BROOME COUNTY SINGLE POINT OF ACCESS (SPOA)

UTILIZATION REVIEW (UR) for extension of LENGTH OF STAY (LOS)

Last Name: **First Name:** **Date of Birth:** **Age:**	**Enrollment Date:** **Initial Approved Service Period:** **Extended LOS Service Period:**
MH, SUD, DD Diagnoses:	**Agency:** _____ **Program for UR:** ☐ **Adult Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)* ☐ **Child Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)* ☐ **Family Peer Support Services** *(initial = 6 mo./extend = 3 mo.)* ☐ **Community Respite** *(initial = 12 mo./extend = 3 mo.)*
Living Situation *(specify setting)*:	**Number of Visits with Provider** *(within the month)*:
Insurance Type:	**Health Home Provider** *(if applicable):*
Dates of CPEP Visits *(within the last year)*:	**Dates of Hospitalizations** *(within the last year)*: ☐ **Psychiatric** _____ ☐ **Medical** _____
Other Providers/Services:	
Describe Relationship with Service Provider(s) (both with individual and family as applicable):	

For Child SPOA Only:		
School District:	***School Placement:***	***CSE Status:***
Describe Relationship with School:		

High Risk Alerts *(check if current issue)*:

☐ 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: _____

_____

_____

Last Name: _____ **First Name:** _____ **Date of Birth:**_____

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:

Attach current *Service Plan* or *Plan of Care* – *If not available, complete the section below.*

Service/Plan Goals	**Progress Made**	**Outstanding Needs**
1.		
2.		
3.		

Comments: **Strengths and Challenges – *Why should this service continue?***

Name of Person Completing Form:	***Title:***
Signature:	***Date:***

SPOA Committee Recommendation(s):	**Date of SPOA Committee Meeting:**
☐ **Approved** for extension of Length of Stay (LOS).	**Remain in program for an additional _____ months** **Next Utilization Review Due** *(date)*:
☐ **Discharge Recommended** – *state linkages to be completed:*	
Barriers to Discharge *(specify)*:	
SPOA Coordinator: *Signature*	