Children's Single Point of Access Application Part 1

Today's date_____

Child's Information			
Full Name (Last, First MI)		People with the following immigration status may be eligible for Medicaid: • Citizen • Permanent resident (green card holder) • Refugee or asylee • U or T visa holder (for victims of crime or trafficking) • Employment authorization card holder • Deferred Action for Childhood Arrivals (DACA) recipient Does the child's immigration status fall into one of the above categories? YES NO	
Date of Birth	SSN		
Home Address			
Mailing Address (if different from home)			
Primary Language(s)	Does the child have health insurance? YES NO	Gender Identity	Fluent in English? YES NO
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	

Children's Single Point of Access Application Part 1

Child's Name _____

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.

Child's Name _____

REQUIRED CONSENT FOR RELEASE OF INFORMATION
for Single Point of Access (SPOA), St. Lawrence County ("County")

This authorization must be completed by the referred individual or his/her legal guardian/personal representative. This authorization permits the use, disclosure and re-disclosure of 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 for the purposes of care coordination, delivery of services, payment for services, and health care operations.

I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and PHI between, the County Single Point of Access (SPOA) team (comprised of County and state employees as well as representatives of local service providers), Other Provider(s) (see attached list of Providers on page 2); **AND** the Referral Source (Person / Title / Agency / School or Correctional Facility):

_____

DESCRIPTION OF INFORMATION to be used / disclosed and re-disclosed *(check ALL that apply):* ☐ **ALL listed below**

- ☐ Referral (including contact info)
- ☐ Psychiatric Evaluation/Assessment
- ☐ Mental Health/Psychosocial Assessment
- ☐ Psychological &/or Neurological Tests
- ☐ Documentation of Medical Necessity
- ☐ Psychosocial History and Assessment
- ☐ Family Planning Information
- ☐ Inpatient/Outpatient Treatment
- ☐ Financial &/or Insurance Info
- ☐ Discharge Summary/Treatment Plan
- ☐ Pre-Sentence Investigation Report
- ☐ HIV/AIDS-related Information
- ☐ Other (specify): _____
- ☐ Diagnosis
- ☐ Physical Health
- ☐ Medications (past & present)
- ☐ Substance Use
- ☐ School Records (including testing)

PURPOSE OR NEED FOR INFORMATION:
Allow SPOA to: make referrals to appropriate providers; consult regarding care; participate in care management services; provide discharge planning information to the providers listed on page 2; coordinate care among providers and through Health Homes; and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization;
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law or regulation;
- I am authorizing the re-disclosure of above-described information to the providers identified on page 2 of this form for the purposes identified on this form;
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on a form provided by **County.** I am aware that my revocation does not affect information disclosed while the authorization was in effect;
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain treatment, nor my eligibility for benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524);

I HEREBY AUTHORIZE the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified on this release as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire: (check one)

☐ When the individual named herein is no longer receiving services from County SPOA;

☐ One Year from the date of signature; ☐ Other: _____

I CERTIFY THAT I AUTHORIZE the use of the PHI 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 Individual, Parent or Legal Guardian	**Printed Name of Individual signing**	**Date**

_____
Description of Authority of Personal Representative

_____	_____	_____
SIGNATURE of WITNESS	**Printed Name of Witness/Title**	**Date**

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

St. Lawrence County Community Services

St. Lawrence Psychiatric Center

St. Lawrence County Department of Social Services

St. Lawrence County Probation

St. Lawrence-Lewis BOCES

Office of People with Developmental Disabilities

Community Health Center of the North Country

Cerebral Palsy Association of the North Country

The Children's Home of Jefferson County

United Helpers

North Country Transitional Living Services

Youth Advocate Program

Northern Rivers

Claxton Hepburn Medical Center

Northern Regional Center for Independent Living

Citizen Advocates

Children and Youth Evaluation Service

COMMUNICATION PREFERENCES

County SPOA wants to respect your wishes regarding Communication. Please indicate your preferences below.

US Mail

Can we send mail to your address with our return address on the envelope? ☐ Yes ☐ No

Telephone:

When calling, can we say we are County SPOA (Single Point of Access)? ☐ Yes ☐ No

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PERMISSION FOR ELECTRONIC COMMUNICATION

I understand the transmission of electronic information may not be secure. E-mails and cell phone communications are unencrypted, and other concerns may exist including but not limited to: email and faxes may accidently be sent to the wrong person; content may be changed without knowledge; copies may exist; some e-mails may contain harmful viruses; cell phone communications may be intercepted or heard by others; texting leaves a record of communication; and there is a risk of loss of device with information on it.

BY SIGNING BELOW, I HEREBY AUTHORIZE County Mental Health SPOA Team permission to correspond ***with me*** via *(check all that apply)*:

□ FAX	Fax Number:	_____
□ E-MAIL	Email Address:	_____
□ CELL PHONE	Phone Number:	_____
□ TEXT MESSAGE	Phone Number:	_____

I understand this permission may be cancelled by me at any time but cannot apply retroactively to communication that has already been sent.

_____ _____ _____

SIGNATURE of Individual, Parent or Legal Guardian **Printed Name of Individual signing** **Date**

_____

Description of Authority of Personal Representative

_____ _____ _____

SIGNATURE of WITNESS **Printed Name of Witness/Title** **Date**

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

St. Lawrence County
Name of SPOA County

The SPOA Committee may get health information, including your child's health records, through a computer system run by HealtheConnections, a Regional Health Information Organization (RHIO) 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.

The SPOA Committee may also get health information, including your child's history of services reimbursed by Medicaid through a computer system called PSYCKES, which is run by the New York State Office of Mental Health. PSYCKES is a computer system maintained by the New York State Office of Mental Health that contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

If you agree and sign this form, SPOA Committee members are allowed to get, see, read and copy 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 and copy 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:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and Dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summary
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data
- Lab Tests

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 GIVE CONSENT** for the SPOA Committee to access ALL of my child's health information through the RHIO and/or through PSYCKES to provide my child care or manage my child's care, to check if my child is in a health plan and what the plan covers.

☐ **I DENY CONSENT** for the SPOA Committee to access ALL of my child's health information through the RHIO and/or through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_____
Print Name of Patient

Patient Date of Birth _____

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 information?**

   If you agree, SPOA providers will use your health information to:
   - Coordinate your health care and manage your care;
   - Check if you have 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 you health insurance or pay your bills.

2. **Where does my health information come from?**

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

   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients.

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

   If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at (315) 229-3871, 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 (315) 229-3871. 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.