2020 Onondaga County Adult SPOA Application

Send with Records and signed SPOA Permission Form to SPOA Fax: 315-435-3279

Referral Information

Referral is for: *See OMH SMI High Priority Eligibility Criteria	☐ OMH Residential Services; Congregate or Apartment Treatment ☐ OMH Supportive Housing ☐ Non Medicaid CM for SMI* Eligible ☐ Forensic Case Management ☐ ACT Team ☐ SRO ☐ To be determined ☐ Other_____		
Date of Referral:		**Applicant Gender:**	☐ **Male** ☐ **Female**
Applicant Name:		**AKA:**	
Social Security Number, last 4 digits:	**Applicant DOB:**		
Home Street Address:			
(City, State, Zip)			
Current Location:		**Applicant's Phone Number:**	

If inpatient, anticipated release date:_____

Alternate Contact, Address and/or Phone # for Client when in the community: May we leave a message? ☐ Yes ☐ No	Emergency Contact Name, Address & Phone #:

Referring person contact information: **Provider Type**: _____

Name: _____ **Role**_____

Agency: _____

Address: _____

Phone: _____ **Fax:** _____

Email Address: _____

Legal Status

Involved with: **If incarcerated, anticipated release date**_____

☐ Parole ☐ County Probation ☐ Federal Probation/history

PO name and phone: _____

Reason/charges/convictions_____Restrictions? _____

☐ CPL _____ ☐ Court Order or Diversion ☐ Town Court ☐ Treatment Court

☐Adult Protective Services ☐Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other: _____

Prior Living Situations: **Section 8 Status:**

If planning to live with family/friend, please list other members of the household:

Name_____

Personal And Demographic Information

Race / Ethnicity	Primary Language	English Proficiency (If primary language is not English)
☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian ☐ American Indian or Native ☐ Other (specify) _____	☐ English ☐ Spanish ☐ American Sign Language ☐ Other (specify) _____	☐ Does Not Speak English. ☐ Poor ☐ Fair ☐ Good - Does Not Need Translator ☐ Literacy level:

Veteran Status

Veteran or served in military? ☐ Yes ☐ No Branch/ type of discharge: _____

Service Connected Disability? ☐ Yes ☐ No If Service Connected _____%

Current Marital Status	Custody Status of Children
☐ Single, never married ☐ Currently married ☐ Divorced/separated ☐ Widowed	☐ No children ☐ Minor children in clients custody, ages:_____ ☐ Have children - older than 18 years ☐ Minor children not in client's custody but have access ☐ Minor children no custody - no access

Current Educational Level	Employment/Vocational
☐ No formal education ☐ Some grade school (1-8th grade) ☐ Completed grade school ☐ Some HS (9-12th grade, but no diploma) ☐ HS diploma or GED ☐ Vocational, business training ☐ Some college, no degree ☐ College degree ☐ Master's degree ☐ Other:_____	☐ If has employment history, describe: ☐ Other vocational training, describe: Recommendations: ☐ Access-VR involvement ☐ Other:

Representative payee history?	☐ No ☐ Yes ☐ Recommended? Debts, if any: _____
Representative Payee Name:	
Agency:	
Phone:	**Address:**

Medicaid Status

Client Medicaid #: __ __ __ __ __ __ __ __ __

Managed Care Company:_____

Medicaid active? Yes_____ No_____ HARP eligible? Yes ____ NO_____ Not known _____

Name_____

Financial Section: Income And Insurance Status

Income and Insurance	Now Receives	Income and Insurance	Now Receives
No Income	☐	Wages/Earned Income	☐
SSI	☐	Unemployment/Amount_____	☐
SSD	☐	Child Support Owed or Received $_____	☐
Temporary Assistance	☐	Worker's Comp	☐
Veterans benefits	☐	Social Security Retirement	☐
Medicare	☐	Pension/Amount:_____ Source _____	
Medicaid	☐	Trust Fund	☐
Food Stamps	☐	Special Needs Trust	☐
Other, Describe:_____		Private Insurance/Third Party Payer	☐

Substance Use

Drugs of Choice:

☐ None ☐ Any IV Drug Use ☐ Alcohol ☐ Marijuana/Cannabis

☐ Crack ☐ Heroin/Opiates ☐ PCP ☐ Hallucinogens

☐ Cocaine ☐ Sedative/Hypnotic ☐ Benzodiazapines ☐ Spike, Synthetic Marijuana

☐ Prescription drugs ☐ Amphetamines ☐ Inhalant: Sniffing Glue/Other Household Product

□ Other:_____Inpatient Rehab?_____

Clinical Information

	Diagnoses	CODE
DSM 5 MH		
DSM 5 SUD		
DSM 5 other		
Disability level		
Chronic health conditions		
Other health conditions		
BH Treatment type:		
Clinician:		
Psychiatrist:		
Other behavioral health supports:		

Number of ER Visits For Psychiatric Reasons in the in last 12 Months:_____

Number of Psychiatric Hospitalizations in the last 24 Months:_____

Date	Hospital	Length of Stay
_____	_____	_____
_____	_____	_____

Physical Health/Wellness

Check off any of the following that apply:

□ Incontinent □ Impaired Walking □ Requires Special Medical Equipment

□ Hard of Hearing/Deaf □ Impaired Vision/Blind □ Lung Problems □ Asthma

□ Diabetes □ Heart Problems □ High Blood Pressure

□ Chronic Pain □ Weight Concern □ Cognitive Impairment □ Sleep apnea

□ Speech Impairment □ Developmental Disorder □ Traumatic Brain Injury □ Seizure Disorder

□ Learning Disability □ Other: _____

Name_____

	Yes	No	Date of most recent episode
History of Homelessness			
Victim of Physical/Sexual Abuse			
History of Domestic Violence in Home			
Chronic Self-Harm/Self-Mutilation			
History of Suicidal Ideation			
History of Suicide Attempts /Self Harm			
Elaborate on Other Serious Attempts			
Arson			
Physically Abusive and/or Assaultive of Another			
Sexually Assaultive Behavior			
Destruction of Property			
Current Access to Firearms			
Criminal Justice Involvement			
AOT Order			
AOT Enhanced			

Reason For Referral

Please include any relevant information!

Reason for referral:

Current symptoms:

Desired outcome:

If there is a significant change from a previous referral, please state it here:

_____

Does the individual have a case manager, or other supports (such as Adult Protective Services, housing worker, etc)?

No ☐ **Yes** ☐

If Yes, please state name and program:

The individual requesting services agreed to submit this application □ **YES** □ **NO**

- **The individual requesting services agreed to review by the SPOA Team and Potential Providers.** □ **YES** □ **NO**

Individual, i.e. Applicant's Signature: _____

Date: _____

Meets OMH high priority criteria:

Onondaga County SPOA Team

Call: 315-435-3355

Jennifer Feliciano x4997, Jan Moag x4696, Naomi Castillo-Lugo x4695

Name_____

SPOA Permission Form

Onondaga County Department of Mental Health SPOA (Adults)
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. **I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.**
2. The person (applicant) whose information may be used or disclosed is:

   Name: _____ _____ **Date of Birth:** _____

3. The information that may be used or disclosed includes (check all that applies):
   - o Mental health treatment records
   - o Alcohol/Drug treatment records
   - o Health records
   - o Education records

4. This information may be disclosed by:
   - o Any person or organization that possesses the information to be disclosed
   - o The persons or organizations listed in Attachment A

   The following persons or organizations that provide services to me:

   _____ _____

   _____ _____

5. This information may be disclosed to:

   Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   - o The persons or organizations listed in Attachment A
   - o The following persons or organizations:

   _____ _____

   _____ _____

6. The purposes for which this information may be used and disclosed include:
   - o Evaluation of eligibility to participate in a program supported by the Onondaga County Department of Mental Health;
   - o Delivery of services, including care coordination and case management;
   - o Payment for services; and Health Care Operations such as quality assurance.

Name_____

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. **This permission expires (fill in choice):**
   - **On** _____
   - **Upon the following event:** _____

9. This permission is limited as follows:
   - Permission only applies to records for the following time period: _____ to _____
   - Other limitation: _____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

- **I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.**

- _____

Signature **Date**

For applicants under 18 or legal guardians: I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is:_____

I give permission to use and disclose records as described in this document.

Signature _____Date_____

Print Name_____

The SPOA Team will determine OMH Priority status and send applications to OMH Residential and housing providers.

Name_____

Attachment A
This permission to receive or disclose records containing Protected Health Information applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Onondaga County.

The SPOA Team determines OMH Priority status and sends applications to one or more of the following agencies:

AccessCNY for OMH Residential and Supportive Housing Programs
Central New York Services (CNYS) for OMH Residential and Supportive Housing Programs
Hutchings Psychiatric Center Outpatient and Residential Programs
Kalet's Adult Residence for DOH Adult Residence
Liberty Resources ESSHI Supportive Housing
Loretto Community Residences for OMH Residential Programs
Salvation Army of Syracuse for OMH Supportive Housing Programs
St. Joseph's Hospital Health Care for OMH Residential Programs
Circare for ACT, or NMCM (non-Medicaid care management), Forensic CM, or AOT Heath Home Plus CM

Agencies which send applications or collaborate with SPOA include:
ACR Health
ARISE
Auburn Community/Memorial Hospital
Bright Path Center
Catholic Charities of Onondaga County
Cayuga Counseling Services
Center for Community Alternatives (CCA)
Center for Court Innovation, Assigned Counsel
Chadwick Residence
Christopher Community
Circare
Claxton-Hepburn Medical Center
Clifton Springs
CNY OPWDD and Developmental Disabilities Regional Office
CNYPC
Conifer Park (Syracuse Outpatient Clinic)
Contact Community Services
Cortland Hospital Health Center
Crouse Hospital and 410 Crouse
Elmcrest Children's Center
Elmira Psychiatric Center
Endeavor Behavioral Health Services
Faxton-St. Luke's Hospital Health System
Greater Binghamton Health Center
(Guthrie) Cortland Medical Center
Helio Health
HHUNY (Health Homes of Upstate NY)
Hillside Children's Center
Hope Connections
Housing and Homeless Coalition of CNY (HHC) HMIS
Huntington Family Center
Hutchings Psychiatric Center
Insight House Chemical Dependency Services
Jail Ministries
Liberty Resources
McPike Addiction Treatment Center

Name_____

Mental Hygiene Legal Services
Mohawk Valley Psychiatric Center
Monroe Plan
Newark Wayne Hospital, Rochester Regional Health
North County Transitional Living Services, INC
NYS DOCCS/Parole
NYS OMH CNYPC Satellite Units Pre-Release Coordinators
NYS OMH Division of Forensics
Onondaga County Adult & LTC Services
Onondaga County Child and Family Services, ACCESS Team C&Y SPOA
Onondaga County Economic Security DSS, Jobs Plus
Onondaga County Health Department
Onondaga County Probation, Sheriff's Dept, Courts
Onondaga Nation Healing Center
Oswego Hospital Behavioral Health
Recovery Counseling, INC
Rome Behavioral Health
Salvation Army
Samaritan Center
St. Elizabeth Medical Center
St. Joseph's Hospital Health Center (SJHHC)
St. Joseph's Medical PC
Syracuse Community Health Center
Syracuse Recovery Services
Syracuse Rescue Mission Alliance
Syracuse RISE
Syracuse Veteran's Administration
The Mary Imogene Bassett Hospital
Tiny Home for Good
Toomey Residential Programs
Unity House of Cayuga County
Upstate Medical University and Community General Hospital
Vera House
Volunteer Lawyer's Project
WellPath
YMCA
YWCA

Note:
Please send, or request that treatment records be sent to the SPOA Team to complete this application!

Complete applications are triaged for quick processing.
Complete OMH high priority applications are assigned to a provider within a few days.

Name_____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Sex ..... Date of Birth .....

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:

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):

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

_____
_____
_____

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)* _____ . 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)* _____ ;
- ❑ 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)*