

APPLICATION

Ulster County Single Point of Access (SPOA) for Children and Families

What is Child SPOA?

Child SPOA is a process designed to help Ulster County parents/guardians access services for their children/adolescents who have Serious Emotional Disturbance (SED).

Children/adolescents between the ages of 5-18 who are struggling with one or more of the following may be eligible for Child SPOA services:

- at risk of being hospitalized or re-hospitalized, placed out of the home;
- involved with multiple systems (mental health, substance use, special education, family court, DSS, OPWDD, Probation, etc.);
- or unable to have success at home, school or community even with services and/or treatment in place.

1. Referral Steps

- a. The person making the referral (referral source) can be a service provider, (clinician, care manager, behavioral health specialist, school staff, hospital staff, physician, etc.) or parent/guardian.
- b. The person making the referral will discuss the Child SPOA referral in detail with the parent/guardian and together complete this application.

2. Application Packet

The Application Packet should include the following:

- Completed application
- Psychiatric evaluation and/or psychosocial assessments completed within the last 6 months
- Most recent IEP (Individualized Education Plan)
- Signed *HIPPA Authorization to Disclose and Obtain Information* on pages 2 and 3. Spanish version is available on request.
- SED Checklist
- Child / Adolescent's Needs and Strengths-NY (CANS NY)

3. Completed Application Packets are to be MAILED, FAXED, EMAILED OR DELIVERED to:

Cathy Woyahn, LCSW-R, Child SPOA Coordinator
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, New York 12401

Phone: (845) 340-4149 or (845) 340-4174; **Fax:** (845) 340-4094; **Email:** cwoy@co.ulster.ny.us

4. The Child SPOA Coordinator will review the Application Packet and may contact you and/or the referral source to gather additional information. The Child SPOA Committee will then determine whether your child meets the eligibility requirements, and if so, which program best meets the needs of your child and family. The parent/guardian will be informed of the decision about services.

HIPAA Authorization to Disclose and Obtain Information

Ulster County Department of Mental Health
239 Golden Hill Lane, Kingston, NY 12401

Dear Parent/Guardian:

Thank you for taking time to read this referral application for services in the Ulster County Child SPOA system. As the child's parent/legal guardian, your consent is required in order for the SPOA Committee to receive your child's information and to communicate with your child's providers listed below.

The SPOA Committee consists of representatives from Ulster County Department of Mental Health, Ulster County Department of Social Services, Probation Department, Mental Health Association of Ulster County, Family of Woodstock, BOCES, Taconic DDSO, Resource Center for Accessible Living, DSS Coordinated Children's Services, NEXIS, Youth Advocate Program, ACCESS: Supports for Living (Ulster County Mobile Mental Health Team), my child's School District, Family Services, Families Now, Institute for Family Health (Ulster clinics), Rockland Children's Psychiatric Center (Ulster clinics), Parsons Child and Family Center, Astor Services for Children and Families (Ulster clinics), Health Alliance of the Hudson Valley (Adolescent Partial Hospital Program).

As the parent/legal guardian of _____ (child's name), I hereby give permission for Ulster County's Child SPOA to obtain information from and communicate with the following service providers.

Name of Referral Source _____	
Program/Agency _____	
Mailing Address: _____	
Provider Phone Number: _____	Email Address: _____

Name of Additional Service Provider _____	
Program/Agency _____	
Mailing Address: _____	
Provider Phone Number: _____	Email Address: _____

Name of Additional Service Provider _____	
Program/Agency _____	
Mailing Address: _____	
Provider Phone Number: _____	Email Address: _____

Name of Additional Service Provider _____	
Program/Agency _____	
Mailing Address: _____	
Provider Phone Number: _____	Email Address: _____

(CONTINUED ON NEXT PAGE)

INFORMATION TO BE RELEASED TO AND EXCHANGED WITH THE CHILD SPOA COMMITTEE MAY INCLUDE:

a) this application, b) mental health assessments such as psychiatric evaluations, psycho-social reports, discharge summaries, psychological evaluations, and c) educational records such as CSE evaluations and IEPs.

THE PURPOSE OF THE CHILD SPOA COMMITTEE'S COMMUNICATION WITH SERVICE PROVIDERS is to determine your child's eligibility for Child SPOA services, and to determine which Child SPOA service is the best fit for your child and family's needs.

I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and 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).
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by *(insert name of facility/program)* _____. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16).
7. This consent will expire at the end of the current SPOA episode.

Signature of Parent or Guardian

Date

Signature of Child/Adolescent

Date

Signature of Witness

Date

SERIOUS EMOTIONAL DISTURBANCE CHECKLIST:

In order for the person making the referral to document a child with Serious Emotional Disturbance,

MINIMUM REQUIREMENTS FOR SED: Criterion A and B must be met.

Check all that apply:

Child meets age requirement (under 18 years of age)

(A) Diagnosis of designated emotional disturbance

- Child has DSM-5 psychiatric diagnosis other than:
- alcohol or drug disorders
 - organic brain syndromes
 - developmental disabilities
 - social conditions (Z codes)
 - ICD-10-CM diagnoses not having a DSM-5 equivalent

AND

(B) EXTENDED impairment in functioning due to emotional disturbance

Serious Emotional Disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) **AND** has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

FAMILY QUESTIONNAIRE

Please take a few minutes to think about your family's needs. In your own words, answer the questions below. This will help us better understand what would be most helpful to your child and family.

Child's Name: _____

Age: _____ DOB: _____

1. What does your child like to do? What are your child's skills, talents and interests?

2. What does your child feel good about?

3. What is the biggest concern you have for your child right now?

4. What would make things better for your child?

FAMILY QUESTIONNAIRE CONTINUED:

5. What has helped you and your child in the past?

6. What does your family currently do together?

7. What would you like your family to be able to do together?

8. What would make things better for your family?

Family Peer Support Services is a Child SPOA program that provides in home support to parents and caregivers.

Please check all areas listed below that you would like help with and are willing to work on.

- I would like to feel stronger and be more positive about my skills and abilities to care for my child.

- I would like help finding the right parenting tools for me and/or my family to use, so eventually I can reduce the need for outside services.

- I would like to talk with another parent or caregiver who has a child with behavioral challenges at home, school, or in the community. This would help me feel less alone.

- I would like to have a good relationship with my child's therapist, provider and/or school so my child's needs can be met.

- I know it's important to take care of myself, so I would like to have a hobby or participate in an activity that I enjoy and feel good about.

Child Single Point of Access Application - Ulster County

Date: _____

Person Making Referral:					
Name:		Agency:		Phone: Email:	
Child's Last Name:	First Name:		Age:	Date of Birth:	
SSN:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Child's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please specify)		Parent/Guardian's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please specify)
Race/Ethnicity: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			Is child fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is parent/guardian fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Contact Information:					
Parent/Guardian's First Name:		Last Name:		Email Address:	
Address:				Home Phone: Cell Phone: Work Phone: Preferred contact number: <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> W	
City:		State:	Zip Code:		
Insurance Information:					
Type of health coverage: <input type="checkbox"/> Straight Medicaid <input type="checkbox"/> Commercial/Third Party Insurance <input type="checkbox"/> Managed Care Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Child Health Plus				Insurance Company:	
				Insurance ID Number:	
Child's Legal Custody Status:					
<input type="checkbox"/> One Parent/Guardian <input type="checkbox"/> Two Parents/Guardians <input type="checkbox"/> DSS custody <input type="checkbox"/> Other (Please specify)					

<p>If your child lives in the household of a relative or family friend, please provide name, address, & phone number.</p> <p>Name of relative/family friend: _____</p> <p>Address: _____ Phone: _____</p> <p>If your child lives in a Residential Facility, is it:</p> <p><input type="checkbox"/> OMH Residential Treatment Facility (RTF) <input type="checkbox"/> Residential Treatment Facility (RTC)</p> <p>Name of facility: _____</p> <p>Expected Discharge Date: _____</p>

Family Information:

If child lives in your home, who lives in your household? Please list name, age and relation to child.

Name	Age	Relation to Child

Education Information:

School District:	School Name:	Current Grade:	CSE Classification Type: (i.e. ED; LD; Autism; other Health Impaired, etc.)
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What type of school placement is your child in (if known)?
 Regular Ed Special Ed Day Treatment Home Instruction Other (Specify)

IQ and Adaptive Functioning (if available)

If test results are available, please list IQ and/or Adaptive Functioning Scores or ranges, and date administered:
 FSIQ_____, VCI _____, POI _____, WMI _____, Proc. Spd _____, Date of Eval: _____
 If no test results are available, please check your best estimate of child’s intellectual functioning:
 Above Average Average Below Average Developmentally Delayed

DSM V Diagnoses (Please write out each diagnosis with F Code.)

Axis I

1. Primary Dx	2.
3.	4.
5.	6.

Medication Information:

Please list current medication(s) for psychiatric conditions: <input type="checkbox"/> None <input type="checkbox"/> Have never been on	Please list medication(s) for physical conditions: <input type="checkbox"/> None <input type="checkbox"/> Have never been on
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Medication	Dosage	Time Given	Medication	Dosage	Time Given

Service Utilization: Please check off all services, both Past (P) and Current (C)

Mental Health Services	Substance Use Svces.	Dept. of Social Services	Juv. Justice /Probation	Other Services
P C	P C	P C	P C	P C
<input type="checkbox"/> <input type="checkbox"/> Res Tx Facility (RTF) <input type="checkbox"/> <input type="checkbox"/> Comm. Residence <input type="checkbox"/> <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> <input type="checkbox"/> SPOA Services <input type="checkbox"/> <input type="checkbox"/> CCS <input type="checkbox"/> <input type="checkbox"/> NEXIS <input type="checkbox"/> <input type="checkbox"/> Multi Systems Therapy	<input type="checkbox"/> <input type="checkbox"/> Detox <input type="checkbox"/> <input type="checkbox"/> Inpatient <input type="checkbox"/> <input type="checkbox"/> Outpatient	<input type="checkbox"/> <input type="checkbox"/> Res Tx Center (RTC) <input type="checkbox"/> <input type="checkbox"/> CPS <input type="checkbox"/> <input type="checkbox"/> Preventive Svces <input type="checkbox"/> <input type="checkbox"/> Foster Care	<input type="checkbox"/> <input type="checkbox"/> PINS Probation <input type="checkbox"/> <input type="checkbox"/> PINS Diversion	<input type="checkbox"/> <input type="checkbox"/> Homeless Svcs <input type="checkbox"/> <input type="checkbox"/> OPWDD <input type="checkbox"/> <input type="checkbox"/> Other: Describe _____ _____ _____

Other Current Providers (who work with you or your child): For each current provider, please list name of agency, program and contact person (if known) below

Provider	Agency/Program/School	Contact Person	Contact Phone Number

Placement:

Has your child ever been placed out of your home by DSS, school district, judge, or Office of Mental Health?
 Yes No

If yes, who placed your child? _____

What were the approximate dates of the placement? _____

Where was your child placed? _____

Hospitalizations:

How many hospitalizations has your child ever had? _____
In the past 12 months, how many times has your child been admitted to a psychiatric hospital? _____
In the past 12 months, how many Psychiatric Emergency Department visits has your child had? _____

Name of Hospital	Admission Date	Discharge Date

BEHAVIOR CHECKLIST - Please check (✓) any of the following behaviors that apply to your child:

Moody	Asks for help when needed	
Bad temper	Easily distracted	
Good peer relationships	Cruel to animals	
Worries a lot	Has very few friends	
Has bad dreams	Prefers to be alone	
Fearful of new situations	Aggressive towards:	
Frequent stomach aches/headaches	<ul style="list-style-type: none"> • Adults 	
Gets along well with authority figures	<ul style="list-style-type: none"> • Authority figures 	
Wets bed or pants	<ul style="list-style-type: none"> • Peers 	
Soils pants	<ul style="list-style-type: none"> • Siblings 	
Demands to be the center of attention	Gets along with siblings	
Tells lies	Has many health complaints	
Steals	Enjoys many different activities	
Plays with fire	Is bullied by peers	
Bullies other children	Talks about emotions when upset	
Destroys property	Uses alcohol	
Does well in school	Uses drugs	

High Risk Behavior

Does your child express thoughts about suicide? Yes No

If yes, how often? _____

Has your child ever been evaluated by a mental health professional for suicidal thoughts? Yes No

If yes, when: _____

Has your child ever attempted suicide? Yes No

Please provide approximate date this occurred: _____

Are you currently concerned that your child may be at risk for suicide? Yes No

If yes, please explain:

Is your child currently self-harming (cutting, burning, using drugs or alcohol, abusing food, etc.)?

Yes No

If yes, what kinds of self-harming behaviors and in what settings: _____

Has your child self-harmed in the past? Yes No

If yes, when and for how long? _____

If yes, what kinds of self-harming behaviors and in what settings? _____

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