ULSTER COUNTY SINGLE POINT OF ACCESS (SPOA) APPLICATION

CHILD & ADULT CARE MANAGEMENT • ASSERTIVE COMMUNITY TREATMENT (ACT)

1. Complete the application ***(please print)*** including Consents to Release/Disclose Confidential Information
2. Submit via mail, fax or email. *Questions? Call us at (845) 340-4110.*

Ulster County Department of Mental Health
239 Golden Hill Lane Kingston, NY 12401
Fax: (845) 340-4094
dmh@co.ulster.ny.us

Providers: Please include a copy of the most recent psychiatric evaluation, psychosocial assessment, written narrative of the case and service needs, or any other supporting documentation.

APPLICATION PROCESS

1. We will contact you to discuss needs and available services.
2. Your application will be reviewed by a team of community providers. See consent for full list.
3. We will contact you to let you know where you've been referred.

Referring Person: _____ **Agency:** _____

Referent Phone: _____ **Referent E-Mail:** _____

Applicant Name: _____ **DOB:** _____ **Gender Identity:** _____

Parent/Guardian (if applicable): _____**Relationship:**_____

Address: _____ **Primary Phone:** _____ **Secondary Phone:** _____

City/State/Zip: _____ **Primary Language:** _____

Insurance: _____ **Plan ID #:** _____

History of Medical Conditions: ☐High Blood Pressure ☐Diabetes ☐COPD ☐Asthma ☐Seizure Disorder ☐Obesity ☐Cardiac Problems ☐Stroke/CVA ☐TBI ☐Other: _____

Psychiatric Diagnoses: _____

Mental Health Provider: _____ **Name of Practice:** _____

Current Medications: _____

Previous Psychiatric Hospitalizations: *(in the last year)*

Hospital	Reason for Admission	Admit Date	Discharge Date

SERVICE NEEDS: *(Check all that apply)*

☐ Medical/Physical ☐ Financial ☐ Educational/Vocational ☐ Housing ☐ Advocacy ☐ Mental Health ☐ Support Systems ☐ Social/Recreational ☐ Alcohol/Substance Abuse ☐ Legal ☐ Other: _____

Applicant Name: DOB:

This authorization must be completed by the i**ndividual, their personal representative or parent/guardian** 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 Individual or another person. A separate authorization is required to use or disclose confidential HIV related information and for the disclosure psychotherapy notes. Treatment, payment, enrollment or eligibility may not be conditioned on whether the individual signs this authorization.

Purpose or Need for Information:

1. This information is being requested:

☐ By the Individual or their personal representative/guardian or parent/guardian for release to a person or entity with a demonstrable need for the information; OR

☒ Other (please describe) **For the SPOA Coordinator**

2. The purpose to release/obtain is (please describe**): The SPOA Committee for Child & Adult Case Management is composed of multiple agencies including, but not limited to, those listed below. This authorization form will permit members of the SPOA Committee to exchange information about the Individual being referred to SPOA with each other in order to link the Individual with the appropriate supportive service or program.**

Information Being Released/Obtained: *All applications, psychiatric evaluations, psychiatric diagnosis, psycho-social reports, clinical discharge summaries, psychological evaluations, educational records, CSE evaluations, IEPs and other supporting documentation may be exchanged between the appropriate SPOA Committee members to link the individual with the services or programs best suited to meet the individual's needs. SPOA Committee members include, but are not limited to, the following entities:*

Abbott House	Gateway Hudson Valley	Resource Center for Accessible Living, Inc.
Access: Supports for Living, Inc.	Greystone	Rockland Children's Psychiatric Center
All About Kids	Green Chimneys	Rockland Psychiatric Center
The Arc Mid-Hudson	Hamaspik Choice	Rural Ulster Preservation Company (RUPCO)
Arms Acres/Conifer Park	Hudson Valley Community Services: a	Samadhi
Assisted Outpatient Treatment	Division of Cornerstone Family Healthcare	Spectrum Behavioral Health
Astor Services for Children and Families	Hudson Valley LGBTQ+ Community Center	St. Anne Institute
Berkshire Farm Center & Services for Youth	HV Veteran Re-Integration Center	St. Catherine's Center for Children
Care Design NY	Institute for Family Health	St. Christopher
Catholic Charities Community Services of	Jewish Child Care	Step One (Child and Family Guidance Center)
Orange/Sullivan	KidsPeace	Tri-County Care
Children's Health Home of Upstate NY	LaSalle Schools	Ulster County Departments of Health & Mental Health
Children's Home of Kingston	LIFEPlan	Ulster County Department of Social Services
Children's Home of Poughkeepsie	Mental Health Association in Ulster, Inc.	Ulster County Jail
Children's Village	New York State Parole	Ulster County Probation Department
Chiz's Heart Street	Northeast Parent and Child Society	WMC Health Alliance of the Hudson Valley
C-YES	Northern Rivers Family Services, Inc.	(Bridge Back, First Step & Methadone Program)
Ellenville Regional Hospital	NYS OPWDD	WMC Mid-Hudson Regional Hospital & Turning Point
Family of Woodstock, Inc.	Parsons Child and Family Center	School District _____
Family Services Inc.	People USA	Emergency Contact _____
Four Winds Hospitals	Rehabilitation Support Services	Other_____

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 pursuing or receiving Child or Adult Care Management SPOA services.

Individual's Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____

Signature of Individual, or Personal Representative, or Parent/Guardian **Date**

_____

Individual's/Child's Name (Printed)

_____

Personal Representative or Parent/Guardian's Name (Printed) Relationship

Description of Personal Representative's Authority to Act for the Individual (required if Personal Representative signs Authorization)

REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information to the person/organization/facility/program listed above

Signature: Date:

Optional - Single Point of Access (SPOA) Patient Information Retrieval Consent Ulster County

By signing this form, you agree to have your 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. In order to support coordination of your care and provide better care, health care providers and other people involved in such care need to be able to talk to each other about your care and share health information with each other. You will still be able to get health care and health insurance even if you do not sign this form.

Your signature on this form will permit the SPOA Committee to get health information, including your health records, through a computer system run by HealtheConnections, 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 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. 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 can get, see, read and copy, and share with each other, ALL of your health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your 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 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:

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 health information must obey all these laws. They cannot give your 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. Under federal law, information disclosed to an entity that is not required to comply with HIPAA may no longer be protected by HIPAA. However, the information is still protected by New York State Law, which prohibits re-disclosure unless otherwise specifically authorized by law. Separate laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your 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 health information through the RHIO and/or through PSYCKES to give me care or manage my care, to check if I am 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 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. This authorization will expire when I am no longer pursuing or receiving Child or Adult Care Management SPOA services.

_____ _____

Print Name of Patient Patient Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative Date

(Please keep for your records. No need to return.)

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. Further, your refusal to sign the authorizations will not affect your abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect your eligibility for benefits. Please note, however, that without the information made available due to your signature on the authorization, SPOA Committee members will not have your information and therefore will be unable to determine if you are eligible for their services or if their services are appropriate for you.

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. Please note that if you authorize your information to be disclosed to someone who is not required to comply with HIPAA, then it 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).

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) 340-4110, 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 (845) 340-4110. 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?
A copy of this form will be provided to you after you sign it.