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

What is Child SPOA?
Each local government in New York State is responsible for providing a Single Point of Access for Children and Families. The purpose of Child SPOA is to identify children/adolescents (ages 5 to 18) in Ulster County with the highest risk of placement outside the home as a result of serious mental health challenges and provide direct services to those children/adolescents and their families. The goal of Child SPOA is to strengthen and empower children/adolescents so they and their families can lead safe and productive lives. Child SPOA services are based on the individual needs of the child/adolescent and provided by the Mental Health Association in Ulster County, Parsons Child and Family Center, Family of Woodstock, Inc. and Astor Services for Children and Families. Care coordinators from each of the Child SPOA services build relationships with the children/adolescents and families with whom they work and partner with the family to teach or strengthen skills, enhance support systems and identify community resources.

How to apply?
In Ulster County, Child SPOA services are accessed through the Child SPOA Coordinator. The completed application with supporting documentation (most recent psychiatric evaluation, psychosocial assessment, psychological evaluation and IEP) will determine if the child/adolescent meets Child SPOA criteria. The Child and Adolescent Needs and Strengths Mental health Assessment Tool (CANS-MH) will be used by the Child SPOA Committee to assess level of need/risk and potential service needs.

The Child SPOA process is voluntary. Parents/guardians are expected to actively participate in the Child SPOA application process and must sign an Authorization to Release Information in order for information to be disclosed.

Completed Applications are to be submitted to:

Eileen Murphy, Child SPOA Coordinator
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, New York 12401

The Child SPOA Team (made up of representatives from Ulster County Department of Social Services, Mental Health Association in Ulster County, Family of Woodstock, Inc., Family Services, Parsons Child and Family Center, Astor Services for Children and Families, Health Alliance of the Hudson Valley, and Ulster County Department of Mental Health LGU) convenes each Wednesday to review new applications, determine level of care, update caseload information, and track Child SPOA applicants. The parent/guardian and the referral source will be contacted upon initial review of the application by the Child SPOA Coordinator.

Please feel free to contact Eileen Murphy at (845) 340-4149 to discuss any questions or situations pertaining to a Child SPOA application. Fax (845) 340-4094.

CHILD SPOA SERVICES AVAILABLE

Home and Community Based Services (Waiver) **MHA in Ulster County, Inc.** Maria Duncan, Program Director Phone: (845) 339-9090 x 164 Fax:(845)-331-1169 **Parsons Child and Family Center** Cecilia Chlystun, ICC Supervisor Phone: (845) 331-2930 Fax: (845) 331-2906	**Intensive Case Management (ICM)** **MHA in Ulster County, Inc.** Michele Sachse Program Director Phone (845) 339-9090 x 180 Fax:(845)-331-1169 **Family Support Services** **MHA in Ulster County, Inc.** Michele Sachse, Program Director Phone: (845) 339-9090 x 180 Fax: (845) 336-4834	**Supportive Case Management (SCM)** **Astor Services for Children and Families** Michele Kelly Program Director Phone: (845-464-3337) **Family Support Care Coordination** **Family of Woodstock, Inc.** Jessica Pierce, Program Director, Adolescent Services Phone: (845) 331-7080 x 156

CHILD SPOA PROGRAM ELIGIBILITY GUIDELINES

Child SPOA Service	Admission Eligibility
Intensive Case Management (ICM) Mental Health Association in Ulster County, Inc.	Child must be seriously emotionally disturbed (SED) and at risk of out of home placement. Parent or guardian is willing and able to maintain child in community. Child must reside in Ulster County. Goal is to link family to community supports and provide safety and service planning.
Supportive Case Management (SCM) Astor Services for Children and Families	Child must be seriously emotionally disturbed (SED). Parent or guardian is willing and able to maintain child in community. Goal is to link family to community supports and safety and service planning. Child must reside in Ulster County.
Home and Community Based Services (Waiver) Mental Health Association in Ulster County, Inc. **AND** Parsons Child and Family Center	Child must be seriously emotionally disturbed (SED) and at risk of long term placement/hospitalization. Parent or guardian is willing and able to maintain child in community. Child must reside in Ulster County. Goal is to link to community supports, minimize hospitalizations and stabilize within community setting.
Family Support Services (for parent/guardian) MHA in Ulster County, Inc	Ulster County parents/guardians who are struggling with a child with mental health issues are eligible. Goal of Family Support is to provide parent specific psycho-education, support, advocacy and linkage to resources.
Family Support Care Coordination (for the parent/guardian AND child) Family of Woodstock, Inc.	Ulster County parents/guardians who are struggling with a child with mental health issues are eligible. Goal is to work with both the child and parent/guardian to identify parent and child goals and provide psycho-education, support, advocacy and linkage to resources.

Ulster County Child SPOA (Single Point of Access)

AUTHORIZATION TO RELEASE INFORMATION

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

Name: _____ _____ _____
Last First MI

Disclosure with Client Authorization

Specific information to be disclosed

(The person authorizing this disclosure has the right to inspect and copy the disclosed information**)**

Purpose or need for disclosure

Service Planning and Coordination

Name or title of person or organization permitted to disclose and exchange information. Please include any individuals/agencies currently providing services to your child.

Referring agency: _____

School: _____

Private therapist: _____

Pediatrician: _____

Hospital: _____

Other: _____

Other: _____

(NOTE: Please include all parties listed in #23 of the application and others who may have necessary information.)

Information will be disclosed and exchanged with:
The Child SPOA Team which includes staff from: Ulster County Department of Mental Health, Ulster County Department of Social Services and Probation Department, Mental Health Association of Ulster County, Family of Woodstock, BOCES, Taconic DDSO, RCAL, CCS, Youth Advocate Program, my child's School District, Family Services, Institute for Family Health, Parsons Child and Family Center, Astor Services for Children and Families, Health Alliance of Ulster County (Adolescent Partial Hospital Program).

I understand, by signing this release, I am permitting the above indicated organizations to disclose and exchange confidential information for the purpose of coordinating treatment services for my child's benefit. I understand that this authorization can be withdrawn by me, in writing, at any time except to the extent that action has been taken in reliance upon it. I further understand that signing this document does not affect protections under state or federal confidentiality law in reference to Part 2 Title 42 of the code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records which states that re-disclosure of this information and/or documentation to any party other than those designated is forbidden without my further written authorization. I understand this release will automatically expire one year from date signed.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature** Date

_____ _____
Witness Date

CANCELLATION/REFUSAL TO RELEASE INFORMATION	
☐ I hereby cancel my authorization to release information to Ulster County Child SPOA.	☐ I hereby refuse to authorize the release of information to Ulster County Child SPOA.

Parent or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Ulster County Child SPOA Application

Child's Name	Child's DOB ___/___/___	Age _____	M☐ F☐ Gender
Parent/Guardian			
Child's Social Security No.	Child's Medicaid CIN #.		
Street Address	Apartment No.	Child's Insurance No #	
Town/City State Zip	Insurance Company or Managed Care Provider		
Phone	☐Check here if currently applying for Medicaid or Medicaid Managed Care		

If child receives Survivor Benefits, please include monthly Benefit amount _____.

If the child/youth meets the criteria for Child SPOA services, a level of care meeting is held with the Child SPOA Committee, consisting of: Parsons Child and Family Center, Ulster County Department of Social Services, Astor Services for Children and Families, Health Alliance of Ulster County (APHP), Ulster County Department of Mental Health, Family of Woodstock, Inc., Mental Health Association in Ulster County, and Family Services. The meetings are held weekly on Wednesdays. The Child SPOA Coordinator will contact you with additional information.

The targeted length of stay for all Child SPOA programs is 9-18 months.

Please check service category for which child is being referred (see Admission Eligibility, on page 1):

CASE MANAGEMENT/CARE COORDINATION (In Home)

☐Family Support Services (MHA)
☐Family Support Program (Family of Woodstock)
☐Children's Supportive Case Management
☐Children's Intensive Case Management
☐Home and Community Based Services (Waiver)

PLACEMENT (Out Of Home)

☐Residential Treatment Facility (RTF)
☐Community Residence

SECTION I: SED CHECKLIST

To document child with serious emotional disturbance

MINIMUM REQUIREMENTS FOR SED: Criterion A must be met, and both parts of B or C 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 (291.x, 292.xx, 303.xx, 304.xx, 305.xx)
- organic brain syndromes (290.xx, 293.xx, 294.x)
- developmental disabilities (299.xx, 315.xx—319x)
- social conditions (V codes)
- ICD-9-CM diagnoses not having a DSM-5 equivalent

AND (*1 and 2 of Part B must be met)*

(B) EXTENDED IMPAIRMENT IN FUNCTIONING DUE TO EMOTIONAL DISTURBANCE

1. ☐Over the last 12 months, continuously or intermittently, child has experienced functional limitations due to emotional disturbance. Problems must be moderate in at least two areas, or severe in at least one area.
   - **Self Care**—personal hygiene; obtaining and eating food; dressing; avoiding injuries.
   - **Family Life**—capacity to live in a family or family-like environment; relationships with parents.
   - **Social Relationships**—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.
   - **Self-Direction/Self-Control**—ability to sustain focused attention for long periods of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability.
   - **Learning Ability**—school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school.

2. ☐During the last 12 months, continuously or intermittently, child has rated 50 or less on the Children's Global Assessment Scale (CGAS) or the Global Assessment of Functioning (GAF) because of emotional disturbance.

OR (*(1 and 2 of Part C must be met).*

(C) CURRENT IMPAIRMENT IN FUNCTIONING WITH SEVERE SYMPTOMS

1. ☐Child currently rates 50 or less on the CGAS (or GAF) because of emotional disturbance.
2. ☐Within the past 30 days, child has experienced at least one of the following:

   - Serious suicidal symptoms or other life-threatening, self-destructive behaviors.
   - Significant psychotic symptoms (hallucinations, delusions, bizarre behavior).
   - Behavior caused by emotional disturbances that placed the youngster at risk of causing personal injuries or significant property damage.

SECTION II: AT RISK CHECKLIST

A. To document child at risk of serious emotional disturbance:

Check all that apply:

☐Child meets age requirements (under 18 years of age)

☐Failed adoption(s)

☐Parent with serious/persistent mental illness

☐Parent with history of chronic alcohol and/or drug abuse

Child has experienced at least one of the following:

☐Has been a victim of physical, emotional or sexual abuse, or severe neglect

☐Has been a victim of, or witness to, serious violent crime or domestic violence

Has experienced residential disruption caused by:

☐Out-of-home placement due to emotional disturbance

☐Multiple family separations

☐Extended period of homelessness

B. Child is at risk of residential placement if any one of these conditions is met:

☐There is a current psychiatric/psychological evaluation recommending placement.

☐CSE has approved/is considering residential placement.

☐There is a pending application for RTF before the PACC.

☐The DSS residential placement unit has received request for placement.

☐Child is awaiting placement through the juvenile justice system.

☐Child has experienced a previous residential placement.

SECTION III: REFERRAL SOURCE IDENTIFICATION

1. DATE OF REFERRAL_____
2. ORGANIZATION/PROGRAM NAME_____
3. NAME OF PERSON MAKING REFERRAL_____

   Address_____

   Phone_____ext._____Fax_____E-mail_____

SECTION IV: CHILD AND FAMILY INFORMATION

4. LIST ALL FAMILY MEMBERS; INCLUDING THOSE LIVING OUTSIDE HOME

Name *(first and last)*	Age	Relationship to Child	Lives in the Home?	Currently in School/ Employed?

5. FAMILY STRENGTHS/NEEDS RELATED TO THE CARE OF THE CHILD:

	Yes	No	Limited	Unknown
Does **caregiver** have any physical or behavioral health limitations?	☐	☐	☐	☐
Is there adequate supervision for the child?	☐	☐	☐	☐
Is family involved with care/treatment child is receiving?	☐	☐	☐	☐
Is family knowledgeable and understanding of child's current needs?	☐	☐	☐	☐
Is family able to organize and maintain services needed by child?	☐	☐	☐	☐
Does family have resources (i.e. financial, extended family)?	☐	☐	☐	☐
Is family housing situation stable?	☐	☐	☐	☐

USE SPACE BELOW FOR ADDITONAL FAMILY **STRENGTHS** OR TO CLARIFY RESPONSES ABOVE.

_____

6. CHILD STRENGTHS/NEEDS

	Yes	No	Limited	Unknown
Child is involved in family activities.	☐	☐	☐	☐
Child communicates well with family members.	☐	☐	☐	☐
Child has stable relationships in his/her life.	☐	☐	☐	☐
Child is doing well in school.	☐	☐	☐	☐
Child can manage in stressful situations.	☐	☐	☐	☐
Child is involved in spiritual/religious activities.	☐	☐	☐	☐

CHILD'S TALENTS/INTERESTS/HOBBIES/STRENGTHS or VOCATIONAL INTERESTS

_____

7. PRIMARY LANGUAGE:

☐English
☐Spanish
☐American Sign Language
☐Other (*specify):*_____

8. RACE/ETHNIC IDENTITY:

☐White
☐Black/African American
☐Asian/Pacific Islander
☐American Indian
☐Significant cultural identity
*(specify):*_____
☐Other *(specify):*_____
☐Hispanic/Latino:
☐Mexican, Mex-Am., Chicano
☐Puerto Rican
☐Cuban
☐Dominican
☐Central American

9. CUSTODY STATUS:

☐Two biological parents *OR* one biological and one step-parent
☐Biological mother only
☐Biological father only
☐Adoptive parent(s)
☐Foster parent(s)
☐Sibling(s)
☐Aunt and/or uncle
☐Grandparent(s)
☐Friend (adult friend)
☐DSS
☐Other *(specify):*_____

10. CURRENT LIVING SITUATION:

☐Two-Parent Biological Family
☐One-Parent Biological Family
☐One Parent Biological & Step Parent
☐Two-Parent Adoptive Family
☐One-Parent Adoptive Family
☐Relative's Home
☐DSS Foster Care
☐DSS Therapeutic Foster Care
☐DSS Group Home
☐DSS Kinship Foster Home
☐OMH C&Y Community Residence
☐Psychiatric Inpatient Care
☐Crisis Residence
☐Shelter for Homeless
☐Temporary Housing for Homeless
☐Residential School (SED)
☐Residential Treatment Center (DSS)
☐Residential Treatment Facility (OMH)
☐OCFS Facility
☐Jail
☐Homeless/Streets
☐Other *(specify):*_____

If child is living in a residential placement, when is he/she anticipated to be discharged from that setting?

_____

Name of discharge coordinator _____
(Please include on release)

Phone number _____

SECTION V: CHILD'S MENTAL HEALTH CRITERIA

11. (A) DSM-5 DIAGNOSIS, IF KNOWN (description):

Axis I_____Axis III _____
Axis I _____
Axis I _____Axis IV_____
GAF current_____Highest Last Year_____
Axis II_____
Axis II_____Date of Diagnostic Evaluation_____
(B) IQ SCORE:
Verbal _____ Performance _____ Full Scale _____ Test Date _____

12. PLEASE CHECK BELOW THE DEGREE TO WHICH THIS CHILD EXHIBITS THE FOLLOWING SYMPTOMS OR BEHAVIORS WHICH ARE ATTRIBUTABLE TO AN EMOTIONAL DISORDER OR ISSUES LEADING TO REFERRAL:

		Not Present	Mild	Moderate	Severe	Duration of Symptoms < 1 year > 1 year	Historical information for items marked with ** only
1	Psychotic Symptoms *(Hallucinations, Delusions, Bizarre Behavior)*	☐	☐	☐	☐		Please indicate latest date of event
2	Attention Deficit/Impulse Control	☐	☐	☐	☐		
3	Depressed Mood/Anxiety	☐	☐	☐	☐		
4	Non-Compliance with Authority Figures	☐	☐	☐	☐		
5	Antisocial/Delinquent Behavior	☐	☐	☐	☐		
6	Alcohol/Substance abuse	☐	☐	☐	☐		
7	Self Abuse/Self Mutilation	☐	☐	☐	☐		**
8	Suicidal threats, ideation	☐	☐	☐	☐		**
9	Suicidal Attempts	☐	☐	☐	☐		**
10	Extreme verbal abuse	☐	☐	☐	☐		
11	Cruelty to Animals	☐	☐	☐	☐		
12	Fire Setting	☐	☐	☐	☐		**
13	Threat to Life of Others	☐	☐	☐	☐		**
14	Running Away	☐	☐	☐	☐		**
15	Sexually Abusive Behavior	☐	☐	☐	☐		
16	Social Behavior Problems	☐	☐	☐	☐		
17	School Behavior Problems	☐	☐	☐	☐		
18	Criminal Behavior/Police Contact	☐	☐	☐	☐		**
19	Academic Problems	☐	☐	☐	☐		
20	Truancy	☐	☐	☐	☐		
21	Inappropriate Sexual Behavior/Acting Out	☐	☐	☐	☐		
22	Poor self-esteem	☐	☐	☐	☐		
23	Anger/Age Inappropriate Tantrums	☐	☐	☐	☐		
24	Social Contact Avoidance	☐	☐	☐	☐		
25	Poor peer interaction	☐	☐	☐	☐		
26	Encopresis	☐	☐	☐	☐		
27	Enuresis	☐	☐	☐	☐		
28	Sleep Problems/Disorders	☐	☐	☐	☐		
29	Obsessive/Compulsive Behavior	☐	☐	☐	☐		
30	Eating Problems/Disorders	☐	☐	☐	☐		
31	Physical Aggression	☐	☐	☐	☐		
32	Mood Swings	☐	☐	☐	☐		
33	Phobias and Fears	☐	☐	☐	☐		
34	Somatic Complaints	☐	☐	☐	☐		
35	Other	☐	☐	☐	☐		
To provide further detail ….., please use back of page							

14. PSYCHIATRIC HOSPITALIZATION HISTORY (for last 3 years only)

Name of Hospital	Admission Date	Discharge Date	No. of Days Hospitalized

☐Check if unknown. If necessary, please use back of page or attach.

15. INDICATE WHETHER THE CHILD IS KNOWN TO HAVE ANY OTHER SIGNIFICANT ISSUES:

		Not Present	Mild	Moderate	Severe
1	Developmental Delays	☐	☐	☐	☐
2	Learning Disability	☐	☐	☐	☐
3	Physical Handicap:	☐	☐	☐	☐
	Blind	☐	☐	☐	☐
	Visually Impaired	☐	☐	☐	☐
	Deaf	☐	☐	☐	☐
	Hard of Hearing	☐	☐	☐	☐
	Speech Impairment	☐	☐	☐	☐
	Other *(specify):*	☐	☐	☐	☐
4	Mental Retardation	☐	☐	☐	☐
5	Disabling or Life-Threatening Medical Condition	☐	☐	☐	☐
6	List any chronic health diagnoses (i.e. asthma, diabetes)	☐	☐	☐	☐

16. MEDICATION FOR MENTAL HEALTH ISSUES

☐Yes, currently *(specify):*_____

☐Yes, in past *(specify):*_____

☐No, never medicated

17. CHILD/FAMILY HISTORY

	Yes	No	Unknown
Has child experienced any trauma or traumatic experience?	☐	☐	☐
If yes, explain briefly_____			
Are there any family situations currently affecting child's behavior?	☐	☐	☐
If yes, explain briefly_____			
Has child ever been physically abused?	☐	☐	☐
Has child ever been sexually abused?	☐	☐	☐
Has child ever been emotionally abused?	☐	☐	☐
Is there a history of domestic violence/spousal abuse in child's biological family?	☐	☐	☐
Is there a history of mental illness in child's biological family?	☐	☐	☐
Is there a history of substance abuse in child's biological family?	☐	☐	☐

SECTION VI: CHILD'S EDUCATIONAL INFORMATION

18. A. EDUCATIONAL PLACEMENT ***(check if present and/or in the past 12 months):***

☐Regular class in age appropriate grade
☐Regular class, retained at grade level _____
☐Special Education, in-district program/services
☐Day Treatment, out of district (including OMH Day Treatment)
☐Residential Program
☐Vocational training only
☐Part-time Vocational/Educational
☐Not enrolled in school
☐High School Graduate/GED
☐Home Instruction
☐Other *(specify):* _____

B. SCHOOL DISTRICT _____

C. BUILDING _____

D. ALTERNATE PLACEMENT_____

E. GRADE _____

19. DOES THIS CHILD HAVE A COMMITTEE ON SPECIAL EDUCATION (CSE) CLASSIFICATION? PLEASE INDICATE BELOW

☐Emotionally Disturbed
☐Learning Disabled
☐Sensory Impaired
☐Physically Disabled
☐Other Health Impaired
☐Multiply Handicapped
☐Not Classified
☐Unknown

20. SCHOOL BEHAVIOR

☐Does not participate
☐Has truancy/attendance problems; cuts classes
☐Has failing grades
☐Lacks friends at school
☐Assaults teachers
☐Does not respond to teacher demands
☐Fights with peers
☐Frequent suspensions

SECTION VII: SERVICE SUPPORT INFORMATION

21. CURRENT OR PREVIOUS CONTACTS WITH *(check all that apply):*

		Check if EVER received	Check if received in past 12 months
(A)	MENTAL HEALTH SERVICES *(specify):*		
	Inpatient	☐	☐
	Emergency Department	☐	☐
	Partial Hospitalization	☐	☐
	Residential Treatment	☐	☐
	Day Treatment	☐	☐
	Clinic	☐	☐
	CCS/MST	☐	☐
	NEXIS	☐	☐
	Mental Health Case Management	☐	☐
	Private Therapist	☐	☐
	Other *(specify):* _____	☐	☐
(B)	MENTAL HEALTH SUPPORT		
	Respite	☐	☐
	Family Supports	☐	☐
	Other *(specify):* _____	☐	☐
(C)	JUVENILE JUSTICE		
	PINS Diversion	☐	☐
	PINS	☐	☐
	JD	☐	☐
(D)	FAMILY COURT	☐	☐
(E)	CHILD WELFARE *(if yes, specify)*		
	Foster Care	☐	☐
	Child Protective Services	☐	☐
	Preventive Services	☐	☐
	Family Preservation	☐	☐
	Other *(specify):*_____	☐	☐
(F)	OPWDD /DEVELOPMENTAL DISABILITIES	☐	☐
(G)	ALCOHOL/SUBSTANCE ABUSE	☐	☐

	Check if EVER received	Check if received in past 12 months
(H) OTHER *(list):*		
_____	☐	☐
_____	☐	☐
_____	☐	☐

22. CURRENT CONTACTS

(Mental Health provider, DSS, Mental Health Association, Private Therapist, Probation Officer, School Representative, Others)

[**Please include on release]**

Agency/Organization	Name	Address	Phone

23. INSURANCE INFORMATION *(check all that apply):*

☐TANF Recipient
☐Medicaid
☐Medicaid Managed Care:
Company Name _____
☐Medicaid Application Pending
☐Medicaid Denied
☐Commercial Insurance:
Name of Policyholder_____
☐Medicare
☐No Insurance
☐Social Security/SSDI
☐SSI
☐Survivor's Benefits
☐Other

	Yes	No
24. IS CHILD CITIZEN OF THE UNITED STATES?	☐	☐
If no, is child a *lega*l resident of the United States?	☐	☐
Does child have any resources of his/her own?	☐	☐

25. WHAT ARE THE SPECIFIC GOALS THAT YOU WOULD LIKE A CARE COORDINATOR TO ACCOMPLISH IN WORKING WITH THIS CHILD AND/OR FAMILY?