

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	<input type="checkbox"/> OMH Residential Services; Congregate or Apartment Treatment <input type="checkbox"/> OMH Supportive Housing <input type="checkbox"/> Non Medicaid CM for SMI* Eligible <input type="checkbox"/> Forensic Case Management <input type="checkbox"/> ACT Team <input type="checkbox"/> SRO <input type="checkbox"/> To be determined <input type="checkbox"/> Other _____		
Date of Referral:		Applicant Gender:	<input type="checkbox"/> Male <input type="checkbox"/> 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:		Emergency Contact Name, Address & Phone #:	
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referring person contact information: Provider Type: _____ Name: _____ Role: _____ Agency: _____ Address: _____ Phone: _____ Fax: _____ Email Address: _____			
Legal Status			
Involved with:		If incarcerated, anticipated release date _____	
<input type="checkbox"/> Parole <input type="checkbox"/> County Probation		<input type="checkbox"/> Federal Probation/history	
PO name and phone: _____			
Reason/charges/convictions _____ Restrictions? _____			
<input type="checkbox"/> CPL _____		<input type="checkbox"/> Court Order or Diversion <input type="checkbox"/> Town Court <input type="checkbox"/> Treatment Court	
<input type="checkbox"/> Adult Protective Services		<input type="checkbox"/> Child Protective Services	
<input type="checkbox"/> Assisted Outpatient Treatment (AOT)		<input type="checkbox"/> 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)
<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Native <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (specify) _____ _____	<input type="checkbox"/> Does Not Speak English. <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good - Does Not Need Translator <input type="checkbox"/> Literacy level:
Veteran Status		
Veteran or served in military? <input type="checkbox"/> Yes <input type="checkbox"/> No Service Connected Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Branch/ type of discharge: _____ If Service Connected _____%
Current Marital Status	Custody Status of Children	
<input type="checkbox"/> Single, never married <input type="checkbox"/> Currently married <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed	<input type="checkbox"/> No children <input type="checkbox"/> Minor children in clients custody, ages: _____ <input type="checkbox"/> Have children - older than 18 years <input type="checkbox"/> Minor children not in client's custody but have access <input type="checkbox"/> Minor children no custody - no access	
Current Educational Level	Employment/Vocational	
<input type="checkbox"/> No formal education <input type="checkbox"/> Some grade school (1-8th grade) <input type="checkbox"/> Completed grade school <input type="checkbox"/> Some HS (9-12th grade, but no diploma) <input type="checkbox"/> HS diploma or GED <input type="checkbox"/> Vocational, business training <input type="checkbox"/> Some college, no degree <input type="checkbox"/> College degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Other: _____	<input type="checkbox"/> If has employment history, describe: <input type="checkbox"/> Other vocational training, describe: Recommendations: <input type="checkbox"/> Access-VR involvement <input type="checkbox"/> Other:	
Representative payee history?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	Wages/Earned Income	<input type="checkbox"/>
SSI	<input type="checkbox"/>	Unemployment/Amount_____	<input type="checkbox"/>
SSD	<input type="checkbox"/>	Child Support Owed or Received \$_____	<input type="checkbox"/>
Temporary Assistance	<input type="checkbox"/>	Worker's Comp	<input type="checkbox"/>
Veterans benefits	<input type="checkbox"/>	Social Security Retirement	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	Pension/Amount:_____ Source _____	
Medicaid	<input type="checkbox"/>	Trust Fund	<input type="checkbox"/>
Food Stamps	<input type="checkbox"/>	Special Needs Trust	<input type="checkbox"/>
Other, Describe:_____		Private Insurance/Third Party Payer	<input type="checkbox"/>

Substance Use

Drugs of Choice:

- | | | | |
|---------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Any IV Drug Use | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana/Cannabis |
| <input type="checkbox"/> Crack | <input type="checkbox"/> Heroin/Opiates | <input type="checkbox"/> PCP | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Sedative/Hypnotic | <input type="checkbox"/> Benzodiazapines | <input type="checkbox"/> Spike, Synthetic Marijuana |
| <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Inhalant: Sniffing Glue/Other Household Product | |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> 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:

- | | | |
|-----------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Incontinent | <input type="checkbox"/> Impaired Walking | <input type="checkbox"/> Requires Special Medical Equipment |
| <input type="checkbox"/> Hard of Hearing/Deaf | <input type="checkbox"/> Impaired Vision/Blind | <input type="checkbox"/> Lung Problems <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Weight Concern | <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Developmental Disorder | <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> 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):

- Mental health treatment records
- Alcohol/Drug treatment records
- Health records
- Education records

4. This information may be disclosed by:

- Any person or organization that possesses the information to be disclosed
- 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.

- The persons or organizations listed in Attachment A
- The following persons or organizations:

6. The purposes for which this information may be used and disclosed include:

- Evaluation of eligibility to participate in a program supported by the Onondaga County Department of Mental Health;
- Delivery of services, including care coordination and case management;
- 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 Health 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.

Rev: 3/2020

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 _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.
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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)*