☐	☐	☐	☐	☐
Residential Treatment Facility	☐	☐	☐	☐	☐	☐	Probation	☐	☐	☐	☐	☐	☐
Community Resident	☐	☐	☐	☐	☐	☐	CCSI	☐	☐	☐	☐	☐	☐
Teaching Family Home	☐	☐	☐	☐	☐	☐	OMRDD Waiver	☐	☐	☐	☐	☐	☐
Home Based Crisis Intervention	☐	☐	☐	☐	☐	☐	Hospitalization (ART 28/31)	☐	☐	☐	☐	☐	☐
Day Treatment	☐	☐	☐	☐	☐	☐	OCFS Placement	☐	☐	☐	☐	☐	☐
Clinic treatment	☐	☐	☐	☐	☐	☐	Educational Placement	☐	☐	☐	☐	☐	☐
Respite	☐	☐	☐	☐	☐	☐	DSS Preventive	☐	☐	☐	☐	☐	☐
Family Support Services	☐	☐	☐	☐	☐	☐	DSS Protective	☐	☐	☐	☐	☐	☐
Alcohol abuse treatment	☐	☐	☐	☐	☐	☐	Out of State Provider	☐	☐	☐	☐	☐	☐
Substance abuse treatment	☐	☐	☐	☐	☐	☐	Private/individual therapy	☐	☐	☐	☐	☐	☐
Medication management	☐	☐	☐	☐	☐	☐	Crisis response services	☐	☐	☐	☐	☐	☐
Vocational training	☐	☐	☐	☐	☐	☐	ADL or Independent living skills	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐	Speech & language therapy	☐	☐	☐	☐	☐	☐
After school/weekend program	☐	☐	☐	☐	☐	☐	Private psychiatric facility	☐	☐	☐	☐	☐	☐
OMRDD Development Center	☐	☐	☐	☐	☐	☐	General hospital psychiatric inpatient	☐	☐	☐	☐	☐	☐
State psychiatric facility	☐	☐	☐	☐	☐	☐	Other *specify*	☐	☐	☐	☐	☐	☐

Diagnosis Information

Axis I Diagnosis: clinical disorders, other conditions that may be a focus of clinical attention – up to 4 diagnoses may be entered. Please list Axis 1 Primary Diagnosis first.

Axis II Diagnosis: personality disorders, mental retardation (if any) – Up to 4 diagnosis may be entered.

Axis III Diagnosis: general medical conditions (if any) – Up to 4 diagnosis may be entered.

Axis IV Diagnosis: psychosocial and environmental problems

- ☐ Problems with primary support group
- ☐ Problems related to the social environment
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Economic problems
- ☐ Problems with access to health care services
- ☐ Problems related to access with the legal system/crime
- ☐ Other psychosocial and environmental problems

Axis V Diagnosis: Global Assessment of Functioning (GAF):

Does the child currently have medication(s) prescribed for a psychiatric condition? (select one)

	Medication	**Dosage**	**Frequency**
☐ **NO**			
☐ **Unknown**			
☐ **YES (please list)**			

Psychiatric hospitalization in last 12 months	
Psychiatric hospitalization in last 6 months	
Emergency Room visits for psychiatric conditions in the last 12 months	
Emergency Room visits for psychiatric conditions in the last 6 month	
Arrest in the last 6 months	
Incarceration in last 6 months	

How frequently was this child a victim of sexual or physical abuse? (Select one response)
NOTE: A hotline report will be required if there has been abuse.

- ☐ Never
- ☐ Not at all in past six months
- ☐ One or more times in the past 6 months, but not in the past 3 months
- ☐ One or more times in the past 3 months, but not in the past month
- ☐ One or more times in the past month, but not in the past week
- ☐ One or more times in the past week
- ☐ Unknown

Referral

Referral Source to SPOA

Services Child referred to SPOA for: (check all that apply)

- ☐ Intensive Case Management
- ☐ Supportive Case Manager
- ☐ Individualized care coordination (Waiver)
- ☐ Clinic treatment
- ☐ Family Support Services
- ☐ Substance abuse treatment
- ☐ Community Residence
- ☐ Day Treatment
- ☐ Respite
- ☐ OPWDD Developmental Center
- ☐ Residential Treatment Facility
- ☐ Other *specify*____

Other than Client, who lives in the home?

Name	**Relationship**

Reason for Referral: (this Section must be completed)			
List Child's Strengths: (Enter as many as desired)			
Interests and Hobbies			
List of Family/Caregiver Strengths: (Enter as many as desire)			
Name of person Referring Child to SPOA:	Title:		
Signature of Person Referring Child to SPOA _____		Phone:	Date of Referral to SPOA

Criteria for Serious Emotional disturbance Among Children and Adolescents
To be considered a child or adolescent with serious emotional (A) must be met.
In addition (B) or (C) must be met

_____A. Designated Emotional Disturbance Diagnosis
The youngster is younger than 18 years of age and currently meets the criteria for DSM-III-R psychiatric diagnosis other than Alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-9-CM categories and codes that do not have an equivalent in DSM-III-R are not included as designated diagnoses.

AND

B. Extended Impairment in Functioning due to Emotional Disturbance
The youngster must meet 1 and 2 below

1. The youngster has experience functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional problems must be in at least two of the following areas or severe in at least one of the following areas.

a. Self –Care (personal hygiene; obtaining and eating food; dressing, avoiding injuries

b. Family life (Capacity to live in a family or family-like environment: relationships with parents or substitute parents, siblings, and other realties; behavior in family setting)

c. Social relationships (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.)

d.Self-direction/self-control (ability to sustain focused attention for long enough periods of time to permit completion of age appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability).

e. Learning ability (school achievement and attendance; receptive and expressive language; relationships with teacher, behavior in school).

2 The youngster has met criteria for ratings of 50 or less on the children's Global Assessment Scale (CGAS) due to emotional disturbance for the past 12 months on a continuous or intermittent basis

OR

C. Current Impairment in Functioning with Severe Symptoms The youngster must meet 1 and 2 below

1. The youngster currently meets criteria for a rating of 50or less on the Children's Global Assessment Scale (CGAS) due to emotional disturbance.

2. The youngster must have experienced at least one of the following within the past 30 days.

a. Serious suicidal symptoms or other life-threatening, self-destructive behaviors.

b. Significant psychotic symptoms (hallucinations, delusions, bizarre behavior)

c. Behavior caused by emotional disturbances that placed the youngster at risk of causing personal injury or significant property damage

1. It is intended that the clinician assess the youngster's functioning in at least these five domains in consideration of assigning a single numerical rating on the CGAS.

2.

2. While the CGAS is recommended, ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-III R) may be substituted.