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| --- | --- | --- | --- | --- |
| **Last Name:** Click or tap here to enter text.  **First Name:** Click or tap here to enter text.  **Date of Birth:** Click or tap to enter a date.  **Age:** Click or tap here to enter text.  **Phone:** Click or tap here to enter text. | | Date: Click or tap to enter a date.Type of Request: (*choose all that apply)* **Situational Update –** *fill in sections that have changed & demographics*  **Additional Services –** *complete the entire form*  **Date of Current SPOA Referral** *(if known):* Click or tap to enter a date. | | |
| **Address:** Click or tap here to enter text. | | **Reason for Request** *(pending discharge, change in situation, etc.):*  Click or tap here to enter text. | | |
| **Email:** Click or tap here to enter text. | | **Requested Services:** | | |
| **Type of Current Residence:**  **Community Residence  OCFS Placement**  **Correctional Facility  Own Home/Caregiver Home**  **Couch Surfing  Residential Treatment Facility**  **Emergency Housing  Substance Use Facility**  **Inpatient Setting  Other *(specify below)***  **Provide details:** Click or tap here to enter text. | | **Child (5-21)**  **◼ Community Residence\***  **Community Respite**  **Family Peer Support Services**  **Medicaid Care Coordination** (Health Home)  **Non-Medicaid Care Coordination**  **◼ Residential Treatment Facility\*** | | **Adult (18+)**  **Assertive Community Treatment (ACT)**  **Certified Apartment**  **Community Residence**  **Medicaid Care Coordination** (Health Home)  **Non-Medicaid Care Coordination**  **Supportive Housing** |
| **MH, SUD, DD Diagnoses:** Click or tap here to enter text. | |
| *\*Contact the Child SPOA Coordinator for information about applying for these services: 607-778-1102 or* [*childspoa@broomecounty.us*](mailto:childspoa@broomecounty.us) | | |
| **Insurance Type:** Click or tap here to enter text. | | **Health Home Provider** *(if applicable):* Click or tap here to enter text. | | |
| **Dates of CPEP Visits** *(within the last year)***:** Click or tap here to enter text. | | **Dates of Hospitalizations** *(within the last year)*:  **Psychiatric** Click or tap here to enter text.  **Medical** Click or tap here to enter text. | | |
| **Current Providers/Services:** *(include the number of visits in the last month for each provider)*  Click or tap here to enter text. | | | | |
| **Describe Relationship with Service Provider(s)** *(both with individual and family as applicable):*  Click or tap here to enter text. | | | | |
| ***For Child SPOA Only:*** | | | | |
| ***School District:*** Click or tap here to enter text. | ***School Placement:*** Click or tap here to enter text. | | ***CSE Status:*** Click or tap here to enter text. | |
| ***Describe Relationship with School:*** Click or tap here to enter text. | | | | |
| **High Risk Alerts** *(check if current issue, within last 90 days)*:   |  |  | | --- | --- | | Caretaker Medical/Behavioral Health Issues | Non-compliance - Appointments | | Crises – Requiring Intensive Services | Non-compliance - Medication | | Fire Setting | Self-Injurious Behaviors | | Homeless - *Current* | Suicidal Ideation/Attempts/Threat | | Homicidal Ideation/Attempts/Threats | Victim of Physical/Sexual Abuse or Neglect | | Inappropriate Sexual Behavior | Violence towards Others |   If checked, provide dates and a brief explanation: Click or tap here to enter text. | | | | |

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| **Please Indicate Responses to the Following Challenges:** | | | YES | **NO** |
| Community Services and/or Supports – *lack of awareness, inappropriate use of, etc.* | | |  |  |
| Cultural Issues/Language Barriers | | |  |  |
| Criminal Justice – *current charges pending, probation or parole involvement, recent release from incarceration* | | |  |  |
| Housing – *changes in, or challenges maintaining* | | |  |  |
| Financial | | |  |  |
| Insurance – *lack of coverage, network availability, etc.* | | |  |  |
| Medical – *current health issues,* *unaddressed needs, medication issues, etc.* | | |  |  |
| Psychiatric Appointments - *scheduling, keeping, attending, following-up with, etc.* | | |  |  |
| Psychiatric Medication Management – *scheduling, co-pay, pharmacy, etc.* | | |  |  |
| Transportation | | |  |  |
| ***For Child SPOA Only:*** | | | **YES** | **NO** |
| *Custody Issues – living with adults other than parents* | | |  |  |
| *School Placement - recent or anticipated change* | | |  |  |
| **Explain “YES” responses above and any barriers to overcoming identified challenges:**  Click or tap here to enter text. | | | | |
| ***Comments:* Strengths and Challenges – *Why is this additional service needed?***  Click or tap here to enter text. | | | | |
| ***Name of Person Completing Form:***  Click or tap here to enter text. | | ***Agency/Program:***  Click or tap here to enter text. | | |
| ***Signature:*** | | ***Date:*** Click or tap to enter a date. | | |
| **SPOA Committee Recommendation(s):** | **Date of SPOA Committee Meeting:** | | | |
| **Approved** for additional services  **Not Approved** for additional services  **Not Applicable** *(Situational Update)* | | | | |
| **Explanation of Determination:** | | | | |
| **Alternative Services Recommended:** | | | | |
| **SPOA Coordinator:**  *Signature* | | | | |

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