Broome County Adult Single Point of Access (A-SPOA) - APPLICATION

Applicant's NAME: _____ **Applicant's DOB:** _____

INSTRUCTIONS: To access services available through A-SPOA, complete both: (1) A-SPOA Application and (2) Universal Consent for Release of Information. For detailed instructions on how to complete forms, please refer to Instructions for Application and/or the Instructions for Universal Consent for Release of Information located at: https://gobroomecounty.com/mh/spoa.

SUBMISSION: Submit completed Application and Universal Consent for Release of Information to: AdultSPOA@BroomeCountyNY.gov

QUESTIONS: Contact A-SPOA Coordinator at: Phone: (607) 778-1119 · Fax: (607) 778-6189 · Email: AdultSPOA@BroomeCountyNY.gov

----- **This document is best suited for Adobe Acrobat Reader.** Download here: https://get.adobe.com/reader/otherversions/ -----

Use *TAB* button to toggle forward through Application. Use *SHIFT + TAB* to toggle backwards.

PROGRAM SELECTION – Programs and/or Services the Applicant is Requesting *(select all that apply)*

TREATMENT	CARE MANAGEMENT	RESIDENTIAL
☐ Assertive Community Treatment (ACT)	☐ Medicaid Care Management	☐ OMH Certified Apartment Treatment Program *(CAP)*
For Correctional Facility Referrals Only:	☐ Non-Medicaid Care Management	☐ OMH Supportive Housing – Apartment Program
☐ *Mental Health Clinic Appt*		☐ Empire State Supportive Housing Initiative *(ESSHI)*
☐ *Substance Use Clinic Appt*		

SECTION 1 – APPLICANT INFORMATION

1. Full Name *(LAST Name, FIRST Name)*

2. Date of Birth *(MM/DD/YYYY)*

3. Gender Identity

4. Currently Homeless ○ Yes ○ No

5. Current Residence
☐ Private Home/Apartment ☐ Emergency Housing ☐ Inpatient Setting
☐ Community Residence ☐ Substance Use Facility ☐ Couch Surfing
☐ Correctional Facility ☐ Other (describe):

6. Physical Address
(Must be a Broome County Resident to be Eligible for Services)

7. Mailing Address *(if different from physical address)*

8. Phone *[(area code) xxx-xxxx]*

9. Primary Language(s)

10. Veteran ○ Yes ○ No

11. Financial Status/Income Status
Check all that apply
☐ SSI $ _____
☐ SSD $ _____
☐ VA $ _____
☐ Public Assistance $ _____
☐ Other $ (Source) _____

12. Health Insurance
Check all that apply
☐ Private Insurance
☐ Medicaid CIN #: _____
☐ Veteran's
☐ Medicare #: _____
☐ Uninsured
☐ Other _____

13. Ethnicity
☐ Caucasian/White
☐ Latino/Hispanic
☐ African American / Black
☐ Pacific Islander
☐ Asian/Asian American
☐ Native American
☐ Other, Specify:_____

14. Current Representative Payee
☐ Yes. If so, who? _____
☐ No

15. Emergency Contact *(LAST Name, FIRST Name, Phone Number with Area Code)*

16. Applicant's Reason for Applying for Services

SECTION 2 – REFERRER'S INFORMATION

17. Referrer Name *(LAST Name, FIRST Name)*

18. Referrer Title

19. Referrer Agency

20. Referrer Mailing Address

21. Referrer Email

22. Referrer Phone

23. Referrer Fax

24. Referrer's Reason for Referral

Broome County Adult Single Point of Access (A-SPOA) - APPLICATION

Applicant's NAME: _____ **Applicant's DOB**: _____

SECTION 3 – DIAGNOSTIC AND CURRENT TREATMENT INFORMATION

25. Diagnosis(es) *(Mental Health, Substance Use Disorder, Medical, Intellectual)*

26. Current MENTAL HEALTH Treatment Provider(s)

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

27. Current SUBSTANCE USE Treatment Provider(s)

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

SECTION 4 – OTHER SERVICE PROVIDERS

28. Primary Care Physician

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

29. Current Care Management Services

☐ None/Not Applicable

Name of Provider _____
Agency _____
Address _____
Phone _____
Email _____

SECTION 5 – HIGH RISK ALERTS

30. Check all that apply

☐ Suicide / Suicide Attempts
☐ Suicidal Threats
☐ Fire Setting
☐ Violent History / Assault
☐ Self-Injurious Behavior
☐ Medication non-compliance
☐ Appointment attendance non-compliance
☐ Frequent Crisis Requiring Readmission
☐ Inappropriate sexual behaviors
☐ Other (specify): _____
☐ Chronic Physical Health Conditions
☐ Homelessness - current
☐ Homelessness – historic
☐ Victim of Physical / Sexual Abuse

For any items checked, please provide details *(dates and brief explanation, if available):* _____

_____

31. Assisted Outpatient Treatment (AOT) Status

Current AOT Order / Recipient	☐ Yes	☐ No	☐ Unknown
AOT Candidate *(in process)*	☐ Yes	☐ No	☐ Unknown

SECTION 6 – CRIMINAL JUSTICE STATUS

32. Indicate if any current - or past - history – check all that apply:

☐ Probation – Expires: _____
PO Name: _____
☐ Parole – Expires: _____
PO Name: _____
☐ CPL Status (§330.90)
☐ Order of Protection
☐ Conviction of a Crime
☐ Charges Pending (active)

For any items checked, please provide details *(dates and brief explanation, if available):* _____

_____

Broome County Adult Single Point of Access (A-SPOA) - APPLICATION

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SECTION 7 – TREATMENT HISTORY

33. Mental Health Treatment

☐ None/Not Applicable

Inpatient Treatment History *(include dates, facility names)*

Outpatient Treatment History *(include dates, facility names)*

34. Substance Use Treatment

☐ None/Not Applicable

Inpatient Treatment History *(include dates, facility names)*

Outpatient Treatment History *(include dates, facility names)*

35. Number of Emergency Department visits in 12 months prior to referral:

SECTION 8 – ADDITIONAL INFORMATION

36. Please include any additional information, pertinent to this application for SPOA services, not otherwise specified:

SECTION 9 – CARE MANAGEMENT SERVICE SELECTION

- ❖ Medicaid Health Home & Health Home Plus
- ❖ Non-Medicaid Care Management

37. What does Care Management do for you?

Once enrolled, you will be assigned a Care Manager who will work with you to create a personal care plan based on your needs. Some of the services may include:

A. Connecting to health care, mental health, and/or substance use treatment providers
B. Connecting to needed medications, social services, and/or other community programs

38. Do I qualify?

Medicaid-eligible adults and children with a chronic medical and/or behavioral health condition(s):

A. Two or more chronic conditions *(e.g., Substance Use Disorder, Asthma, etc.)* ***OR***
B. One single qualifying condition
   i. HIV/AIDS ***OR***
   ii. Serious Mental Illness (SMI) (Adults) ***OR***
   iii. Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Substance Use Disorders (SUD) do not, by themselves, qualify an individual for Medicaid Health Home services and can be used to qualify individuals in conjunction with another chronic condition.

For more detailed information: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

39. Medicaid Care Management Options *(Select ONE, if applicable)*

☐ Addiction Center of Broome County (ACBC)
☐ Catholic Charities of Broome County
☐ Complete Care by United Methodist Homes
☐ Family & Children's Counseling Services
☐ Lourdes
☐ Monroe Plan
☐ Rehabilitation Support Services
☐ Southern Tier Care Coordination (STCC/STAP)
☐ No Preference (A-SPOA will select based on availability)
☐ None / Not applicable
☐ Other: _____

40. Non-Medicaid Care Management Options *(Select ONE, if applicable)*

☐ Catholic Charities of Broome County
☐ Family & Children's Counseling Services
☐ No Preference (A-SPOA will select based on availability)
☐ None / Not applicable

----- Signature is not required on this document ----- End of Application ----- Submit to: AdultSPOA@BroomeCountyNY.gov -----

Broome County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME:_____ **Individual's DOB:** _____

This authorization must be completed by the referred individual or their legal guardian/personal representative.

This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42, Part 2 of the *Code of Federal Regulations (42 CFR Part 2)* that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and Protected Health Information (PHI) between, *Broome County Single Point of Access (SPOA) Team* (comprised of Broome County Mental Health Department staff), ***Other Providers*** (see attached list of Providers on page 2) which comprise the ***SPOA Committee***; **AND** the ***Referral***

Name & Address of Referral Source: _____

DESCRIPTION OF INFORMATION to be used / disclosed and re-disclosed ***(check ALL that apply):***

- ☐ ***ALL listed below***
- ☐ Mental Health/Psychosocial Assessment
- ☐ Psychiatric Evaluation/Assessment/ Consultation
- ☐ Discharge Summary/Treatment Plan
- ☐ Psychological &/or Neurological Tests
- ☐ Documentation of Medical Necessity
- **X** ***Referral (including contact info)- required***
- ☐ Inpatient/Outpatient Treatment
- ☐ Financial &/or Insurance Info
- ☐ Medications (past & present)
- ☐ Pre-Sentence Investigation Report
- ☐ Physical Health (including family planning if applicable)
- ☐ Other (specify): _____
- ☐ Diagnosis(es)
- ☐ HIV/AIDS-related Information
- ☐ School Records (including testing)
- ☐ Substance Use Evaluation
- ☐ Substance Use Diagnosis
- ☐ Substance Use Treatment Plan
- ☐ Substance Use Medication(s)
- ☐ Substance Use Discharge

PURPOSE OR NEED FOR INFORMATION:

Allow SPOA to: consult with and make referrals to appropriate providers; collect and provide documentation (e.g.: discharge planning information) and coordinate care among providers (listed on page 2 of this document); and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- I am applying for services and programs, appropriate to my wants and needs, accessible via the SPOA process.
- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization.
- With some exceptions, health information once disclosed may be re -disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- I authorize the re-disclosure and digital storage, including Cloud-based services, of the above-described information to the providers identified on page 2 of this document for the purposes identified on this form.
- I have the right to revoke *(take back)* this authorization at any time. My revocation must be in writing on a form provided by Broome County. I am aware that my revocation does not affect information disclosed while the authorization was in effect.
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain medical treatment nor access to benefits to which I may be eligible.
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524).
- I have been offered a copy of the *Notice of Privacy Practices* and/or notified that a copy can be located at www.gobroomecounty.com/mh/requestforrecords and I have the right to request and receive a copy at any time.

I HEREBY PERMIT the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified in this *Universal Consent for Release of Information* as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire:

(Check one)

- ◯ When the individual named herein is no longer receiving services accessed through Broome County SPOA.
- ◯ One Year from the date of signature.
- ◯ Other: _____

I CERTIFY THAT BY SIGNING THIS AUTHORIZATION I acknowledge I have read, understand, and consent to use of the PII and PHI as set forth in this document. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE of Individual or Personal Representative	**Printed Name of Individual**	**Date**
Printed Name of Personal Representative *(if applicable)*	**Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*	
SIGNATURE of WITNESS	**Printed Name of Witness/Title**	**Date**

Broome County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME: _____ **Individual's DOB:** _____

List of PROVIDERS with which Adult Single Point of Access (A-SPOA) is permitted to exchange information.

Addiction Center of Broome County
Binghamton Vet Center
Broome County Council of Churches
Broome County Department of Social Services
Broome County Health Department
Broome County Mental Health Department
Broome County Office for Aging
Broome County Probation Department
Capital District Physicians' Health Plan
Catholic Charities of Broome County
Cornerstone Family Healthcare
Crime Victim's Assistance Center
Excellus BlueCross BlueShield
Family & Children's Counseling Services
Fairview Recovery Services
Fidelis Care
Greater Binghamton Health Center
Greater Opportunities for Broome & Chenango
Helio Health Inc.
Health Homes of Upstate New York/Circare LIFEPlan CCO-NY Lourdes Center for Mental Health
Mental Health Association of the Southern Tier
Molina Healthcare of New York
Monroe Plan for Medical Care
NYS Department of Corrections and Community Supervision NYS Office for People with Developmental Disabilities NYS Office of Addiction Services and Supports
NYS Office of Mental Health
Our Lady of Lourdes Memorial Hospital (Ascension Health)
Prime Care Coordination
REACH Medical
Rehabilitation Support Services
Rescue Mission
RISE-NY
Salvation Army of Binghamton
Southern Tier AIDS Program
Southern Tier Connect
Southern Tier Homeless Coalition
Southern Tier Independence Center
United Healthcare Community Plan
United Health Services *(Hospitals, Medical Groups, Outpatient Services, Primary Care Practices)*
United Methodist Homes
Volunteers of America
YMCA of Broome County
YWCA of Binghamton

If not listed above - include* AGENCY NAME, ADDRESS AND PHONE NUMBER *for:

Mental Health Treatment/Psychiatric Records:

_____

Substance Use Treatment/Records:

_____

Primary Care Practitioner:

_____

Other:

Broome County Adult Single Point of Access (A-SPOA) – *UNIVERSAL CONSENT for RELEASE OF INFORMATION*

Individual's NAME:_____ **Individual's DOB:** _____

Broome County Adult Single Point of Access (A-SPOA) Patient Information Retrieval Consent

The SPOA Committee may get health information, including your health records, through a computer system operated by *HealtheConnections*, a Regional Health Information Organization (RHIO). 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.

The SPOA Team and Committee may also get health information through a NYS Office of Mental Health database called *PSYCKES* (Psychiatric Services and Clinical Knowledge Enhancement System). It can contain health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in *PSYCKES*, visit www.psyckes.org.

If you agree and sign this form, SPOA Team and Committee members can access, read, and your health information - including all of the health information obtained from the RHIO and/or from *PSYCKES* – needed to arrange your care, manage such care or study such care to make health care better for patients. The health information they see, read and copy 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:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and dosages
- Diagnostic Information
- Allergies
- Substance use history summaries
- Clinical notes
- Discharge summaries
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data
- Lab tests

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 you, an appropriate personal representative 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. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your health information and the SPOA Team and Committee must obey these laws and rules.

Please read all of the information on this form before signing it.

◯ **I GIVE CONSENT f**or the SPOA Committee to access ALL of my health information through the RHIO and/or through PSYCKES to provide me care or manage my care, to check if I am in a health plan and what the plan covers.

◯ **I DENY CONSENT** for the SPOA Committee to access ALL of my health information through the RHIO and/or through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

SIGNATURE of Individual or Personal Representative | **Printed Name of Individual** | **Date**

Printed Name of Personal Representative *(if applicable)* | **Description of Authority of Personal Representative** *(e.g. Parent / Legal Guardian)*

SIGNATURE of Witness | **Printed Name of Witness/Title** | **Date**

Individual's NAME: _____ **Individual's DOB:** _____

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**
   By signing the *Universal Consent for Release of Information*, SPOA providers can use your health information to coordinate and manage your health care; check if you have health insurance and what it pays for; and study and make health care better for patients. The choice you make does not let health insurers see your information, decide whether to give you health insurance, or pay your bills.

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. An example of where this information is accessed is Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). If you have any questions, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider.

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 the HIPAA Privacy Rule – or - "HIPAA" – *Health Information Portability and Accountability Act*).

4. **How does SPOA protect health information?**
   The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose Protected Health Information about them, as well as their rights and the covered entity's obligations with respect to that information.
   - The *Notice of Privacy Practices* of the Broome County Mental Health Department can be found on the department's website, located here: https://www.gobroomecounty.com/mh/requestforrecords

5. **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. For the purposes of SPOA, this may include treatment and services providers who work for SPOA or for a SPOA provider.

6. **What if a person uses my information and I didn't agree to let them use it?**
   If you think someone used your information, and you did not agree to give the person your information, you can contact: the Broome County SPOA at (607) 778-2351; the NYS Office of Mental Health Customer Relations at (800) 597-8481; or the United States Attorney's Office at (212) 637-2800.

7. **How long does the *Universal Consent for Release of Information* last?**
   The *Universal Consent for Release of Information* is valid until you revoke (take back) permission or when SPOA Team or SPOA service providers discontinue/complete working with you.

8. **What if I change my mind later and want to take back my consent?**
   You have the right to revoke (take back) the written consent at any time. The revocation must be in writing on a form provided by Broome County located here: https://www.gobroomecounty.com/mh/requestforrecords. The revocation of consent does not affect information disclosed while the authorization was in effect. 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.

9. **How do I get a copy of this form?**
   You can request to have a copy of this form after you sign it from: AdultSPOA@BroomeCountyNY.gov.