Consumer Name: _____

**APPLICATION**
**ULSTER COUNTY SINGLE POINT OF ACCESS (SPOA)**
**FOR ADULT RESIDENTIAL SERVICES**

**HOW TO APPLY?**

The SPOA for Adult Residential Services is a centralized intake system to manage, and triage housing referrals to all available Office of Mental Health (OMH) vacancies. Attached is an application for your use in submitting referrals. For an application to be considered, the following information must be included:

1. Adult Residential Program Application (see attached)
2. Psychiatric Evaluation (within last 12 months)
3. Four (4) Consents to Release Information (see attached)
4. Level of Housing form is enclosed in the application. Please check the level requested. Please note that if the client ***is already receiving Section 8 assistance***, he/she is **ineligible** for supported housing.
5. The following information is optional, but helpful and can be submitted to the Adult SPOA Coordinator after the initial application is received:
   - A psycho-social assessment
   - A psychological evaluation
   - Proof of income
   - A current comprehensive treatment plan
   - Recent medication notes
   - Any other specialized tests/evaluations/consultations as deemed appropriate
6. 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, New York 12401

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

**SPOA PROCESS AND ADMISSION REQUIREMENTS:**

1. Once the application/referral packet is received, it will be presented to the SPOA Adult Residential Services Committee. The Committee is comprised of the various providers of residential services in Ulster County. The Committee determines whether the client/consumer meets the criteria and is deemed appropriate.

2. Once eligibility is determined, a trial visit will be arranged for the client/consumer. In order for a trial visit to occur, the following must be in place:

   - FUNDING (SSI/SSD/DSS/MEDICAID, etc.)
   - OUTPATIENT MENTAL HEALTH TREATMENT SERVICES

3. Upon Admission to a residential service the following documentation is required:
   - PHYSICIAN'S AUTHORIZATION FOR RESTORATIVE SERVICES (Must be filled out by a psychiatrist only. A Nurse Practitioner is not acceptable).
   - MEDICAL/PHYSICAL EXAMINATION WITH RESULTS OF A PPD TEST (Done within the last 12 months).

Consumer Name: _____

Check appropriate box to where referral is to be made:

## *GATEWAY COMMUNITY INDUSTRIES (GCI)*

***LEVEL I Community Residence***

☐Penrose Manor (Rosendale Dually Diagnosed MH/MRDD) ***24 Hour Supervision***

☐Gateway Manor (New Paltz) ***24 Hour Supervision***

***LEVEL II Supportive Apartments***

☐Scattered Site Supportive Apartments (Kingston) ***1-3 Visits per Week***

***LEVEL III Supported Housing***

☐Gateway Apartments (Kingston, Scattered) ***Regular Visits as Needed***

☐Gateway Family Apartment ***Regular Visits as Needed***

## *REHABILITATION SUPPORT SERVICES (RSS)*

***LEVEL II Supportive Apartments***

☐Kingston ***1-3 Visits per Week***

## *MULTI COUNTY COMMUNITY DEVELOPMENT CORPORATION (MCCDC)*

***LEVEL III Supported Housing***

☐Ulster County ***Regular Visits as Needed***

## *MENTAL HEALTH ASSOCIATION (MHA)*

***LEVEL II Supportive Apartments***

☐Training Apartment Program (TAP) (Lake Katrine, NY) ***24 Hour Supervision***

☐Locust Street Certified Apartment Program (Kingston, NY) ***Daily Visits***

☐Scattered Site ***1-3 Visits per Week***

***LEVEL III Supported Housing***

☐Kingston Area Units ***Regular Visits as Needed***

## *PEOPLe, Inc*

***LEVEL III Supported Housing***

☐Ulster County ***Regular Visits as Needed***

## *ADDITIONAL HOUSING*

☐Woodstock Manor Community Residence PFP ***24 Hour Supervision***

Consumer Name: _____

# RESIDENTIAL SERVICES APPLICATION

**Level of Care Being Requested: _____**

| REFERRAL SOURCE DATA | | | |
|---|---|---|---|
| **Date of Referral:** | **Referred By:** | **Title:** | |
| **Agency:** | | **Phone #: _____ Extension: _____**<br>**E-mail address _____** | |
| **Mailing Address:** | **City** | **State** | **Zip Code** |

| APPLICANT DATA | | | | |
|---|---|---|---|---|
| **Name: Last First Middle** | | | | **Current Address:** |
| **Age:** | **Date of Birth:** | **Current Telephone #:**<br>**SSN:** | | **City/State/Zip:** |
| **County of Residence:** | | **Length of Residence:** | | **Last Community Address (if different from above):** |
| **Sex:**<br>☐**Male**<br>☐**Female** | **Marital Status:**<br>☐**Single** ☐**Married** ☐**Divorced**<br>☐**Widowed** | | | **City/State/Zip:** |
| **List last three previous addresses chronologically:**<br>1. _____<br>2. _____<br>3. _____ | | | | **For each address at left, fill in housing type using the code below:**<br>**Community Residence Intensive Supportive Scattered Site**<br>**Supported Housing Independent Hospital Respite**<br>**Boarding/Rooming House Living with Relative Living with SO**<br>Current address _____<br>Previous address #1 _____<br>Previous address #2 _____<br>Previous address #3 _____ |
| **Number of Children: _____**<br>**Ages: _____** | | **Religion (if declared):** | | **Veteran:**<br>☐**Yes** ☐**No** ☐**Unknown** |
| **Education (Highest completed):**<br>☐GR ☐HS ☐College<br>☐Graduate | **Read:** ☐Yes ☐No **Write:** ☐Yes ☐No<br>Primary Language: | | **Employment Status:** | **Homeless**<br>☐**Yes** ☐**No** |

**HUD Chronic Homeless**

Unaccompanied homeless individual with a disabling condition who has either:

☐been continuously homeless for 1 year or more

OR

☐who has had at least 4 episodes of homelessness in past 3 years*

*Episode of homelessness is a separate, distinct, and sustained stay on the streets and/or in a homeless shelter

| | | |
|---|---|---|
| **Wrap Plan?** ☐**Yes** ☐**No** | **Advanced Directives?** ☐**Yes** ☐**No (if so, please attach)** | |

Consumer Name: _____

| ASSISTED OUTPATIENT TREATMENT (AOT) | |
|---|---|
| **Check any that apply**:<br>☐**AOT** ☐**AOT Petition** ☐**High Risk**<br>**Has High Risk Core Assessment been completed?** ☐Yes ☐No **(If yes, attach)** | |
| **AOT Coordinator Signature:** **Date:** | **Intensive Case Manager Signature:** **Date:** |

| APPLICANT DSM IV DIAGNOSIS (as stated on Psychiatric Evaluation) | | | | | |
|---|---|---|---|---|---|
| **Axis I:** | | | | **.** | |
| **Axis I:** | | | | **.** | |
| **Axis II:** | | | | **.** | |
| **Axis III:** | | | | **.** | |
| **Axis IV: 1 2 3 4 5 6 7** | | | | | |
| **Axis IV: Current GAF: _____ Highest GAF Past Year: _____** | | | | | |

| DEVELOPMENTAL DISABILITIES DIAGNOSIS ONLY (OPWDD): | |
|---|---|
| **Diagnosis:** ☐**Mental Retardation** ☐**Autism** ☐**Cerebral Palsy** ☐**Epilepsy**<br>☐**Neurological Impairment** ☐**Other** _____ | |
| **Full Scale IQ:** | **Disability Manifested Prior to Age 18?**<br>☐**Yes** ☐**No** |
| **Does this individual have OPWDD eligibility and /or WAIVER status?** ☐**Yes** ☐**No** | |

| SERVICE PROVIDER INFORMATION: | | | |
|---|---|---|---|
| **Provider** | **Name** | **Agency** | **Phone #** |
| **Primary Therapist:** | | | |
| **Prescribing Physician/Psychiatrist:** | | | |
| **Probation/Parole Department** ***If applicable:*** | | | |
| **Case Management:** | | | |
| **Current Treatment Program:** | | | |

Consumer Name: _____

| FINANCIAL INFORMATION | | | |
|---|---|---|---|
| **SSN:** | **Medicaid #:** ☐**Active** ☐**Not Active** | **Medicare #:** | **Temporary Assistance/Welfare Amount:** |

| | | | |
|---|---|---|---|
| **Employment Earnings (Monthly)** | **SSI:** ☐Yes ☐No<br>**SSI Amount: $_____** | **SSDI:** ☐**Yes** ☐**No**<br>**SSDI Amount: $_____**<br>**Spend down:** ☐**Yes** ☐**No** | **Does Applicant Have Bank Account?** ☐Yes ☐No |
| **Other Benefits or Income?** | | **Other Insurance: (Health, Life, Auto): List below:** | |

| | | | |
|---|---|---|---|
| **Current Payee** ☐Yes ☐No ☐Pending ☐Payee Recommended | **Current Payee's Name:** | **Relationship:** | **Phone #:** |
| **Payee's Address:** | **City:** | **State:** | **Zip:** |

| FAMILY AND SIGNIFICANT RELATIONSHIP INFORMATION | |
|---|---|
| **Next of Kin/Legal Guardian/Significant Other:** | **Address:** |
| **Relationship:** | **Phone:** |

**Is family involved with applicant:** ☐**Yes** ☐**No**

**Describe quality of relationships (include emotional and health factors of family when applicable)**

_____

| SERVICE PROVIDER |
|---|
| **Current Schedule of Clinical/Vocational/Work/School** ***(Please include days and times):*** |

| REASON FOR REFERRAL TO THIS LEVEL OF CARE |
|---|
| **Briefly explain (excluding symptoms) why the applicant is in <u>need</u> of this level of care. Include how much supervision applicant needs:** |

Consumer Name: _____

## MEDICAL INFORMATION

**Physical Problems/Disabilities/Restriction:** ☐**Yes** ☐**No**

***If yes, explain***

_____

**Allergies:** ☐**Yes** ☐**No**

***If yes, list and/or explain***

_____

**Does Applicant Have a History of Seizure Disorder?** ☐**Yes** ☐**No**

***If yes, explain***

_____

## ALCOHOL AND SUBSTANCE USE/ABUSE (Last Five Years)

**Does Applicant Have a History of Alcohol/Substance Abuse?** ☐**Yes** ☐**No**

***If yes, list substance(s), date of last use, treatment history.***

| Substance | Date of Last Use | Treatment History |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## PREVIOUS PSYCHIATRIC HOSPITALIZATIONS (Last Five Years)

| Hospital | Reason for Admission | Admit Date | Discharge Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## MEDICATIONS

**Is Applicant Self-Medicating?** ☐Yes ☐No

**Does Applicant Have History of Medication Non-compliance?** ☐**Yes** ☐**No** **If Yes, Explain:**

_____

Consumer Name: _____

| RISK FACTORS | |
|---|---|
| Arson: ☐Yes ☐No | ***If Yes, Explain (with dates, if possible):*** |
| Suicide Attempts: ☐Yes ☐No | |
| Suicide Gestures: ☐Yes ☐No | |
| Criminal Offenses: ☐Yes ☐No | |
| Assaultive Behavior: ☐Yes ☐No | |
| Drug/Alcohol Abuse: ☐Yes ☐No | |
| CPL Status: ☐Yes ☐No | |
| Danger to Others: ☐Yes ☐No | |
| Danger to Property: ☐Yes ☐No | |

Consumer Name: _____

# AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

☐Initial Authorization

| | |
|---|---|
| **CLIENT'S NAME:** | |
| **CLIENT'S MEDICAID NUMBER:** | |
| **DSM IV & CODE DIAGNOSIS:** | |
| **DATE LAST SEEN:** | |

I, the undersigned licensed physician based on my review of the assessments made available to me, have

determined that _____ would benefit for the provision of mental
(Client's Name)
health restorative services defined pursuant to Part 595 of the 14 NYCRR.

This determination is in effect for the period _____to_____,

At which time there will be an evaluation for continued stay.

_____/_____/_____ _____ _____
Mo. Day Year Name (Please Print) License #

_____
Signature

☐Check here if client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter Primary Care Physician and Managed Care Provider Identification Number.

_____ _____
Physician Managed Care Provider ID#

| | |
|---|---|
| **RESIDENTIAL**<br><br>**AUTHORIZATION FOR RELEASE OF INFORMATION** | Patient's Name (Last, First, M.I.) "C" No.<br><br>Sex Date of Birth<br><br>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, Mental Health Diagnosis; Psychiatric Evaluation; Psychosocial evaluation; Psychological Testing (if applicable); Physical Exam and PPD.

**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) RESIDENTIAL SPOA 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 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<br>***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.* |
|---|---|
| Lynn Leffler, LCSW-R<br>Residential SPOA Coordinator | Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health Association; 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; Ulster-Greene Counties Chapter of NYSARC; Hudson Valley Mental Health Inc; Washington Manor; Other _____ |

**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 *(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).

*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 _____

**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)*

| | |
|---|---|
| **RESIDENTIAL**<br><br>**AUTHORIZATION FOR RELEASE OF INFORMATION** | Patient's Name (Last, First, M.I.) "C" No.<br><br>Sex Date of Birth<br><br>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, Mental Health Diagnosis; Psychiatric Evaluation; Psychosocial evaluation; Psychological Testing (if applicable); Physical Exam and PPD.

**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) RESIDENTIAL SPOA 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 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<br>***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.* |
|---|---|
| Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health Association; 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; Ulster-Greene Counties Chapter of NYSARC; Hudson Valley Mental Health Inc; Washington Manor; Other (Fill in) _____ | Lynn Leffler, LCSW-R<br>Residential SPOA Coordinator |

**B.** 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).

| 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 _____

**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.

WITNESSED BY: _____ _____

Signature of witness — Print name of witness

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)*

**RESIDENTIAL**

**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 (chest 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 HOSPITAL
- ☐ 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
Residential SPOA COORDINATOR

239 Golden Hill Lane
Kingston, NY 12401

* In addition, if this is a hospital discharge, please check the agencies the individual is being referred to

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

7. Only the information described in this form may be used and/or disclosed as a result of this authorization.
8. 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.
9. 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).
10. 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)* SPOA COORDINATOR OF ULSTER COUNTY (UCDMH). 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.
11. 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.
12. 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

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| 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.

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| 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: |