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County Executive

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Commissioner



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Deputy Commissioner

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*Coordinator/Children's Mental
Health Services*

DEPARTMENTS OF MENTAL HEALTH,
SOCIAL SERVICES & YOUTH BUREAU

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 Putnam 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 Dawn Mullins at (845) 808-1600, ext. 46139 or Brandon Lillard at (845) 225-2700, ext. 257.**
- ❖ **There are two consent forms attached to this application.**
 - **The Consent for Release of Information is REQUIRED 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 NOT required, 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 Dawn.Mullins@putnamcountyny.gov, by fax to 845-808-1931, or by mail to Putnam County Mental Health, 110 Old Route 6, Bldg. 3, Carmel, NY 10512.

PUTNAM COUNTY MENTAL HEALTH
DONALD B. SMITH COUNTY GOVERNMENT CAMPUS
110 OLD ROUTE SIX – BUILDING THREE - CARMEL, NY 10512
(845) 808-1600 EXT. 46139 FAX: (845) 808-1931 (CONFIDENTIAL)

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: <ul style="list-style-type: none"> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date of Birth	SSN				
Home Address					
Mailing Address (if different from home)					
Primary Language(s)	Does the child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	Gender Identity	Fluent in English? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Insurance Plan	Insurance Policy Number	Medicaid/CIN#			
Is this child enrolled in Health Home Care Management? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		Relationship to Child	Legal Guardian? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Caregiver Primary Language	Fluent in English? <input type="checkbox"/> YES <input type="checkbox"/> NO		Caregiver Primary Language	Fluent in English? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is this caregiver the primary contact? <input type="checkbox"/> YES <input type="checkbox"/> NO			Is this caregiver the primary contact? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is this caregiver enrolled in Health Home Care Management? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			Is this caregiver enrolled in Health Home Care Management? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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	
<input type="checkbox"/> Both parents together	<input type="checkbox"/> Joint custody
<input type="checkbox"/> Biological mother only	<input type="checkbox"/> DSS
<input type="checkbox"/> Biological father only	<input type="checkbox"/> Adult Sibling
<input type="checkbox"/> Other Legal Guardian (describe):	<input type="checkbox"/> Emancipated Minor
	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Does the child have HIV/AIDS?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Do you believe the child has a Serious Emotional Disturbance? (child meets one of the below criteria)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
<ul style="list-style-type: none"> • 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 	
Has the child been exposed to multiple traumatic events that have left a long-term and wide-ranging impact?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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.

Children's Single Point of Access Application Part 1

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

Physician's Authorization for Restorative Services

Psychosocial History & Assessment

Diagnosis

Psychological & Neurological Tests

Inpatient/Outpatient History

Financial Status

Discharge Summary / Treatment Plans

Psychiatric Assessment

Physical Exam History

School Records

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

Printed Name of Witness

Date

"I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION."

List of agencies with which the SPOA Committee is permitted

to exchange information

Putnam County Dept. of Mental Health

Putnam County Youth Bureau

Putnam County Dept. of Social Services

Putnam County Dept. of Probation

Putnam County Dept. of Health

CoveCare Center

Green Chimneys

Mental Health Association of Putnam

Putnam Independent Living Services

Arms Acres

Four Winds Hospital

School District _____

Putnam/Northern Westchester Women's Resource Center

Carmel Psychological Associates

Children and Youth Evaluation Service (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

Putnam County

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 _____, 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

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 (845) 808-1600, ext. 46139, 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 Dawn Mullins at (845) 808-1600, ext. 46139. 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.