Ulster County CSPOA (Child Single Point of Access)
Referral for Medicaid Care Management Services for Children/Youth Ages 0-21

Ulster County CSPOA accepts referrals for Care Management Services through Children's Health Homes for Medicaid enrolled children/youth.

Children's Health Homes serving Ulster County:

- Children's Health Home of Upstate New York (CHHUNY)
- Institute of Family Health (IFH)

Children/youth ages 0-21 must meet **ALL** eligibility requirements to be considered for enrollment in Children's Health Home Care Management. Please make sure all 4 boxes are checked to ensure eligibility.

☐ 1. Child/youth meets the NYS DOH eligibility criteria of:
- ☐ Two chronic conditions (i.e. Substance Use Disorder, Asthma, Diabetes, etc.) **OR**
- ☐ HIV/AIDS **OR**,
- ☐ Serious Emotional Disturbance (SED) **OR**
- ☐ Complex Trauma (Screening form required); **AND**

☐ 2. Child/youth currently has active Medicaid; **AND**

☐ 3. Child/youth resides in Ulster County; **AND**

☐ 4. Child/youth has significant behavioral, medical, or social risk factors which can be addressed through Care Management.

1. Complete the attached Referral form and include as much information as possible. This will allow Ulster County CSPOA to determine eligibility and facilitate the referral for Children's Health Home Care Management. Please note that **diagnosis is required in order to make the referral**.

2. Parent/guardian must sign and date the Consent form in order for CSPOA to complete the referral.

3. **Completed Referral form is 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. Medicaid enrolled children/youth approved for Children's Health Home Care Management will be assigned to a Care Management Agency. IFH and CHHUNY, Ulster County's two Children's Health Homes, contract with many Care Management Agencies that provide the care management services. The assigned Care Management Agency will contact the parent/guardian, conduct outreach, obtain consent, and engage the child/youth and family in Care Management services.

Referral for Medicaid Care Management Services for Children/Youth Ages 0-21

Identifying Information for Child/Youth **Ages 0-21 Being Referred**		
Child /Youth Name:	Date of Birth:	Child/Youth identifies gender as:
Child/Youth Address:	Medicaid CIN:	
	Medicaid Managed Care Plan: ☐ Yes ☐ No	
Child/Youth in Foster Care: ☐ Yes ☐ No	County of Residence:	
Child/Youth Phone (if 18 or older):	Child/Youth Email (if 18 or older):	

Identifying Information for Parent/Guardian **Giving Consent to Refer**	
Name:	Relationship to Youth: ☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Self (18 years or older) ☐ Self (Under 18, but is parent, pregnant or married)
Address: ☐ Check if same as Child/Youth	
Home Phone: Cell Phone: Work Phone:	
Preferred Contact #: ☐ H ☐ C ☐ W	Email:

Information for Services Currently Being Provided
List Current Medical and/or Behavioral Health Treatment Providers, if known:
Is child/youth currently receiving DSS Child Preventative Services? ☐ Yes ☐ No ☐ Unknown
Is Parent/Guardian enrolled in Health Home Care Management? ☐ Yes ☐ No ☐ Unknown If yes, please provide Medicaid CIN:

Eligibility Category Information (**DIAGNOSIS REQUIRED TO PROCESS THE REFERRAL**)		
Serious Emotional Disturbance:	Specify Diagnosis:	Date of Diagnosis:
Chronic Conditions:	Specify Diagnosis:	Date of Diagnosis:

Referral for Medicaid Care Management Services for Children/Youth Ages 0-21

Care Management Needs - Check All that Apply			
✓	Need	✓	Need
☐	At risk for adverse event (i.e. death, disability, inpatient admission, mandated preventive services, or out of home placement	☐	Has inadequate social/family/housing support or serious disruptions in family relationships
☐	Has inadequate connectivity with healthcare system	☐	Does not adhere to treatments or has difficulty managing medications
☐	Has recently been released form incarceration, placement or detention	☐	Has recently been released from psychiatric hospital
☐	Has deficits in activities of daily living such as dressing, eating, etc.	☐	Has learning or cognitive issues

Risk and Safety Concerns - Check All that Apply			
✓	Concern	✓	Concern
☐	Suicidal Ideation	☐	History of Suicide Attempts
☐	Homicidal Ideation	☐	History of Violence
☐	Active Substance Use	☐	Unsafe Living Environment
☐	Sexual Aggression	☐	Runaway
☐	Cruelty to animals	☐	Fire Setting
☐	Other - Specify		

Narrative - Provide any additional information that may be helpful in assignment to a Care Management Agency.

Contact Information for Person **Completing Referral**	
Name:	Title:
Organization:	
Phone:	Email:

HIPAA Authorization to Disclose and Obtain Information

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 CSPOA Team to obtain information about your child, review the application, and communicate with your child's providers listed below.** The CSPOA Team determines eligibility and refers to a Children's Health Home or the appropriate Child SPOA service to fit your child and family's needs.

The CSPOA Team consists of representatives from Ulster County Department of Mental Health, Ulster County Department of Social Services, Probation Department, Family of Woodstock Inc., OPWDD Taconic DDRO, Resource Center for Accessible Living, DSS Coordinated Children's Services, Youth Advocate Program, Kingston City Schools, ACCESS: Supports for Living Inc., Families Now, Institute for Family Health, Children's Health Home of Upstate New York (CHHUNY), Rockland Children's Psychiatric Center, Parsons Child and Family Center, Astor Services for Children and Families, WMC Health Alliance of the Hudson Valley, Abbott House, Berkshire Farm Center and Services for Youth, Children's Home of Kingston, KidsPeace, Mental Health Association in Ulster, Inc., Northeast Parent & Child Society, St. Catherine's Center for Children, Step One Child & Family Guidance Center Addiction Services, Inc., Arms Acres, PEOPLe, Inc., my child's School District.

INFORMATION TO BE RELEASED TO AND EXCHANGED WITH THE CHILD SPOA TEAM MAY INCLUDE: a) this application, b) behavioral health assessments, i.e. psychiatric evaluations, psycho-social reports, discharge summaries, psychological evaluations, and c) educational records such as CSE evaluations and IEPs.

Please list any providers who provide services to your child.

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:

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/Guardian Date

_____ _____
Signature of Child/Youth (if 18 or older) Date

_____ _____
Signature of Witness Date

I give permission to submit a referral to the Medicaid Analytics Performance Portal (MAPP) for Care Management services through DOH Children's Health Home.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Child/Youth (if 18 or older) Date

☐ Obtained verbal consent on _____
Date

REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION
☐ I hereby revoke my authorization to release/obtain information.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Child/Youth Date

_____ _____
Signature of Witness Date