APPLICATION
ULSTER COUNTY SINGLE POINT OF ACCESS (SPOA)
FOR ADULT CASE MANAGEMENT
CARE COORDINATION
ASSERTIVE COMMUNITY TREATMENT (ACT)

WHAT IS CASE MANAGEMENT AND CARE COORDINATION?
Case management and care coordination is a direct resource for adults 18 years of age and up. An individual case manager or care coordinator provides services in the home and the community. Case management has varying levels of intensity depending on the program. The goals of case management and care coordination are to strengthen and empower adults so that they can live safe and productive lives.

Case management and care coordination services include ongoing assessment of the adult's strengths and challenges; development of an adult/person-centered; goal oriented service plan; linking the adult to appropriate services; monitoring effectiveness of services as they relate to the service plan; and advocacy.

WHAT IS ACT?
The ACT team provides highly individualized mental health treatment for adults with serious psychiatric disorders who have been unable to benefit from traditional treatment. Potential participants must have demonstrated a need for continuous high levels of service through frequent psychiatric hospitalizations or use of psychiatric emergency services. Additionally, participants may be homeless or have co-existing substance use disorders or criminal justice involvement.

A team of mobile clinical staff will provide all mental health services and crisis coverage 24 hours a day, seven days a week. Services are often provided in the recipient's home.

SPOA SERVICES INCLUDE:

- **ASSERTIVE COMMUNITY TREATMENT (ACT**) - requires a primary psychiatric Axis I diagnosis.
- **MENTAL HEALTH ASSOCIATION CASE MANAGEMENT (MHA CM)** - requires a primary psychiatric Axis I diagnosis.
- **OFFICE OF MENTAL HEALTH CARE COORDINATION (OMH CC)** - requires a primary psychiatric Axis I diagnosis.
- **FAMILY OF WOODSTOCK ADULT CASE MANAGEMENT** – requires a primary psychiatric Axis I diagnosis.
- **FAMILY OF WOODSTOCK AND MENTAL HEALTH ASSOCIATION TRANSITIONS CASE MANAGEMENT** - requires a primary psychiatric Axis I diagnosis.
- **FAMILY OF WOODSTOCK GETTING AHEAD PROGRAM CASE MANAGEMENT (GAP CM) -** requires a primary psychiatric Axis I diagnosis.

(Axis II diagnosis and increased levels of behavioral impairment will be considered in the absence of an Axis I diagnosis.)

HOW TO APPLY?

1. Complete the Adult SPOA application in full.
2. Include a copy of the most recent psychiatric evaluation, psycho-social assessment, psychological testing, or other supporting documentation.
3. Complete all 4 Consents to Release/Disclose Confidential Information.
4. Submit the application and supporting documentation via mail, fax or email (scan) to:

Lynn Leffler, Adult SPOA Coordinator
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, NY 12401

Telephone #: 845-340-4193
Fax: 845-340-4094
llef@co.ulster.ny.us

APPLICATION PROCESS

1. Applications are reviewed by the Adult SPOA Team. The Adult SPOA team is comprised of representatives from Ulster County Department of Social Services, Gateway Industries, Multi-County Development Corp., Rockland Psychiatric Center-Pine Grove, Health Alliance of the Hudson Valley-Inpatient/Partial Programs, Family of Woodstock Inc., Willcare, Always There Home Care, Ulster County Probation, PEOPLe Inc., Resource Center for Accessible Living (RCAL), Rural Ulster Preservation Company (RUPCO), Family Empowerment Council, Institute for Family Health, Woodstock Manor, Rehabilitation Support Services, Inc., Hudson Valley Mental Health, Washington Manor and Ulster-Greene ARC.

2. The Adult SPOA Team determines eligibility and refers to the appropriate level of Adult SPOA service.

3. The Adult SPOA Coordinator or designee will then contact the applicant and referent and inform them of the Adult SPOA service to which the applicant has been referred. If the applicant is not deemed eligible, the Adult SPOA coordinator or designee will contact the applicant and referent and explore other service options.

4. In the event the SPOA service maintains a wait list, the applicant and referent will be contacted by the Adult SPOA Coordinator for status updates.

Consumer's Name: _____ SSN: _____

SPOA CASE MANAGEMENT/ACT REFERRAL PACKET

Date of Referral: _____ Date Presented to SPOA: _____

Referring Person: Name: _____ Agency: _____

Phone #: _____ E-Mail Address: _____

Treating MH MD: _____

Check all that apply:
☐ACT Team* ☐MHA Case Management ☐Family of Woodstock Adult Case Management ☐OMH Care Coordination
☐Transitions ☐GAP
*See page 5 for basic criteria

Consumer's name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____ Cell phone: _____

Primary language: _____ Marital Status: _____

Medicaid: Active:☐Yes ☐No Medicaid #: _____ Medicaid pending:☐Yes ☐No Medicare:☐Yes ☐No

Managed Medicaid:☐Yes ☐No If so, what insurance company: _____

SSI:☐ SSD:☐ DSS:☐ Spend down:☐ Rep Payee:☐Yes ☐No Other Income: _____

Current Housing Category: ☐Indep ☐Boarding Home ☐Hospital ☐Homeless ☐Shelter ☐CR
☐SS ☐SH ☐Incarcerated ☐Other _____

If homeless, number of episodes of homelessness in the past 3 years: _____

Employment Status: ☐part time ☐full time ☐unemployed ☐retired ☐Disabled

Education Status (highest completed):☐GS ☐HS ☐GED/TASK ☐vocational training ☐some college ☐college degree

Physical diagnoses by history: _____

History of medical conditions (check all that apply): ☐High blood pressure ☐Diabetes ☐COPD ☐Asthma
☐Seizure disorder ☐Obesity ☐Cardiac problems ☐Stroke/CVA ☐TBI

Height: _____ Weight: _____ Primary Physician: _____

Where is the client receiving medical care: _____

Current physical medical medications: _____

_____

List all Psychiatric diagnoses: _____

Where is the client receiving mental health treatment? _____

Current psychiatric medications: _____

_____

Consumer's Name: _____

Intellectual disability: _____

Significant psychosocial issues: _____

If currently hospitalized, where will outpatient treatment be upon discharge? _____

Does a Psychiatric Evaluation accompany this packet? ☐Yes ☐No If not, why not? _____

Does a Psychosocial evaluation accompany this packet? ☐Yes ☐No

Has the consumer ever received case management services before? ☐Yes ☐No
If yes, explain what they were and approximately when:

Does the client receive other support services? ☐home psych nursing ☐PCA ☐HHA ☐Wellness Coordinator ☐probation ☐parole ☐Other: _____

Is the individual open to a Health Home? ☐Yes ☐No If yes: Agency/Provider: _____

Does applicant have a history of Alcohol/Substance Problems? ☐Yes ☐No
If yes, list substance(s), date of last use, treatment history.

Substance	Date of Last Use	Treatment History
Cigarettes/Nicotine		

Previous Psychiatric Hospitalizations (last three years):

Hospital	Reason for Admission	Admit Date	Discharge Date

Consumer's Name: _____

REASON FOR REFERRAL, BASED ON CASE MANAGEMENT NEEDS:

SERVICE NEEDS: (Check all that apply)

☐Medical/Physical ☐Financial ☐Educational/Vocational ☐Housing ☐Advocacy

☐Mental Health ☐Support Systems ☐Social/Recreational ☐Alcohol/Substance Abuse

☐Legal ☐Other

Emergency Contact: _____ Phone: _____

***ACT REFERRAL**

PLEASE CHECK ALL THAT APPLY

☐consumer has been unable to benefit from traditional mental health treatment
☐consumer has a serious psychiatric disorder (they may have a co-occurring substance abuse disorder) (Need psych eval)
☐consumer has serious difficulties in daily functioning and is unable to perform their adult roles

Exhibits the need for continuous high service demonstrated by:
☐frequent hospitalizations or use of psychiatric emergency services
☐recurrent severe psychiatric symptoms
☐recent history or high risk of criminal justice involvement
☐co-existing substance use
☐homelessness

SPOA ADULT CASE MANAGEMENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) _____ "C" No. _____

Sex _____ Date of Birth _____

Facility Name _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed: Mental Health treatment history and Psychiatric diagnosis;

Purpose or Need for Information:

1. This information is being requested:

☐ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or

☑ Other (please describe) CM/ACT SELECTION COMMITTEE

2. The purpose of the disclosure is (please describe): TO EXCHANGE INFORMATION ABOUT THE SPOA APPLICANT, WITH THE AGENCIES OR PERSONS LISTED BELOW, IN ORDER TO LINK THE APPLICANT WITH A NEEDED SERVICE OR PROGRAM.

From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information	**To:** Name, Address, & Title of Person/Organization/Facility/ Program to Which this Disclosure is to be Made
Lynn Leffler, LCSW-R Case Management SPOA Coordinator	***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.* Committee consists of representatives from Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health; Gateway Community Industries; Multi-County Community Development Corp; Rockland Psychiatric Center-Pine Grove Center; Health Alliance of the Hudson Valley-Inpatient; Health Alliance of the Hudson Valley Partial Programs; Family of Woodstock; Willcare; Always There Home Care; UC Probation; PEOPLe, Inc; Resource Center for Accessible Living; Rural Ulster Preservation Company; Chiz's Heart Street; Family Empowerment Council; Institute of Family Health; Woodstock Manor; Rehabilitation Support Services, Inc; Hudson Valley Mental Health Inc.; Washington Manor; and Ulster-Greene Counties Chapter of NYSARC, who meet for purposes of treatment planning

A. 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 _____.
   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).

Continue on Next Page ➔

Facility/Agency Name	Patient's Name (Last, first, M.I.)	"C"/Id. No.

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☐When I am no longer receiving services from *(insert name of facility/program)* ;

☐One year from this date;

☑Other consent will terminate when the individual is no longer being considered for or is already receiving Case Management or ACT services);

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

X

X _____ _____

Signature of Patient or Personal Representative — X Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

X

WITNESSED BY: _____ _____

Signature of witness — Print name of witness

X

Date: _____

To be Completed by Facility:

_____

Signature of Staff Person Using/Disclosing Information

_____

Title

_____

Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____ _____

Signature of Patient or Personal Representative — Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

SPOA ADULT CASE MANAGEMENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) _____

"C" No. _____

Sex _____

Date of Birth _____

Facility Name _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed: Mental Health treatment history and Psychiatric diagnosis;

Purpose or Need for Information:

1. This information is being requested:

☐ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or

☑ Other (please describe) CM/ACT SELECTION COMMITTEE

2. The purpose of the disclosure is (please describe): TO EXCHANGE INFORMATION ABOUT THE SPOA APPLICANT, WITH THE AGENCIES OR PERSONS LISTED BELOW, IN ORDER TO LINK THE APPLICANT WITH A NEEDED SERVICE OR PROGRAM.

From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information	**To:** Name, Address, Title of Person/Organization/Facility/ Program to which this Disclosure is to be made ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Committee consists of representatives from Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health; Gateway Community Industries; Multi-County Community Development Corp; Rockland Psychiatric Center-Pine Grove Center; Health Alliance of the Hudson Valley-Inpatient; Health Alliance of the Hudson Valley Partial Programs; Family of Woodstock; Willcare; Always There Home Care; UC Probation; PEOPLe, Inc; Resource Center for Accessible Living; Rural Ulster Preservation Company; Chiz's Heart Street; Family Empowerment Council; Institute of Family Health; Woodstock Manor; Rehabilitation Support Services, Inc; Hudson Valley Mental Health Inc.; Washington Manor; and Ulster-Greene Counties Chapter of NYSARC, who meet for purposes of treatment planning	Lynn Leffler, CSW-R Case Management SPOA Coordinator

A. 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 _____.
   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).

Continue on Next Page ➔

Facility/Agency Name	Patient's Name (Last, first, M.I.)	"C"/Id. No.

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☐When I am no longer receiving services from *(insert name of facility/program)* ;

☐One year from this date;

☑Other consent will terminate when the individual is no longer being considered for or is already receiving Case Management or ACT services);

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

X

X _____ _____

Signature of Patient or Personal Representative — X Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

X

WITNESSED BY: _____ _____

Signature of witness — Print name of witness

X

Date: _____

To be Completed by Facility:

_____

Signature of Staff Person Using/Disclosing Information

_____

Title

_____

Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____ _____

Signature of Patient or Personal Representative — Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

CASE MANAGEMENT

AUTHORIZATION FOR TREATMENT PROVIDERS TO RELEASE INFORMATION TO SPOA

Patient's Name (Last, First, M.I.) _____

"C" No. _____

Sex _____

Date of Birth _____

Facility Name _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed: PHYSICAL HEALTH EXAM, PPD 9chest x-ray if required), PSYCHIATRIC EVALUATION/UPDATE, MENTAL HEALTH EVALUATION THAT INCLUDES MENTAL STATUS AND DIAGNOSIS.

Purpose or Need for Information:

1. This information is being requested:

☐ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or

☑ Other (please describe) SPOA APPLICANT IS REQUESTING SERVICES IN ULSTER COUNTY

2. The purpose of the disclosure is (please describe): TO OBTAIN ADDITIONAL INFORMATION REGARDING THE APPLICANT IN ORDER TO COMPLETE THE SPOA APPLICATION.

From: Check all Programs/Facilities Disclosing information

NOTE: *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*

☐ ACT TEAM
☐ HAHV ER
☐ HAHV PARTIAL HOSP
☐ CHIZ'S
☐ CREATE
☐ GATEWAY
☐ KINGSTON HOSPITAL
☐ MHA
☐ OMH FAMILY CARE
☐ PARSON'S
☐ PHELPS HOSP
☐ PUTNAM HOSP
☐ RCPC
☐ ST FRANCIS HOSP
☐ SPECTRUM BEHAV
☐ UCDMH
☐ PROBATION/PAROLE
☐ WILLCARE
☐ ALWAYS THERE HOMECARE
☐ HAHV HOSPITAL
☐ BRIDGEBACK
☐ CHILDREN'S HOME – POK/Kingstn
☐ FOW
☐ IFH
☐ MCCDC
☐ NY PRESBYTERIAN
☐ OCCUPATIONS INC
☐ PEOPLe
☐ PINE GROVE CTR
☐ RCAL
☐ ROCKLAND CHILDREN'S
☐ STEP ONE
☐ UCDSS
☐ UC JAIL
☐ WASHINGTON MANOR
☐ HUDSON VALLEY MENTAL HEALTH
☐ OTHER:

To: Name, Address, & Title of Person / Organization/Facility/Program Receiving Information

Lynn Leffler, LCSW-R
Case Management SPOA COORDINATOR

239 Golden Hill Lane
Kingston, NY 12401

A. 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 SPOA COORDINATOR OF ULSTER COUNTY.
   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).

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☐When I am no longer receiving services from *(insert name of facility/program)* ;

☐One year from this date;

☑Other: WHEN I AM NO LONGER BEING CONSIDERED FOR CASE MANAGEMENT, ACT OR RESIDENTIAL SERVICES

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

Signature of Patient or Personal Representative _____ Date _____

Patient's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)* _____

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

X WITNESSED BY: _____ _____

Signature of witness — Print name of witness

X Date: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information _____

Title _____

Date Released _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

Signature of Patient or Personal Representative

Date

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

SPOA PACKET

PSYCKES Consent Form

This PSYCKES consent form allows your provider/referent to obtain Medicaid information through PSYCKES, an electronic database. This database contains all the different types of health services you have received through Medicaid. Once you consent, those providers/referents will have access to indicators which will enable them to help you in treatment planning and help coordinate all the different types of health services you have received through Medicaid. Your choice to consent or deny will not affect your ability to get medical care or health insurance coverage. Understand that your provider may be able to obtain your information even without your consent for certain limited purposes if specifically authorized by the state and federal laws and regulations.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I give consent** for the SPOA Providers to access all of my electronic health information through PSYCHES in connection with providing me any health care services. YOU ARE ABLE TO WITHDRAW THIS CONSENT AT ANY TIME DURING THE SPOA PROCESS. SEE ATTACHED WITHDRAWAL FORM.

☐ **I deny consent** for the SPOA Provider to access my electronic health information through PSYCKES.

The following are SPOA Providers: Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health Association and ACT; Gateway Community Industries, Multi-County Community Development Corp; Rockland Psychiatric Center (Pine Grove Center); Hudson Valley Health Alliance-Inpatient; Hudson Valley Health Alliance Partial Programs; Family of Woodstock, Willcare Home Care; Always There Home Care; UC Probation; PEOPLe, Inc., Resource Center for Accessible Living; Rural Ulster Preservation Company; Washington Manor; Family Empowerment Council, Institute of Family Health; Woodstock Manor, habilitation Support Services , Inc.; Ulster-Greene Counties Chapter of NYSARC; Hudson Valley Mental Health

Print Name of Patient: _____	Date of Birth of Patient: _____	Patient Medicaid ID #: _____
Signature of Patient or Patient's Legal Representative:	Date:	
Print name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):	
Print name of Witness:	Signature of Witness:	

Information About the PSYCKES Consent for Your Records

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by only to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care provided to all patients

Note: The choice you make in this Consent form does *not* allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You are Included?** If you give consent , Ulster Co. SPOA Agencies may access all of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to :
    - Mental health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or test
    - HIV/AIDS
    - Sexually transmitted diseases
3. **Where Health Information About You Comes From.** Information about you in PSYCKES comes from the New York State Medicaid Program.
4. **Who May Access Information about You, if you Give Consent.** Only these people may access information about you; doctors and other health care providers who serve on the Ulster Co. SPOA Agency's medical staff who are involved in your medical care; health care providers who are covering or on call for the SPOA Agency's doctors; and staff members who carry out activities permitted by this Consent Form as described in paragraph one.
5. **Penalties for Improper Access to or Use of your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Ulster co LGC at 340-4110; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.
6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws

provide special protections for some kinds of sensitive health inform, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **EFFECTIVE PERIOD.** This consent Form will remain in effect until three (3) years after the last date you received any medical services, or until the day you withdraw your consent, whichever comes first.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to the Ulster Co. SPOA Coordinator at USDMH, 239 Golden Hill Lane, Kingston, NY 112401 or phone her at 845-349-4193. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms form this provider or from the PSYCKES website at www.psyckes.com or by calling Ulster Co. Department of Mental Health at 340-4110. Note: Organizations that access your health information through SPOA Agencies that serve you while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw you consent, they are not required to return it or remove it from their records.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

PSYCKES Withdrawal of Consent Form

You previously signed a PSYCKES Consent form allowing your provider to obtain access to your Medicaid medical records electronically through PSYCKES and now want to withdraw that consent. This form may be filled out now or at a later date.

By withdrawing Consent, you understand that:

1. Health care providers and health insurers that you are enrolled with will no longer be able to access Medical Information about you through PSYCKES, except in an emergency or if another exception to the State and federal confidentiality laws and regulations applies. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern.

2. Your provider is not completely barred from accessing your medical information in any way. It may still be able to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

3. The Withdrawal of Consent will not affect the exchange of your Medical Information made while your Consent was in effect.

4. No PSYCKES participating provider will deny you medical care and your insurance eligibility will not be affected based on your Withdrawal of Consent.

5. If you wish to reinstate Consent, you may do so by signing and completing a new PSYCKES Consent form and returning it to a participating provider.

6. Withdrawing your consent does not prevent your health care providers from submitting claims to your health insurer for reimbursement for services rendered to you.

7. You understand that you will get a copy of this form after you sign it.

Print Name of Patient: _____	Date of Birth of Patient: _____
Signature of Patient or Patient's Legal Representative:	Date:
Print name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):
Signature of Witness:	Print name of Witness: