Broome County

Child Single Point of Access

(C-SPOA)

Instructions

for

APPLICATION

This document provides item-by-item descriptions of information needed to successfully complete the C-SPOA *Application.*

This document is best suited for *Adobe Acrobat Reader*.

Download here: https://get.adobe.com/reader/

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

PURPOSE:

Broome County Child Single Point of Access (C-SPOA) provides access to high-intensity mental health services for youth, to better integrate medical and behavioral health, and improve overall quality of care.

To ensure timely processing, this document provides itemized guidance to assist referral sources to complete the *C-SPOA Application*.

SECTION 1 – YOUTH'S INFORMATION

Item No.	Item	Description
1.	Full Name	Enter the full, legal name of the youth. *[LAST Name, FIRST Name]*
2.	Date of Birth	Enter the youth's Date of Birth. *[MM/DD/YYYY]*
3.	Gender Identity	Gender Identity refers to the gender the youth identifies as currently, *not* the sex assigned at birth.
4.	Date of Referral	Click to enter date the referral is completed/submitted. *[MM/DD/YYYY]*
5.	Physical Address	Enter Street Address where the youth primarily lives.
6.	Current Living Situation	Select which options best describes the youth's current living situation • See SECTION 3 for Caregiver 1 & Caregiver 2 descriptions.
7.	Is the Youth Fluent in English?	This information is about the youth. Caregiver information is captured in SECTION 3. *[☐ Yes – if "No", see question #8]*
8.	Primary Language	This information is about the youth. Caregiver information is captured in SECTION 3. *[Enter text]* of Primary Language.
9.	Health Insurance for the Youth	If known, indicate the status of Health Insurance for the youth: *☐ Private* *☐ Medicaid CIN #: Enter Medicaid CIN #* *☐ Uninsured* *☐ Unknown* If unknown, this information can be collected later.
10.	Is the YOUTH enrolled in Medicaid-eligible Health Home Care Management?	If the youth is currently enrolled in Medicaid-eligible *Health Home Care Management*, please indicate: *[☐ Yes ☐ No ☐ Unknown]* If currently enrolled with a [*Care Management Provider*], enter name of agency.

SECTION 2 – REFERRER INFORMATION

Item No.	Item	Description
11.	Referrer Name	Enter the name of the person making the referral. *[LAST Name, FIRST Name]*
12.	Title	Enter the title of the person making the referral. *[Title] – i.e. Case Manager*

13.	Agency/Program	Enter the agency the referral source works for, including the specific program as applicable. [*Name of Agency/Program*] - *i.e. Broome County Mental Health Department/C-SPOA Program*
14.	Referrer Email	Enter the email address of the referral source. *[Email address]*
15.	Referrer Mailing Address	Enter the mailing address of the location the referral source.
16.	Referrer Phone	Enter the phone number where the referral source can be reached. [(xxx) xxx – xxxx]
17.	Referrer Fax	Enter the fax number where the referral source can receive a fax. [(xxx) xxx – xxxx]
18.	Reason for Referral	Enter a brief description as to why the referral source is submitting this application for SPOA services for the youth.
SECTION 3 – CAREGIVER INFORMATION		
Item No.	**Item**	**Description**
Be advised this section repeats itself to capture information for different caregivers who may have different contact information.		
19. & 20	Full Name	Enter the full name of the youth's caregiver(s). *[LAST Name, FIRST Name]*
21. & 22.	Home Address	Enter the physical address of the youth's caregiver(s).
23. & 24.	Mailing Address	Is this address the same as the Home Address? If yes, check this box: [☐ *Same as Home Address*] If not, enter address where USPS mail is received.
25. & 26.	Phone	Enter the phone number of caregiver(s). *[(xxx) xxx – xxxx]*
27. & 28.	Text	If caregiver(s) would like to correspond via text message, enter number. *[(xxx) xxx – xxxx]*
29. & 30.	Email	Enter caregiver(s) email address. *[Email Address]*
31. & 33.	Relationship to Youth	Enter the relationship of the caregiver to the youth being referred. *i.e. mother, grandparent, sibling, guardian, adoptive parent*
32. & 34	Legal Guardian	Is caregiver a Legal Guardian for this youth? *[☐ Yes or ☐ No]*
35. & 37.	Caregiver Primary Language	This information is about the caregiver. Youth information is captured in SECTION 1. *[☐ Yes or ☐ No]*
36. & 38.	Fluent in English	This information is about the caregiver. Youth information is captured in SECTION 1. *[☐ Yes or ☐ No]*
39. & 40.	Is this Caregiver the Primary Contact?	Is the caregiver the Primary Contact? *[☐ Yes or ☐ No]*

SECTION 4 – LEGAL CUSTODY STATUS		
Item No.	**Item**	**Description**
41.	Select the option that best describes the custody status of the youth.	Choose One: • Both Biological Parents – *custody not formalized in Court* • Joint Custody – *formalized in Court* • Biological Mother only - *OR* - Biological Father only • Adoptive Parent(s) • Adult Sibling • Department of Social Services • Emancipated Minor • Other Legal Guardian Status (describe):
SECTION 5 - EDUCATION		
Item No.	**Item**	**Description**
42.	Current Grade	Choose CURRENT Grade from drop-down menu of choices. *[Choose CURRENT Grade]* If specific grade situation is not listed, or "other" option was selected, please describe: [*If other, specify: Describe here]*
43.	IEP/504 Plan?	Does the youth have an *Individualized Education Plan* (IEP) or a *504 Plan* (as indicated under Section 504 of the Rehabilitation Act of 1973) with the school district regarding accommodations for eligible students with disabilities? *[☐ Yes ☐ No ☐ Unknown]*
44.	Public School District	This question refers to the Public School District and generally corresponds to the physical home address of the youth. *[Choose Home Public District]* Select the actual, public school building, where the youth attends school – even if the school building is not physically located in the home district *i.e., Chenango Valley/Port Dickinson Elementary – or BOCES Oak Tree* *[Choose School Building]* If "Other" response best suits the question, enter text. *[Other: Specify]*
45.	Other Education Setting	If the youth is attending a faith-based school enter the name of that school. *[☐ Faith-Based School]* *[Name: Enter text]* If the youth is being homeschooled select: *[☐ Home Schooled]*
SECTION 6 – BEHAVIORAL HEALTH		
Item No.	**Item**	**Description**
46.	Diagnosis (es)	Enter any mental health or substance use diagnosis(es) of the youth. [Enter MH and/or SUD Diagnoses]
47.	Mental Health Treatment Provider(s)	If the youth has a current mental health treatment provider, enter the name of therapist or prescriber: *Name of Provider [Ex. Jane Smith]* and the Agency or Organization where the provider works: *[Agency [Agency or Organization]* If the youth does not have a current mental health treatment provider select: *[☐ None]*

48.	Substance Use Treatment Provider(s)	If the youth has a current substance use treatment provider, enter the name of therapist or prescriber: *Name of Provider [Ex. Jane Smith]* and the Agency or Organization where the provider works: *Agency [Agency or Organization]* If the youth does not have a current substance use treatment provider select: *[☐ None]*
49.	Is youth currently admitted to an inpatient facility?	At the time of referral, is the youth psychiatrically hospitalized? *[☐ Yes ☐ No]* If yes, indicate where and anticipated date of discharge (if known). *Name of Facility: [Enter Facility Name]* *Anticipated Date of Discharge: [Enter date, if known]*
50.	Number of visits to CPEP in 12 months prior to referral	Indicate the number of visits to CPEP (Comprehensive Psychiatric Emergency Program) in the twelve (12) months prior to referral. *[Choose Number] from the drop-down menu*
51.	Number of Psychiatric Inpatient Hospitalizations in 12 months prior to referral	Indicate the number of psychiatric inpatient hospitalizations in the twelve (12) months prior to referral. *[Choose Number] from the drop-down menu*

SECTION 7 – OTHER SERVICE PROVIDERS

Item No.	Item	Description
52.	Indicate any other community programs or services involved with the youth/family	Indicate if youth or family is working with any other community service providers and/programs *[Enter Name(s), Organization(s), or Program(s)]*
53.	Indicate any additional information pertinent to this referral	Indicate any other information pertinent to the youth/family that is pertinent to this referral. *i.e.: other youth in the same household who may be involved in similar services* *[Add Information or Details]*

SUBMISSION & REVIEW

- Submit completed *Application* and *Universal Consent for Release of Information* to: ChildSPOA@BroomeCounty.us
- To ensure timely access to SPOA services, the *Application* should be submitted as completely and correctly as practicable. C-SPOA will contact the referral source for clarification and/or corrections as necessary.

For questions, please contact:

Broome County Child SPOA
Broome County Mental Health Department
501 Reynolds Road
Johnson City, NY 13790
Phone: (607) 778-1102
Fax: (607) 778-6189
Email: ChildSPOA@BroomeCounty.us
Website: www.gobroomecounty.com/mh/SPOA

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