

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: _____

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 CHILD AND ADULT CARE MANAGEMENT CONSENT TO RELEASE/OBTAIN INFORMATION

Individual's/ Child's Name:	DOB:
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This authorization must be completed by the **Individual, their personal representative or parent/guardian** 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 Individual or another person. A separate authorization is required to use or disclose confidential HIV related information.

Purpose or Need for Information:

1. This information is being requested:

By the Individual or their personal representative/guardian or parent/guardian for release to a person or entity with a demonstrable need for the information; OR

Other (please describe) **For the SPOA Coordinator**

2. The purpose to release/obtain is (please describe): **to exchange information about the Individual being referred to SPOA, with the agencies or persons listed below, in order to link the Individual with a supportive service or program.**

CHILD SPOA

Information Being Released/Obtained: *All applications, including the following information: psychiatric evaluations, psychiatric diagnosis, psycho-social reports, clinical discharge summaries, psychological evaluations, educational records, CSE evaluations, IEPs and other supporting documentation are exchanged with:*

- | | |
|---|--|
| <ul style="list-style-type: none"> • Abbott House • Access: Supports for Living • The ARC of Ulster-Greene • Arms Acres/Conifer Park • Astor Services for Children and Families • Berkshire Farm Center and Services for Youth • Catholic Charities Community Services of Orange and Sullivan • Children's Health Home of Upstate New York (CHHUNY) • Children's Home of Kingston • Mental Health Association of Ulster County, Inc. • Family of Woodstock, Inc. • Family Services • Four Winds Hospitals • Hudson Valley Mental Health • Institute for Family Health • KidsPeace | <ul style="list-style-type: none"> • Northeast Parent and Child Society • Northern Rivers Family Services, Inc. • NYS Office of People with Developmental Disabilities • Parsons Child and Family Center • PEOPLE, Inc. • Rehabilitation Support Services • Resource Center for Accessible Living, Inc. • Rockland Children's Psychiatric Center • St. Catherine's Center for Children • Step One - Child and Family Guidance Center Addictions Services, Inc. • Ulster County Department of Mental Health • Ulster County Department of Social Services • Ulster County Probation Department • WMC Health Alliance of the Hudson Valley - All units • Child's school district_____ • Other_____ |
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ADULT CARE MANAGEMENT SPOA

Information Being Released/Obtained: *All applications, including the following information: mental health treatment history, psychiatric diagnosis, psychiatric evaluations/updates, psycho-social reports, psychological testing, clinical discharge summaries and other supporting documentation are exchanged with:*

- | | |
|---|--|
| <ul style="list-style-type: none"> • Access: Supports for Living • The ARC of Ulster - Greene • Arms Acres/Conifer Park • Assisted Outpatient Treatment • The Bridgeback • Catholic Charities Community Services of Orange and Sullivan • Family of Woodstock, Inc. • Gateway Community Industries, Inc. • Hudson Valley Community Services • Hudson Valley Mental Health • Institute for Family Health • Mental Health Association in Ulster County, Inc. • NYS Office of People with Developmental Disabilities • New York State Parole | <ul style="list-style-type: none"> • PEOPLE, Inc. • Rehabilitation Support Services, Inc. • Rockland Psychiatric Center • Rural Ulster Preservation Company (RUPCO) • Spectrum Behavioral Health • Step One - Child and Family Guidance Center Addictions Services, Inc. • Ulster County Department of Mental Health • Ulster County Department of Social Services • Ulster County Jail • Ulster County Probation Department • WMC Health Alliance of the Hudson Valley - All Units • Emergency Contact - Name and telephone number_____ • Other_____ |
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SPOA CHILD AND ADULT CARE MANAGEMENT CONSENT TO RELEASE/OBTAIN INFORMATION

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 CHILD or ADULT CARE MANAGEMENT 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 pursuing or receiving Child or Adult Care Management SPOA services.

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

Signature of Individual, or Personal Representative, or
Parent/Guardian

Date

Individual's/Child's Name (Printed)

Personal Representative or Parent/Guardian's Name (Printed)

Relationship

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

REVOCAION OF AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby revoke my authorization to release/obtain information to the person/organization/facility/program listed above

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: