Livingston County Adult Single Point of Access (A-SPOA) - APPLICATION

Applicant's NAME: _____ **Applicant's DOB:** _____

INSTRUCTIONS: To access services available through A-SPOA, complete both: (1) A-SPOA Application and (2) Universal Consent for Release of Information. For detailed instructions on how to complete forms, please refer to Instructions for Application and/or the Instructions for Universal Consent for Release of Information located at: www.livingstoncountyny.gov/898/Referral-Forms

SUBMISSION: Submit completed Application and Universal Consent for Release of Information to: AmberMurphy@livingstoncountyny.gov

QUESTIONS: Contact A-SPOA Coordinator at: Phone: (585) 243-7811 · Fax: (585) 243-7264 · Email: AmberMurphy@livingstoncountyny.gov

----- **This document is best suited for Adobe Acrobat Reader.** Download here: https://get.adobe.com/reader/otherversions/ -----

Use *TAB* button to toggle forward through Application. Use *SHIFT + TAB* to toggle backwards.

PROGRAM SELECTION – Programs and/or Services the Applicant is Requesting *(select all that apply)*

CARE MANAGEMENT

- ☐ Medicaid Care Management
- ☐ Non-Medicaid Care Management

HOUSING

Lakeview Health Services Supportive Housing
Arbor Housing and Development Supportive Housing
DePaul Supportive Scattered-Site Housing
Skybird Landing Supportive Housing

- Lakeview Treatment Apartment Program
- No Preference (A-SPOA will select based on availability)
- None / Not applicable
- Other:

SECTION 1 – APPLICANT INFORMATION

1. Full Name

2. Date of Birth *(MM/DD/YYYY)*

3. Gender Identity

4. Currently Homeless
- ☐ Yes
- ☐ No
- ☐ Pending Eviction

5. Current Residence
- ☐ Private Home/Apartment
- ☐ Community Residence
- ☐ Correctional Facility
- ☐ Emergency Housing
- ☐ Substance Use Facility
- ☐ Other (describe):
- ☐ Inpatient Setting
- ☐ Couch Surfing

6. Physical Address

7. Mailing Address *(if different from physical address)*

8. Phone *[(area code) xxx-xxxx]*

9. Do you have full custody of at least one (1) child under the age of 18?
☐ Yes , How many? _____ ☐ No

10. Veteran
- ☐ Yes
- ☐ No

11. Primary Language(s)

12. Financial Status/Income Status
Check all that apply
- ☐ SSI $ _____
- ☐ SSD $ _____
- ☐ VA $ _____
- ☐ Public Assistance $ _____
- ☐ Other $ (Source) _____

13. Health Insurance
Check all that apply
- ☐ Private Insurance
- ☐ Medicaid CIN #: _____
- ☐ Veteran's
- ☐ Medicare #: _____
- ☐ Uninsured
- ☐ Other _____

14. Ethnicity
- ☐ Caucasian/White
- ☐ Latino/Hispanic
- ☐ African American / Black
- ☐ Pacific Islander
- ☐ Asian/Asian American
- ☐ Native American
- ☐ Other, Specify: _____

15. Current Representative Payee
- ☐ Yes. If so, who? _____
- ☐ No

16. Alternative Contact *(Name, Phone Number with Area Code, Relationship)*

17. Applicant's Reason for Applying for Services:

SECTION 2 – REFERRER'S INFORMATION

18. Referrer Name

19. Referrer Title

20. Referrer Agency

21. Referrer Mailing Address

22. Referrer Email

23. Referrer Phone

24. Referrer Fax

Livingston County Adult Single Point of Access (A-SPOA) - APPLICATION

Applicant's NAME: _____ **Applicant's DOB:** _____

25. Referrer's Reason for Applying for Services:

SECTION 3 – DIAGNOSTIC AND CURRENT TREATMENT INFORMATION

26. Diagnosis(es) *(Mental Health, Substance Use Disorder, Medical, Intellectual)*

27. Current MENTAL HEALTH Treatment Provider(s)

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

28. Current SUBSTANCE USE Treatment Provider(s)

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

SECTION 4 – OTHER SERVICE PROVIDERS

29. Primary Care Physician

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

30. Current Care Management Services

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

SECTION 5 – HIGH RISK ALERTS

31. Check all that apply

☐ Suicide Attempt(s)
☐ Suicidal Threats
☐ Fire Setting
☐ Violent History / Assault
☐ Self-Injurious Behavior
☐ Medication non-compliance
☐ Appointment attendance non-compliance
☐ Frequent Crisis Requiring Readmission
☐ Inappropriate sexual behaviors
☐ Other (specify): _____
☐ Chronic Physical Health Conditions
☐ Homelessness - current
☐ Homelessness – historic
☐ Victim of Physical / Sexual Abuse

For any items checked, please provide details *(dates and brief explanation, if available):* _____

_____

32. Assisted Outpatient Treatment (AOT) Status

Current AOT Order / Recipient	☐ Yes	☐ No	☐ Unknown
AOT Candidate *(in process)*	☐ Yes	☐ No	☐ Unknown

SECTION 6 – CRIMINAL JUSTICE STATUS

33. Indicate if any current - or past - history – check all that apply:

☐ Probation – Expires: _____
PO Name: _____

☐ Parole – Expires: _____
PO Name: _____

☐ No Legal History
☐ CPL Status (§330.90)
☐ Order of Protection
☐ Conviction of a Crime
☐ Charges Pending (active)

For any items checked, please provide details *(dates and brief explanation, if available):* _____

_____

Applicant's NAME:_____ **Applicant's DOB:** _____

SECTION 7 – TREATMENT HISTORY

34. Mental Health Treatment

☐ None/Not Applicable

Inpatient Treatment History *(include dates, facility names)*

Outpatient Treatment History *(include dates, facility names)*

35. Substance Use Treatment

☐ None/Not Applicable

Inpatient Treatment History *(include dates, facility names)*

Outpatient Treatment History *(include dates, facility names)*

36. Number of Emergency Department visits in 12 months prior to referral:

SECTION 8 – ADDITIONAL INFORMATION

37. Please include any additional information, pertinent to this application for SPOA services, not otherwise specified:

☐ ----- Signature is not required on this document ----- End of Application ----- Submit to: AmberMurphy@livingstoncountyny.gov-----

Livingston County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME:_____ **Individual's DOB:** _____

This authorization must be completed by the referred individual or their 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, Part 2 of the *Code of Federal Regulations (42 CFR Part 2)* 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 Protected Health Information (PHI) between, *Livingston County Single Point of Access (SPOA) Team* (comprised of Livingston County Mental Health Department staff), ***Other Providers*** (see attached list of Providers on page 2) which comprise the ***SPOA Committee***; **AND** the ***Referral Name & Address of Referral Source***: _____

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

- ☐ ***ALL listed below***
- ☐ Mental Health/Psychosocial Assessment
- ☐ Psychiatric Evaluation/Assessment/ Consultation
- ☐ Discharge Summary/Treatment Plan
- ☐ Psychological &/or Neurological Tests
- ☐ Documentation of Medical Necessity
- **X** ***Referral (including contact info)- required***
- ☐ Inpatient/Outpatient Treatment
- ☐ Financial &/or Insurance Info
- ☐ Medications (past & present)
- ☐ Pre-Sentence Investigation Report
- ☐ Physical Health (including family planning if applicable)
- ☐ Other (specify): _____
- ☐ Diagnosis(es)
- ☐ HIV/AIDS-related Information
- ☐ School Records (including testing)
- ☐ Substance Use Evaluation
- ☐ Substance Use Diagnosis
- ☐ Substance Use Treatment Plan
- ☐ Substance Use Medication(s)
- ☐ Substance Use Discharge

PURPOSE OR NEED FOR INFORMATION:

Allow SPOA to: consult with and make referrals to appropriate providers; collect and provide documentation (e.g.: discharge planning information) and coordinate care among providers (listed on page 2 of this document); and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- I am applying for services and programs, appropriate to my wants and needs, accessible via the SPOA process.
- 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.
- I authorize the re-disclosure and digital storage, including Cloud-based services, of the above-described information to the providers identified on page 2 of this document 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 Livingston 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 medical treatment nor access to benefits to which I may be eligible.
- 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 have been offered a copy of the *Notice of Privacy Practices* and I have the right to request and receive a copy at any time.

I HEREBY PERMIT the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified in this *Universal Consent for Release of Information* 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 accessed through Livingston County SPOA.
- ◯ One year from the date of signature.
- ◯ Other: _____

I CERTIFY THAT BY SIGNING THIS AUTHORIZATION I acknowledge I have read, understand, and consent to use of the PII and PHI as set forth in this document. 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 or Personal Representative	**Printed Name of Individual**	**Date**
Printed Name of Personal Representative *(if applicable)*	**Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*	
SIGNATURE of WITNESS	**Printed Name of Witness/Title**	**Date**

Livingston County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME: _____ **Individual's DOB:** _____

List of PROVIDERS with which Adult Single Point of Access (A-SPOA) is permitted to exchange information.

Arbor Housing and Development
Arbor Housing Scattered-Site Supportive and Respite Housing
CASA Trinity
Catholic Charities Family & Community Services
Catholic Charities of Steuben/Livingston Catholic Charities of the Finger Lakes
Center for Dispute Settlement
Chances and Changes Inc.
Community Action of Wyoming County
Compeer West
Depaul Community Services
DePaul Supportive Scattered-Site Housing
Elm & Oak Health
Genesee Valley BOCES
HCR Home Care
Health Homes of Upstate New York
Heritage Christian Services
Hillside
Lakeview Health Services Inc.
Living Opportunities of DePaul, Scattered Site Supportive Housing/ Respite
Livingston County Department of Health
Livingston County Department of Social Services
Livingston County Family Court
Livingston County Mental Health Services
Livingston County Office for the Aging
Livingston County Probation
Livingston County Sheriff's Department
Livingston County Youth Advocacy
Livingston/Wyoming Arc
Mental Health Association of Rochester
Noyes Mental Health
NYS Department of Health
NYS Office of Mental Health
Office of Addiction Services and Supports (OASAS)
Office of Housing/Section 8
Rochester Psychiatric Center
Rochester Regional Health
Skybird Landing Apartments Supportive Housing
Social Security Administration
Spectrum Health & Human Services
United States Department of Housing and Urban Development
University of Rochester Medical Center VESID
Westside Community Care Management
Wyoming County Community Health System

If not listed above - include* AGENCY NAME, ADDRESS AND PHONE NUMBER *for:

Mental Health Treatment/Psychiatric Records:

_____

Substance Use Treatment/Records:

_____

Primary Care Practitioner:

_____

Other ***(include Alternative Contact)***:

Individual's NAME:_____ **Individual's DOB:** _____

Livingston County Adult Single Point of Access (A-SPOA) Patient Information Retrieval Consent

The SPOA Committee may get health information, including your health records, through a computer system operated 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 doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with people who you say can see or get such health information.

The SPOA Team and Committee may also get health information through a NYS Office of Mental Health database called *PSYCKES* (Psychiatric Services and Clinical Knowledge Enhancement System). It can contain 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.

If you agree and sign this form, SPOA Team and Committee members can access, read, and copy your health information - including all of the health information obtained from the RHIO and/or from *PSYCKES* – needed to arrange your care, manage such care or study such care to make health care better for patients. The health information they 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 you had or may have had before; test results, like x-rays or blood tests; and the medicines you are now taking or have taken before. Your 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 summaries
- 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 health information must obey all these laws. They cannot give your information to other people unless you, an appropriate personal representative 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 health information and the SPOA Team and Committee must obey these laws and rules.

Please read all of the information on this form before signing it.

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

◯ **I DENY CONSENT** for the SPOA Committee to access ALL of my 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.

SIGNATURE of Individual or Personal Representative | **Printed Name of Individual** | **Date**

Printed Name of Personal Representative *(if applicable)* | **Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*

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

Individual's NAME: _____ **Individual's DOB:** _____

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**
   By signing the *Universal Consent for Release of Information*, SPOA providers can use your health information to coordinate and manage your health care; check if you have health insurance and what it pays for; and study and make health care better for patients. The choice you make does not allow health insurers to see your information, 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 you 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. An example of where this information is accessed is Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). If you have any questions, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider.

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 the HIPAA Privacy Rule – or – "HIPAA" – *Health Information Portability and Accountability Act)*.

4. **How does SPOA protect health information?**
   The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose Protected Health Information about them, as well as their rights and the covered entity's obligations with respect to that information.

5. **If I agree, who can get and see my information?**
   Only individuals whom you have authorized are permitted to access and view your health information. For the purposes of SPOA, this may include treatment and services providers who work for SPOA or for a SPOA provider.

6. **What if a person uses my information and I didn't agree to let them use it?**
   If you think someone used your information, and you did not agree to give the person your information, you can contact: Livingston County Mental Health at (585) 243-7250; the NYS Office of Mental Health Customer Relations at (800) 597-8481; or the United States Attorney's Office at (212) 637-2800.

7. **How long does the *Universal Consent for Release of Information* last?**
   The *Universal Consent for Release of Information* is valid until you are no longer receiving/being connected to services accessed through Livingston County SPOA, you revoke (take back) permissions, or as otherwise specified on page 1 of this document.

8. **What if I change my mind later and want to take back my consent?**
   You have the right to revoke (take back) the written consent at any time. The revocation must be in writing on a form provided by Livingston County located here: www.livingstoncountyny.gov/898/Referral-Forms. The revocation of consent does not affect information disclosed while the authorization was in effect. 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.

9. **How do I get a copy of this form?**
   You can request to have a copy of this form after you sign it from: AmberMurphy@livingstoncountyny.gov.

CRITERIA FOR SEVERE MENTAL ILLNESS AMONG ADULTS
595.4

Client Name:_____

DOB: _____

To be considered an adult diagnosed with severe mental illness A must be met. In addition, B or C or D must be met. Please check all criteria which pertain to the client.

☐ A. SEVERE MENTAL ILLNESS DIAGNOSIS

The individual is 18 years of age or older and currently meets the criteria for an **ICD 10**- psychiatric diagnosis **other than** alcohol or drug disorder. (291.xx, 292.xx, 303.xx, 305.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx) or social conditions (Vxx.xx).

☐ B. SSI or SSDI ENROLLMENT/ELIGIBILITY DUE TO MENTAL ILLNESS

The individual is currently enrolled, or has applied, in SSI or SSDI due to a designated mental illness.

☐ C. EXTENDED IMPAIRMENT IN FUNCTIONING DUE TO MENTAL ILLNES

1. The individual has experienced **two (2)** of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis, please check:

   ☐ Marked difficulty in self-care (personal hygiene, diet, and clothing, avoiding injuries, securing health care or complying with medical advice).

   ☐ Marked restriction of activities of daily living (maintaining a residence, using transportation, day-to-day money management, accessing community services).

   ☐ Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children, other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).

   ☐ Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitation in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in completion of tasks).

2. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of the ICD-10) due to designated mental illness over the past twelve month on a continuous or intermittent basis.

☐ D. RELIANCE ON PSYCHIATRIC TREATMENT, REHABILITATION, AND SUPPORTS

☐ A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder

COMPLETED BY:_____ **DATE:**_____

Credentials: (LCSW, LMSW, LMHC, PhD, MD, etc.)