NEW YORK STATE | Office of Mental Health

SPOA Universal Referral Form

Bolded – CAIRS Core Elements Non-Bold – CAIRS Optional Elements *Italic type – Paper Transfer*

Client Information

Child's First Name		**Middle Initial**	**Last Name**
Date Of Birth	**Gender** ❑ Male ❑ Female	**Child's Social Security Number**	**Phone**

Medicaid ID 1 (Required for referral to Health Home Care Management)	**Medicaid ID 2**	**Primary Language**

Child's Race
❑ Hispanic ❑ White ❑ African American ❑ Native American/Alaskan ❑ Asian/Pacific Islander ❑ Other (Specify) _____

County of SPOA (Fiscal) Responsibility	**County of Residence**

Current Address

Parents

Mother's Name (First, MI, Last)	Primary Contact? ❑ Yes ❑ No	County
Address, City, State, Zip	Home Phone	Work Phone
	Primary Language	

Father's Name (First, MI, Last)	Primary Contact? ❑ Yes ❑ No	County
Address, City, State, Zip	Home Phone	Work Phone
	Primary Language	

Has family been referred for other services? ❑ Yes ❑ No	Please list services:
Are parents legal guardians? ❑ Yes ❑ No If no, please list guardian in "Other Significant Contacts".	Is either parent/legal guardian enrolled in a Health Home? ❑ Yes ❑ No If yes, which Health Home? _____

Other Significant Contacts — Please list other significant contacts

First Name, MI, Last Name	Primary Contact? ❑ Yes ❑ No	County
Address, City, State, Zip	Home Phone	Work Phone
First Name, MI, Last Name	Primary Contact? ❑ Yes ❑ No	County
Address, City, State, Zip	Home Phone	Work Phone

Current Providers

First Name, MI, Last Name	Relationship	County
Address, City, State, Zip	Home Phone	Work Phone
First Name, MI, Last Name	Relationship	County
Address, City, State, Zip	Home Phone	Work Phone
First Name, MI, Last Name	Relationship	County
Address, City, State, Zip	Home Phone	Work Phone

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Background Information

Child's living situation: (Check one box only)

01 ❑ Independent living
02 ❑ Two parent family
03 ❑ One parent family
04 ❑ Two parent adoptive family
05 ❑ One parent adoptive family
06 ❑ Other relatives' home
07 ❑ OCFS Family Foster Care
08 ❑ OMH CY Community Residence
09 ❑ Teaching Family Home
10 ❑ OCFS Group Home
11 ❑ DFY Community Group Home
12 ❑ Family Based Treatment
13 ❑ OCFS Therapeutic Foster Care
14 ❑ Crisis Residence
15 ❑ Runaway shelter
16 ❑ Residential school (SED)
17 ❑ Residential Treatment Center (OCFS)
18 ❑ Residential Treatment Facility (OMH)
19 ❑ Psychiatric inpatient care - unspecified
20 ❑ OCFS/DRS Facility
21 ❑ Jail
22 ❑ Homeless/streets
24 ❑ Grandparent(s)
25 ❑ Private psychiatric inpatient- Article 31
26 ❑ Gen. hospital psych inpatient- Article 28
27 ❑ State psychiatric inpatient
88 ❑ Other (specify) _____
99 ❑ Unknown

Child's custody status: (Check one box only)

01 ❑ Biological Parents
02 ❑ Adoptive Parents
03 ❑ Grandparent(s)
04 ❑ Other Family/Legal Guardians
05 ❑ Local DSS
06 ❑ Emancipated Minor
88 ❑ Other

Highest level of education completed: (Check one box only)

01 ❑ Kindergarten
02 ❑ First
03 ❑ Second
04 ❑ Third
05 ❑ Fourth
06 ❑ Fifth
07 ❑ Sixth
08 ❑ Seventh
09 ❑ Eighth
10 ❑ Ninth
11 ❑ Tenth
12 ❑ Eleventh
14 ❑ Ungraded – Elementary
15 ❑ Ungraded – Middle School
16 ❑ Ungraded – High School
17 ❑ College
18 ❑ Graduate
19 ❑ Post Graduate
99 ❑ Unknown

School District:

Child's Educational Placement: (Check one box only)

01 ❑ Regular class in age-appropriate grade
02 ❑ Regular class, above grade level
03 ❑ Regular class, but behind at least one grade
04 ❑ Special class for students with handicapped conditions
05 ❑ Residential school for the educationally (emotionally) handicapped
06 ❑ Vocational training only
07 ❑ Part time vocational/educational
09 ❑ High school graduate/GED
10 ❑ Day Treatment
11 ❑ Home instruction
12 ❑ BOCES
13 ❑ College
77 ❑ Not enrolled in school
88 ❑ Other (specify) _____
99 ❑ Unknown

Home School Name: *Current School Name:* *Date of Last IEP:*

Committee on Special Education Status:

02 ❑ Emotional Disturbance
03 ❑ Learning Disability
04 ❑ Sensory Impaired
05 ❑ Physical Disability
06 ❑ Other Health Impaired
07 ❑ Multiple Disability
08 ❑ Autism
09 ❑ Intellectual Disability
10 ❑ Deafness
11 ❑ Hearing Impairments
12 ❑ Speech or Language Impairment
13 ❑ Visual Impairment (includes blindness)
77 ❑ None
99 ❑ Unknown

Child's IQ: *Verbal Score– Performance Score:* *Full Scale Score:* *Date:*

Child's Legal Status: (Check one box only)

01 ❑ PINS
02 ❑ PINS Diversion
03 ❑ Juvenile Delinquent
04 ❑ Juvenile Delinquent - restricted
05 ❑ Juvenile Offender
77 ❑ None
88 ❑ Other (specify) _____
99 ❑ Unknown

Income or benefits child is currently receiving: (Check all that apply)

01 ❑ Supplemental Security Income (SSI)
02 ❑ Social Security Disability Income (SSDI)
03 ❑ Veteran Benefit
04 ❑ Social Security Retirement, survivor or dependent (SSA)
05 ❑ Any public assistance cash program:
Family Assistance (TANF), Safety Net, Temporary Disability
06 ❑ Medicaid
07 ❑ Medicare
08 ❑ Medication Grant
09 ❑ Private insurance, employer coverage, no third party insurance
10 ❑ Other (please specify) _____

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Other Benefits (Annual or Monthly Amounts)

Insurance Type, Policy Holder, Policy Number:	*Citizenship:* ❑ Yes ❑ No	*Legal Alien:* ❑ Yes ❑ No
Income:		*Date of Entry:*
HI number, currently enrolled? ❑ Yes ❑ No		*Country of Origin:*
Child Support (Specific Amounts): ❑ Yes ❑ No		*Alien ID number:*
Resources/Assets (savings, bonds, trust) type & amount:		
TANF Eligibility (low income, public assistance):		

DSM-V Diagnosis Information

Behavioral Health Diagnosis and Related Health Conditions DSM-V

Primary Diagnosis	Code	Narrative, if needed.
❑		
❑		

Who Made the Diagnosis:	*Date of Diagnosis:*

Symptoms and Behavior

Using the scale below, indicate the degree of the child's symptoms/behaviors.

SCALE

0 NOT EVIDENT Child does not display this symptom/behavior

1 MILD This symptom/behavior exists, but there is no impairment (loss of effectiveness) in carrying out daily activities or in meeting major role requirements.

2 MODERATE This symptom/behavior exists. This child maintains an appropriate level of functioning in daily activities and major roles only with difficulty and increased effort and support.

3 MARGINALLY SEVERE This symptom/behavior exists. There is definite impairment in carrying out daily activities and/or performing major roles. Major roles are able to be perform

4 SEVERE This symptom-behavior exists Definite impairment exists in daily activities. The child is unable to perform one or more major role at any level. The child may not be allowed to remain in one or more major roles due to severity of symptom/ behavior.

9 UNKNOWN

DURATION SCALE

1= in past 30 days
2= with in 90 days
3= with in past 6 months
4= with in past year
5= over 1 year

	Not Evident 0	Mild 1	Moderate 2	Marginally Severe 3	Severe 4	Unknown 9
35 Suicidal Ideation	❑	❑	❑	❑	❑	❑
36 Psychotic Symptoms	❑	❑	❑	❑	❑	❑
37 Depression	❑	❑	❑	❑	❑	❑
38 Anxiety	❑	❑	❑	❑	❑	❑
39 Phobia	❑	❑	❑	❑	❑	❑
40 Danger to self	❑	❑	❑	❑	❑	❑
41 Danger to Others	❑	❑	❑	❑	❑	❑
42 Temper Tantrums	❑	❑	❑	❑	❑	❑
43 Sleep Disorders	❑	❑	❑	❑	❑	❑
44 Enuresis/Encopresis	❑	❑	❑	❑	❑	❑
45 Physical Complaints	❑	❑	❑	❑	❑	❑
46 Alcohol Abuse	❑	❑	❑	❑	❑	❑
47 Drug Abuse	❑	❑	❑	❑	❑	❑
48 Developmental Delays	❑	❑	❑	❑	❑	❑
49 Sexually Inappropriate	❑	❑	❑	❑	❑	❑
50 Sexually Aggressive	❑	❑	❑	❑	❑	❑
51 Verbally Aggressive	❑	❑	❑	❑	❑	❑
52 Physically Aggressive	❑	❑	❑	❑	❑	❑
53 Eating Disorder	❑	❑	❑	❑	❑	❑
54 Peer Interactions	❑	❑	❑	❑	❑	❑
55 Hyperactive	❑	❑	❑	❑	❑	❑
56 Impulsive	❑	❑	❑	❑	❑	❑
57 Self-injury	❑	❑	❑	❑	❑	❑
58 Runaway	❑	❑	❑	❑	❑	❑

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Using the scale below, indicate the level that most accurately reflects the frequency with the child engaged in the following behaviors in the past 18 months.

SCALE

0 NEVER This behavior not observed or reported.
1 RARELY The child has engaged in behavior once in the past 18 months.
2 SOMETIMES The child has engaged in behavior two times in the past 18 months.
3 OFTEN The child has engaged in behavior five times in the past 18 months.
4 ALWAYS The child has routinely engaged in behavior more than five times in the past 18 months.
9 UNKNOWN

	Never 0	Rarely 1	Some-times 2	Often 3	Always 4	Unknown 9
44 Suicide Attempt	❑	❑	❑	❑	❑	❑
45 Destruction of Property	❑	❑	❑	❑	❑	❑
46 Fire Setting	❑	❑	❑	❑	❑	❑
47 Cruelty to Animals	❑	❑	❑	❑	❑	❑

Functioning

SCALE

0 NOT EVIDENT Child does not display this symptom/behavior
1 MILD This symptom/behavior exists, but there is no impairment (lost of effectiveness) in carrying out daily activities or in meeting major role requirements.
2 MODERATE This symptom/behavior exists. This child maintains an appropriate level of functioning in daily activities and major roles only with difficulty and increased effort and support.
3 MARGINALLY SEVERE This symptom/behavior exists There is definite impairment in carrying out daily activities and/or performing major roles. Major roles are able to be perform.
4 SEVERE This symptom/behavior exists Definite impairment exists in daily activities. The child is unable to perform one or more major role at any level. The child may not be allowed to remain in one or more major roles due to severity of symptom/behavior
9 UNKNOWN

	Not Evident 0	Mild 1	Moderate 2	Marginally Severe 3	Severe 4	Unknown 9
55 Self Care	❑	❑	❑	❑	❑	❑
56 Social Relationships/Functioning	❑	❑	❑	❑	❑	❑
57 Cognitive Functioning/Communication	❑	❑	❑	❑	❑	❑
58 Self Direction	❑	❑	❑	❑	❑	❑
59 Motor Functioning	❑	❑	❑	❑	❑	❑

Physical Health Information

Current Medical Conditions:

Any Medical Alerts:

Drugs for Medical Conditions:

Is child taking medications for psych condition? ❑ Yes ❑ No

Medication Name: (If yes is checked)

Child's Treatment and Services History

SCALE

0 Never
1 Not at all in past six months
2 One or more times in the past 6 months, but not in the past 3 months
3 One or more times in the past 3 months, but not in the past month
4 One or more times in the past month, but not in the past week
5 One or more times in the past week

(Enter number. Please enter 0 for none.)

Psychiatric Hospitalization in last 12 months _____
Psychiatric Hospitalization in last 6 months _____
Emergency Room visits in last 12 months-NYC only _____
Emergency Room visits in last 6 months _____
Arrests in last 6 months _____
Incarceration in last 6 months _____

How frequently was this recipient a victim of sexual or physical abuse?

History of Past and Present Services: (Check all that apply)

01 ❑ Intensive Case Management
02 ❑ Service Coordination/Case Management
03 ❑ Individualized Care Coordination
04 ❑ Clinic Treatment
05 ❑ Private/Individual Therapy
06 ❑ Crisis Response Services
07 ❑ Home Based Crisis Intervention
08 ❑ Day Treatment
09 ❑ Respite
10 ❑ Medication Management
11 ❑ Vocational Training
12 ❑ ADL or Independent Living Skills
13 ❑ Alcohol Abuse Treatment
14 ❑ Substance Abuse Treatment
15 ❑ Family Support Services
16 ❑ Transportation
17 ❑ After School/Weekend Program
18 ❑ Specialized Summer Program
19 ❑ Specialized Educational Services
20 ❑ Speech & Language Therapy
21 ❑ Mentoring
22 ❑ Flexible Funding
23 ❑ Foster Care
24 ❑ State Psychiatric Facility
25 ❑ Private Psychiatric Facility
26 ❑ General Hospital Psychiatric Inpatient
27 ❑ OPWDD Developmental Center
28 ❑ Intensive in Home
29 ❑ CCSI
30 ❑ Supportive Case Manager
31 ❑ Residential Treatment Facility
88 ❑ Other *(Specify)* _____

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Referral

Referral Source to SPOA:

01 ❑ Family/Legal Guardian
02 ❑ Self
03 ❑ School/Education System
04 ❑ State-Operated Inpatient Program
05 ❑ Local Hospital Acute Inpatient Unit
06 ❑ Juvenile Justice System
07 ❑ Social Services
08 ❑ Other Mental Health Program
09 ❑ Physician
11 ❑ Emergency Room (Psychiatric & General Hospital)
12 ❑ Private Psychiatric Inpatient Hospital
13 ❑ Residential Treatment Facility
14 ❑ Community Residence
15 ❑ Intensive Case Management
16 ❑ OPWDD
88 ❑ Other *(Specify)* _____

Services Child referred to SPOA for: (Check all that apply.) *Services availability varies by county, referral does not guarantee acceptance.

01 ❑ Health Home Care Management
02 ❑ Service Coordination/Case Management
03 ❑ Individualized Care Coordination
04 ❑ Clinic Treatment
05 ❑ Private/Individual Therapy
06 ❑ Crisis Response Services
07 ❑ Home Based Crisis Intervention
08 ❑ Day Treatment
09 ❑ Respite
10 ❑ Medication Management
11 ❑ Vocational Training
12 ❑ ADL or Independent Living Skills
13 ❑ Alcohol Abuse Treatment
14 ❑ Substance Abuse Treatment
15 ❑ Family Support Services
16 ❑ Transportation
17 ❑ After School/Weekend Program
18 ❑ Specialized Summer Program
19 ❑ Specialized Educational Services
20 ❑ Speech & Language Therapy
21 ❑ Mentoring
22 ❑ Flexible Funding
23 ❑ Foster Care
24 ❑ State Psychiatric Facility
25 ❑ Private Psychiatric Facility
26 ❑ General Hospital Psychiatric Inpatient
27 ❑ OPWDD Developmental Center
28 ❑ Intensive in Home
29 ❑ CCSI
30 ❑ Residential Treatment Facility
88 ❑ Other *(Specify)* _____

Please describe why child requires the highest level of service that SPOA provides:

_____

_____

_____

List Child's Strengths: (Enter as many as desired)

_____

_____

_____

List of Family/Caregiver Strengths: (Enter as many as desired)

_____

_____

_____

Name of Person Referring Child to SPOA:	Title:	
Signature of Person Referring Child to SPOA:	Phone:	Date of Referral to SPOA:

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AUTHORIZATION FOR RELEASE OF INFORMATION

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. A separate authorization is required to use or disclose confidential related information.

PART 1: Authorization for Release of Information

Description of Information to be Used/Disclosed:

I, *(insert Parent/legal Guardian/ACS/Foster Care)* _____ , consent to release clinical information to the Single Point of Access (SPOA). I understand that the SPOA will review and evaluate the information to determine eligibility for services in Home and Community Based Services Waiver, Health Home Care Management, Family Based Treatment or Community Residence.

Purpose or Need for Information:

1. This information is being requested by:
   - ❑ The individual or his/her personal representative; or
   - ❑ Other *(please describe)* _____
2. The purpose of the disclosure is *(please describe):*

It is understood that this information will be used to evaluate *(Insert Child's Name)* _____ for possible placement with HCBS Wavier, Case Management, Family Based Treatment or Community Residence. Upon acceptance, my child will be receiving services from one of the above.

It is understood that this information will be used to evaluate *(Insert Child's Name)* _____ for possible placement with HCBS Wavier, Health Home Care Management, Family Based Treatment or Community Residence. Upon acceptance, my child will be receiving services from one of the above.

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 authorize the SPOA to release clinical information and make recommendations for the appropriate program for possible enrollment. I also understand that the SPOA may recommend other appropriate programs/services, such as Residential Treatment Facility, the Coordinated Children's Services Initiative, or the Parent Resource Center. 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 this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. 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.
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 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 ability 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).

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Please select one choice from either B-1 or B-2:

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;

B-2. **Periodic Use/Disclosure:** I hereby permit the periodic use or 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 one of the intensive high end mental health services;
- ❑ One Year from this Date;
- ❑ Other _____

C. Patient Signature: I certify that I authorize the use of my medical/mental 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 Personal Representative

WITNESSED BY: _____ _____
Staff person's name and title Date

Authorization Provided To: _____

To be Completed by Facility:

_____ _____
Signature of Staff Person Using/Disclosing Information Date Released

_____
Title

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility Program whose name and address is:

_____

_____

_____

I hereby revoke my authorization to use/disclose information indicated in Part 1, 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 Authorization)*