Delaware County Adult Single Point of Access (ASPOA)

243 DELAWARE STREET
WALTON, NY 13856
PHONE: (607) 832-5704
FAX: (607) 832-6081

Thank you for your interest in residential and care management services for adults residing in Delaware County who are diagnosed with a serious and persistent mental illness.

Please complete the application form if you are referring an adult to:

*Health Home Care Management
*Delhi Community Residence
*Supportive Apartment Program
*Supported Housing

Referral Process:

1) The referral source completes the application packet, including the consent form, and attaches a recent (less than 6 months) psychiatric evaluation and/or a comprehensive assessment. The completed application packet should be sent to:

   Crystal Moore, LCSW
   Delaware County SPOA Program Coordinator for Children and Adults
   243 Delaware Street
   Walton, NY 13856

2) Once a completed packet is received and reviewed, the SPOA Committee will determine whether the person is appropriate for SPOA services. The client and the referring person will be notified of the SPOA committee's decision.

3) Please note: The person being referred may be placed on a waiting list since openings are not always readily available in these programs. It is the responsibility of the referral source and the existing service providers to create and implement a plan that will safely maintain the person in the community. SPOA is a point for accessing residential and Care Management services and is **NOT** a service provider; therefore, SPOA should **NOT** be considered a component of a safety plan for the client/family.

4) If not eligible for the above services, the SPOA committee may provide other recommendations.

5) The person will be offered the appropriate service when an opening is available and as long as the service is still needed.

6) The SPOA committee meets the second Tuesday of each month at 9:30 am.

7) The client and referral source are encouraged to attend the meeting to discuss the referral and answer questions from committee members. Please call the SPOA Program Coordinator if you are planning to attend the meeting.

Eligibility Checklist

SPOA Eligibility Determination

To be eligible for services through SPOA, applicants for Residential or Care Management Services must be diagnosed with a severe and persistent mental illness.

Please complete the checklist below to determine if the applicant is eligible for services. **A must be met. In addition, B, C or D must be met.**

☐ **Yes** ☐ **No** **A.** The applicant is 18 years of age or older and currently meets the criteria for **a** primary DSM5/ICD10 Mental Health diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions.

☐ **Yes** ☐ **No** **B. SSI or SSDI enrollment due to Mental Illness.** The applicant is currently enrolled in SSI or SSDI **DUE TO A Designated Mental Illness.**

☐ **Yes** ☐ **No** **C. Extended Impairment in Functioning due to Mental Illness.**

1. The applicant has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis. (Documentation in Comprehensive Assessment is required).

☐ **Yes** ☐ **No** **a. Marked difficulties in self-care.**
☐ **Yes** ☐ **No** **b. Marked restrictions of activities of daily living.**
☐ **Yes** ☐ **No** **c. Marked difficulties in maintaining social functioning.**
☐ **Yes** ☐ **No** **d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school setting.**

☐ **Yes** ☐ **No** **D. Reliance on Psychiatric Treatment, Rehabilitation and Supports**

A documented history shows that the applicant at some prior time met the threshold for **C above** but may not any longer because the symptoms and/or functioning problems are currently reduced or significantly better from their consistent use of their psychotropic medication or psychiatric rehabilitation and supports.

Delaware County SPOA APPLICATION

SPOA Applicant Information (Please Print)

Date of Referral: _____

Name Format (Last, First, M.I.)

Name: _____ Date of Birth: _____
Preferred Name: _____ Soc. Sec. Number: _____
Sex Assigned at Birth: _____ Race: _____
Gender: _____ Preferred Pronouns: _____
Address: _____ Primary language: _____
City and Zip Code: _____ Phone: _____
Health Insurance: _____ Medicaid Number: _____
Emergency Contact: _____ Phone: _____
Relationship: _____ E-Mail: _____

Current Living Situation

☐ Room
☐ Own Apt./Home
☐ Supervised Living
☐ Supportive Housing
☐ Lives with spouse
☐ RSS CR
☐ Correctional Facility
☐ Homeless (Shelter)
☐ Homeless (streets)
☐ Nursing Home
☐ Psychiatric Hospital
☐ Lives with parents
☐ RSS TAP
☐ Other_____

Custody Status of Children

☐ No Children
☐ Children are above 18 yrs. of age
☐ Minor children in client's custody
☐ Minors not in custody but has access
☐ Minors not in custody and no access

Insurance and Financial Information (Currently Receives):

☐Social Security
☐SSI/SSDI
☐Public Assistance
☐Medicaid
☐Medicare
☐Earned Income/Wages
☐Food Stamps
☐VA Benefits
☐Representative Payee (Relationship to applicant)
☐Other: _____

(Application Continued)

Referral Source:

Contact Person: _____ Phone: _____
Agency: _____ Fax: _____
Program/Service: _____
Mailing Address: _____
Relationship to Applicant: _____

Outpatient Treatment Provider:

Agency: _____ Telephone: _____
Therapist: _____ Fax: _____
Psychiatrist: _____ E-Mail:_____

Psychiatric/Medical Information:

Psychiatric Diagnosis (include ICD 10 codes):

_____ _____
_____ _____
_____ _____

Current Medical Conditions including any Physical Disability (include ICD 10 codes):

_____ _____
_____ _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____ _____

(Application Continued)

Number of Psychiatric Hospitalizations in the past 12 months: _____

Dates and Facilities:

Number of Psychiatric ED visits in past 12 months: _____

Dates and Facilities:

Substance Abuse History:

Drugs of choice:

☐ None	☐ Any IV Drug Use	☐ Alcohol	☐ Marijuana
☐ Cocaine	☐ Crack	☐ Heroin/Opiates	☐ Tobacco
☐ Hallucinogens	☐ PCP	☐ Amphetamines	☐ Inhalants
☐ Sedatives/Hypnotics		☐ Benzodiazepines	
☐ Prescription Drugs		☐ Other _____	

Frequency of Use:

☐ Daily	☐ 3 to 6 times/week	☐ 1 to 2 times/week
☐ 1 to 3 times in the last month	☐ Not in the last month	☐ Unknown

Length of Time Applicant Has Been Substance Free: _____

AOT Status

Current AOT Status: ☐ YES ☐ NO
Past AOT Status: ☐ YES ☐ NO

If Yes: Effective Date: _____ Expiration Date: _____

AOT Contact Person: _____ Phone #: _____

(Application Continued)

Criminal Justice: Current Status:

☐ None ☐ Incarcerated-Jail ☐ Incarcerated-Prison:
☐ Probation ☐ Parole ☐ Other

Parole/Probation Officer's Name: _____ Phone #: _____

Number of arrests/incarcerations in past year: _____

Number of lifetime arrests: _____

Reason for Arrest(s): _____

Care Management Service Requested:

☐ Health Home Care Manager
☐ Health Homes Plus

Residential Service Requested:

☐ Supervised Community Residence
☐ Supportive Apartment Program
☐ Supported Housing

To Be Completed by Applicant:
Please describe your request for service(s) in your own words and indicate if you require handicap accessible housing.

(Application Continued)

Any Additional Information: _____

Applicant's Signature: _____ Date: _____

Referral Source's Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Birth Gender Identified

Sex Date of Birth

Delaware County SPOA Committee
Facility Name Unit/Ward/Residence No.

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

SPOA Application, Comprehensive Assessment and/or Psychiatric Assessment, and verbal communication

Purpose or Need for Information:

1. This information is being requested:
   - ☐ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or
   - ☐ Other (please describe) _____
2. The purpose of the disclosure is (please describe):

   ____ Continuity of Care

To/**From:** Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information

SPOA Committee: Rehabilitation Support Services (RSS), Southern Tier Care Coordination (STCC), Bassett Health Home Care Coordination, Delaware County Supportive Housing, MCAT, DSS, Delaware County Mental Health, RSS In home Stablization, OPWDD (Southern Tier Connects)

From/**To:** Name, Address, & Title of Person/Organization/Facility/ Program to Which this Disclosure is to be Made

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 here.*

A. 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 the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
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)* Delaware County SPOA Committee . 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, 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 and NYS Mental Hygiene Law §33.16.

B-1. 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_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

State of New York
OFFICE OF MENTAL HEALTH

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

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the 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)* Delaware County SPOA for Care Coordination and//or Residential Services ;
- ☐ One year from this date;
- ☐ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
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

Authorization Provided To: _____

Date: _____

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 I, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

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

_____

_____

_____

_____ _____
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 Revocation of Authorization)*