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

WHAT IS CARE MANAGEMENT AND CARE COORDINATION?
Care management and care coordination is a direct resource for adults 18 years of age and up. An individual care 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 care management and care coordination are to strengthen and empower adults so that they can live safe and productive lives.

Care 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 THE ELGIBILITY CRITERIA?
The consumer must possess a DSM-5 diagnosis that meets criteria for Serious Mental Illness (SMI), or a DSM-5 diagnosis with extended impairment of functioning due to mental illness.

WHAT IS ACT?
ACT is an evidenced-based practice that offers treatment, rehabilitation and support services, using a person-centered, recovery-based approach, to individuals that have been diagnosed with a severe and persistent mental illness. ACT services are provided to individuals by a mobile, multi-disciplinary team in community settings.

SPOA SERVICES INCLUDE:

- **ASSERTIVE COMMUNITY TREATMENT (ACT**)
- **MENTAL HEALTH ASSOCIATION CARE MANAGEMENT HEALTH HOME (MHA CMHH)**
- **OFFICE OF MENTAL HEALTH CARE COORDINATION (OMH CC)**
- **FAMILY OF WOODSTOCK AND MENTAL HEALTH ASSOCIATION TRANSITIONS CARE MANAGEMENT**
- **FAMILY OF WOODSTOCK GETTING AHEAD PROGRAM CARE MANAGEMENT (GAP CM)**
- **STATE INTENSIVE CARE MANAGEMENT (ICM)**

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 3 Consents to Release/Disclose Confidential Information.
4. Submit the application and supporting documentation via mail, fax or email (scan) to:

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

Telephone #: 845-340-4110
Fax: 845-340-4094
mshl@co.ulster.ny.us

APPLICATION PROCESS

1. Applications are reviewed by the Adult SPOA Committee. The Adult SPOA Committee is comprised of representatives from Access Supports for Living: Mobile Mental Health, Family of Woodstock, Gateway Industries, Health Alliance of the Hudson Valley-Inpatient/Partial Programs, Hudson Valley Mental Health, Institute for Family Health, Mental Health Association, PEOPLe Inc. and Rockland Psychiatric Center-Pine Grove Clinic.
2. The Adult SPOA Committee determines eligibility and refers to the appropriate level of adult SPOA service.
3. The adult SPOA coordinator or designee will then contact the consumer and referent and inform them of the adult SPOA service to which the consumer has been referred. If the consumer is not deemed eligible, the adult SPOA coordinator or designee will contact the consumer and referent and explore other service options.
4. In the event the SPOA service maintains a wait list, the consumer and referent will be contacted by the adult SPOA coordinator for status updates.

Consumer's Name: _____ SSN: _____

SPOA CARE MANAGEMENT/ACT REFERRAL PACKET

Date of Referral: _____

Referring Person: Name: _____ Agency: _____

Phone #: _____ E-Mail Address: _____

Treating MH MD: _____

Check all that apply:

☐ACT Team* ☐MHA Care Management ☐OMH Care Coordination ☐Transitions ☐GAP
☐ State ICM Care Management

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

Address: _____ Phone: _____ Cell phone: _____

City/State/Zip: _____

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 _____

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 ☐Other: _____

Primary Physician: _____

Where is the consumer receiving medical care: _____

Current physical medical medications: _____

_____

List all Psychiatric diagnoses: _____

Where is the consumer receiving mental health treatment? _____

Current psychiatric medications: _____

_____

Consumer's Name: _____

Developmental Disorder: _____

Significant psychosocial issues: _____

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

Does the consumer have access to transportation? ☐Yes ☐No

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

Does the consumer receive other support services? ☐home psych nursing ☐personal care aide ☐home health aide ☐wellness coordination ☐probation ☐parole ☐Other _____

Does consumer 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 CARE 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

***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)
☐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 CARE MANAGEMENT/CARE COORDINATION/ACT CONSENT: PART 1

Consumer's Name: DOB:

This authorization must be completed by the consumer 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 consumer or another person. A separate authorization is required to use or disclose confidential HIV related information.

AUTHORIZATION TO RELEASE INFORMATION TO THE SPOA COMMITTEE

Description of Information to be Used/Disclosed: Mental Health Treatment history; Mental Health Diagnosis; Psychiatric Evaluation/update; Psychosocial Evaluation, Psychological testing, Discharge Summary and other supporting documentation.

Other: _____

Purpose or Need for Information:

1. This information is being requested:

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

☒ Other (please describe) **SPOA COMMITTEE FOR CARE MANAGEMENT/CARE COORDINATION/ACT**

2. The purpose of the disclosure is (please describe**): to exchange information about the SPOA consumer with the agencies or persons listed below, in order to link the consumer with requested care management, care coordination or ACT services**

Information Being Disclosed From: (Name, Address of Organization/Facility/Program)

Information Being Disclosed To: (*Note: All referrals, including the information indicated above, are forwarded to the SPOA Coordinator who then disseminates them to any of the Service Providers listed below)*

- MVP
- Fidelis
- WellCare
- United Health Care
- Mental Health Association in Ulster County, Inc.
- Gateway Community Industries, Inc.
- Health Alliance Hospital/WMC, Inpatient/Partial
- PEOPLe, Inc.
- Willcare Home Health Care
- Rehabilitation Support Services, Inc. (RSS)
- Family of Woodstock
- Institute for Family Health
- Hudson Valley Mental Health
- Rockland Psych Center/ Pine Grove Center
- Access Supports for Living: Mobile Mental Health
- Other_____

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)* **UCDMH SPOA**.
   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).

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

_____ _____

Signature of Consumer or Personal Representative Date

_____

Consumer's Name (Printed)

_____

Personal Representative's Name (Printed)

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

SPOA CARE MANAGEMENT/CARE COORDINATION/ACT CONSENT: PART 1

Consumer's Name:	DOB:
REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information, indicated in Part 1, to the person/organization/facility/program listed below:	
Signature:	Date:

SPOA CARE MANAGEMENT/CARE COORDINATION/ACT CONSENT: PART 2

AUTHORIZATION FOR THE EXCHANGE OF INFORMATION
BETWEEN ULSTER COUNTY DEPARTMENT OF MENTAL HEALTH SPOA COMMITTEE AND OTHER SERVICE PROVIDERS

Name: _____ DOB: _____

This authorization must be completed by the consumer 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 consumer or another person. A separate authorization is required to use or disclose confidential HIV related information.

PURPOSE OF NEED FOR INFORMATION:
The UCDMH SPOA coordinator requires your permission to release and obtain your confidential information in order to pursue your request for care management, care coordination or ACT services. The information to be released/obtained includes: the SPOA application, psychiatric evaluation/update, psychosocial assessment (including diagnosis, mental status), psychological testing, discharge summary or other documentation that supports the need for care management, care coordination or ACT services.

I hereby authorize the Ulster County Department of Mental Health SPOA Coordinator to exchange information with the following agencies as part of the SPOA Process:

☐ Access: Supports for Living, Inc./Clinic Treatment
☐ Access: Supports for Living, Inc./Mobile Mental Health Team
☐ ACT Team (MHA in Ulster County, Inc.)
☐ Always There Home Care
☐ Bob Hasbrouck's
☐ Bon Secours Hospital
☐ The Bridge Back
☐ Children's Home-Poughkeepsie/Kingston
☐ Chiz's Heart Street
☐ CREATE/PROS
☐ Department of Social Services Ulster/Dutchess
☐ Family Care/OMH
☐ Family of Woodstock, Inc.
☐ Fidelis
☐ Four Winds Hospital
☐ Gateway Community Industries, Inc.
☐ HAHV/Broadway Campus
☐ HAHV/Emergency Department
☐ HAHV/Mary's Avenue Campus/Inpatient
☐ HAHV/Partial Hospitalization-Adult/Adolescnt
☐ Hudson Valley Community Services
☐ Hudson Valley Mental Health, Inc.
☐ The Institute for Family Health
☐ Mental Health Association- Ulster/Dutchess
☐ Mid-Hudson Regional Hospital of Westchester
☐ MVP
☐ New York Presbyterian
☐ Parole (New York State)
☐ Parson's Child and Family Center
☐ PEOPLe, Inc
☐ Phelps Hospital
☐ Pine Grove Center
☐ Probation (Ulster County)
☐ Putnam Hospital
☐ RCAL
☐ Rehabilitation Support Services, Inc.
☐ Rockland's Children's Psychiatric Center
☐ Rockland's Psychiatric Center
☐ RUPCO
☐ Spectrum Behavioral Health
☐ Step One
☐ UGARC
☐ Ulster County Department of Mental Health
☐ Ulster County Jail
☐ United Health Care
☐ WellCare
☐ Willcare Home Health Care
☐ Other _____
☐ Emergency Contact _____

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)* **UCDMH SPOA**.
   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).

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 SPOA care management, care coordination or ACT services

☐ other_____

CONSUMER SIGNATURE: I certify that I authorize the use of my health information as set forth in this document

Signature of Consumer or Personal Representative _____ Date:_____

Consumer's Name (Printed) : _____ Personal Representative's Name (Printed): _____

Description of Personal Representative's authority to act for the Client (required if Personal Representative signs authorization): _____

_____

REVOCATION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information, indicated in Part 2, to the person/ organization/facility/program listed below:

_____

_____

SIGNATURE:_____ DATE: _____

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 participants to access all of my electronic health information through PSYCKES 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 participants to access my electronic health information through PSYCKES.

The following are SPOA participants: Ulster County Department of Mental Health; Department of Social Services-Adult; Mental Health Association and ACT; Gateway Community Industries; Rockland Psychiatric Center (Pine Grove Center); Hudson Valley Health Alliance-Inpatient; Hudson Valley Health Alliance Partial Programs; Family of Woodstock; Willcare Home Care; UC Probation; PEOPLe, Inc.; Resource Center for Accessible Living; Institute of Family Health; Woodstock Manor; Rehabilitation Support Services, Inc. and 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 consumers

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 County. 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 County 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 County LGU 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 PSYCKES Withdrawal of Consent Form and submitting it to the Ulster County. SPOA coordinator at UCDMH, 239 Golden Hill Lane, Kingston, NY 12401. 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 UCDMH 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. They are not required to return the information or remove it from their records, should you withdraw your consent at a later date.

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: