ULSTER COUNTY SINGLE POINT OF ACCESS (SPOA) APPLICATION

• ADULT RESIDENTIAL SERVICES •

HOW TO APPLY? SPOA is a centralized intake system to manage and prioritize housing referrals to available Office of Mental Health (OMH) vacancies. The following must be included. All information must be legible to be accepted.

1. A DSM-5 diagnosis that meets criteria for Serious Mental Illness (SMI)
2. A psychiatric evaluation completed within the last 12 months or within 24 months with a medication note from last 3 months
3. A psychosocial assessment
4. Signed consents to release information (included in this application)
5. **A source of income must be identified on the application**

Level 1-2 only: Physician's Authorization for Restorative Services (**Must be filled out by a licensed MD**. Nurse Practitioner is NOT acceptable.)

The following information is optional but helpful:

- Psychological evaluation
- Current comprehensive treatment plan
- Recent medication notes
- Other specialized tests/evaluations/consultation

Submit the application and supporting documentation via mail, fax or email to:

Ulster County Department of Mental Health
239 Golden Hill Lane Kingston, New York 12401
Tel: (845) 340-4110 | Fax: (845) 340-4094
dmh@co.ulster.ny.us

Please note: Those currently receiving Section 8 assistance are not eligible for SPOA housing.

SPOA PROCESS AND ADMISSION REQUIREMENTS:

1. Applications are held until all required information is obtained. Accepted applications are held until a slot is available.
2. Prior to admission, a trial visit may be arranged. Level 1-2: prior to a trial visit, the following must be in place:
   - Funding (SSI/SSD/DSS/ Ulster County Medicaid, etc.)
   - Outpatient mental health treatment
3. Upon admission to a residential service, the following documentation is required:
   - Physical Exam with PPD test results within the last 12 months

LEVEL REQUESTED - Check appropriate box to where referral is to be made:

☐ ***LEVEL I (Highest Level) Community Residence – Gateway Manor***

Provides 24-hr on-site support and supervision. Residents develop individualized plans based on the goals of psychiatric rehabilitation. Medication management, treatment adherence, daily living skills, vocational training, links to community supports, interpersonal development and other areas are addressed in a home-like setting based on individual goals and treatment recommendations. The program is highly structured with an emphasis on movement toward an increased level of independent living.

☐ ***LEVEL 2 (Mid-Level) Supportive Apartment – Gateway, MHA & RSS***

Typically, shared apartment programs in the community. Most apartments are 2 bedroom and shared with a roommate. Staff visit residents a minimum of 3x/week (more if needed) to assist with continued medication management, interpersonal relations, daily living skills, apartment maintenance, socialization, symptom management and community integration. Staff are available 24/7 to provide crisis resolution and support. Some programs offer on-site support during the day and 24-hours depending on the program. The goal is to maintain a high level of functioning in daily living and emotional stability to move toward more independent living.

☐ ***LEVEL 3 (Lowest Level) Supported Housing – Gateway, MHA, RSS, People USA & Access: Supports for Living***

Long-term/permanent housing with minimal residential and care management services. Providers help individuals find safe and affordable housing (generally at or below Fair Market Value) integrated in the community. Lease and utility agreements are primarily between the resident and the landlord. Providers and residents develop a support plan, have monthly face-to-face contact, home visits at least every 3 months, and income verification at least annually. The tenant's contribution to the rent is 30% of their income.

REFERRAL SOURCE INFORMATION			
Date of Referral:	**Referred By:**	**Agency:**	**Title:**
Phone #:	**Extension:**	**E-mail address:**	

APPLICANT INFORMATION			
Name: Last First Middle			**Current Address:**
Date of Birth:	**Primary Telephone #:** **Secondary Telephone #:**		**City/State/Zip:**
County of Residence:	**Length of Residence:**		**Marital Status:** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**
Gender Identity:	**Sex at Birth:**		**Number of Children Living with Applicant:** **Ages:**

List last 3 previous addresses and type (private residence, boarding home, supported housing, prison, etc.):

1. _____

2. _____

3.

Read: ☐Yes ☐No **Write:** ☐Yes ☐No **Languages Spoken:**	**Veteran:** ☐Yes ☐No ☐Unknown

Currently Homeless: **If yes, where is the applicant staying now:**

☐**Yes** ☐**No** **History of Homelessness:**

FINANCIAL INFORMATION			
SSN:	**Medicaid #:** ☐**Active** ☐**Not Active**	**Medicare #:**	**Temporary Assistance Amount:**
Employment Earnings (Monthly)	**SSI:** ☐Yes ☐No **SSI Amount: $_____**	**SSDI:** ☐**Yes** ☐**No** **SSDI Amount: $_____** **Spend down:** ☐**Yes** ☐**No**	**Does Applicant Have Bank Account?** ☐Yes ☐No
Other Benefits or Income?		**Other Insurance:**	

Current Payee ☐Yes ☐No ☐Pending ☐ 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 the applicant's family involved? ☐**Yes** ☐**No**

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

REASON FOR REFERRAL TO THIS LEVEL OF CARE
Briefly describe the applicant's functioning in the following areas: Activities of Daily Living, Self-Care, Concentration/Memory, Social

APPLICANT DSM-5 DIAGNOSIS (must match psychiatric evaluation)	ICD-10 Codes			
1.	F		.	
2.	F		.	
3.	F		.	
4.	F		.	
5.	F		.	

DEVELOPMENTAL DISABILITIES DIAGNOSIS:

☐ Intellectual Developmental Disorder ☐ Autism Spectrum Disorder ☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome ☐ Down Syndrome

Full Scale IQ:

MEDICAL INFORMATION

Physical Problems/Disabilities/Accessibility Needs: ☐Yes ☐No *If yes, explain*:

Allergies: ☐Yes ☐No *If yes, list and/or explain*:	**History of Seizure Disorder?** ☐Yes ☐No *If yes, explain:*

MEDICATIONS

Is the Applicant able to self-administer medications? ☐Yes ☐No **History of Medication Non-adherence?** ☐Yes ☐No

Explain:

SERVICE PROVIDER INFORMATION:

Provider	Name	Agency	Phone #
Primary Therapist:			
Prescriber:			
Current Treatment Program:			
Care Management:			
Probation/Parole:			

ALCOHOL AND SUBSTANCE USE DISORDER (Last 5 Years)

History of Alcohol/Substance Use Disorder? ☐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

RISK FACTORS		
Arson: ☐Yes ☐No	***Date/Age:***	***Explain:***
Suicide Attempts: ☐Yes ☐No		
Self-Injurious Behavior: ☐Yes ☐No		
Criminal Offenses: ☐Yes ☐No		
Assaultive Behavior: ☐Yes ☐No		
Sex Offender: ☐Yes ☐No		
Danger to Others: ☐Yes ☐No		
Danger to Property: ☐Yes ☐No		

LEVEL 1 OR 2 ONLY: AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

☐Initial Authorization ☐Semi-Annual Authorization ☐Annual Authorization

APPLICANT'S NAME:	
APPLICANT'S MEDICAID NUMBER:	
ICD-10 DIAGNOSIS CODE:	
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
(Applicant's Name)
health restorative services defined pursuant to Part 595 of the 14 NYCRR.

This determination is in effect for the period _____to_____,
(Start Date) (End Date)
At which time there will be an evaluation for continued stay.

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

_____
Signature

☐Check here if applicant 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#

SPOA RESIDENTIAL CONSENT TO RELEASE/OBTAIN INFORMATION

Individual's Name: DOB:

This authorization must be completed by the **Individual, their personal representative or legal 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 for release to a person or entity with a demonstrable need for the information; OR

☒ Other (please describe) **RESIDENTIAL SPOA COORDINATOR**

2. The purpose to release/obtain is (please describe**): to exchange information about the Individual being referred to SPOA, with the Organizations/Facility/Programs listed below, in order to link the Individual with a residential service or setting.**

Information Being Released/Obtained: *All SPOA applications, including mental health treatment history, psychiatric diagnosis, psychiatric evaluations/updates, psycho-social reports, psychological testing, clinical discharge summaries and other supporting documentation may be exchanged between the appropriate SPOA Committee members to link the individual with the services or programs best suited to meet the individual's needs. SPOA Committee members include, but are not limited to, the following entities:*

- Access Supports for Living
- All Courts under the 3rd Judicial District in the State of NY
- The Arc Mid-Hudson
- Assisted Outpatient Treatment
- The Bridge Back
- Bob Hasbrouck (Boarding Home)
- Catholic Charities Community Services of Orange/Sullivan
- Chiz's Heart Street (Boarding Home)
- Coordinated Entry Committee
- Elizabeth Manor
- Family of Woodstock, Inc.
- Family Services, Inc.
- Gateway Hudson Valley
- HUD (Housing and Urban Development)
- Hudson Valley Community Services
- Hummel's (Boarding Home)
- Institute for Family Health
- Joseph Sangi (Boarding Home)
- Legal Services of the Hudson Valley
- Mental Health Association in Ulster County, Inc.
- NYS Office of People with Developmental Disabilities
- New York State Parole
- People USA
- Rehabilitation Support Services, Inc.
- Rockland Psychiatric Center (Inpatient)
- Rockland Psychiatric Center - Pine Grove Clinic
- Rural Ulster Preservation Company (RUPCO)
- Spectrum Behavioral Health
- Step One - Child and Family Guidance Center Addictions Services
- Ulster County Departments of Health and Mental Health
- Ulster County Department of Social Services
- Ulster County District Attorney's Office
- Ulster County Jail
- Ulster County Probation Department
- Ulster County Public Defender's Office
- Ulster County Veterans Department
- Veterans Administration
- WMC Health Alliance Hospital - All Units
- WMC – Mid-Hudson Regional Hospital
- Other_____
- Other_____
- Emergency Contact - Name and telephone number_____

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 RESIDENTIAL 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 residential 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 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)

REVOCATION 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: _____

Optional - Single Point of Access (SPOA) Patient Information Retrieval Consent Ulster County

By signing this form, you agree to have your health information shared with the SPOA Committee. The goals of the SPOA Committee are to improve the integration of medical and behavioral health and to help healthcare providers improve quality of care. In order to support coordination of your care and provide better care, health care providers and other people involved in such care need to be able to talk to each other about your care and share health information with each other. You will still be able to get health care and health insurance even if you do not sign this form.

Your signature on this form will permit the SPOA Committee to get health information, including your health records, through a computer system run by HealtheConnections, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with people who you say can see or get such health information. PSYCKES is a computer system to collect and store health information from doctors and health care providers to help them plan and coordinate care.

If you agree and sign this form, the SPOA Committee members can get, see, read and copy, and share with each other, ALL of your health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your care, manage such care or study such care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1.Alcohol or drug use programs which you are in now or were in before as a patient;
2.Family planning services like birth control and abortion;
3.Inherited diseases;
4.HIV/AIDS;
5.Mental health conditions;
6.Sexually-transmitted diseases (diseases you can get from having sex);
7.Social needs information (housing, food, clothing, etc..) and/or
8.Assessment results, care plans, or other information you or your treatment provider enter into PSYCKES.

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your health information must obey all these laws. They cannot give your information to other people unless an appropriate guardian agrees, or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Under federal law, information disclosed to an entity that is not required to comply with HIPAA may no longer be protected by HIPAA. However, the information is still protected by New York State Law, which prohibits re-disclosure unless otherwise specifically authorized by law. Separate laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your health information and the SPOA Committee must obey these laws and rules.

Please read all the information on this form before you sign it.

☐ **I AGREE** that the SPOA Committee can get ALL my health information through the RHIO and/or through PSYCKES to give me care or manage my care, to check if I am in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the SPOA Committee and the health provider agencies may share my health information with each other. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the SPOA participating providers. This authorization will expire when I am no longer pursuing or receiving SPOA services.

_____ _____

Print Name of Patient Patient Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative Date

(Please keep for your records. No need to return.)

Details About Patient Information and the Consent Process

1. How will SPOA providers use my information?
If you agree, SPOA providers will use your health information to:
• Coordinate your health care and manage your care;
• Check if you have health insurance and what it pays for; and
• Study and make health care for patients better.
The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills. Further, your refusal to sign the authorizations will not affect your abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect your eligibility for benefits. Please note, however, that without the information made available due to your signature on the authorization, SPOA Committee members will not have your information and therefore will be unable to determine if you are eligible for their services or if their services are appropriate for you.

2. Where does my health information come from?
Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

3. What laws and rules cover how my health information can be shared?
These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. If I agree, who can get and see my information?
The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients. Please note that if you authorize your information to be disclosed to someone who is not required to comply with HIPAA, then it 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).

5. What if a person uses my information and I didn't agree to let them use it?
If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at (845) 340-4110, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. How long does my consent last?
Your consent will last until the day you take back your consent, or if the SPOA stops working, or three years after the last date of service from the SPOA, whichever comes first.

7. What if I change my mind later and want to take back my consent?
You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the SPOA. You can get this form by calling (845) 340-4110. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

8. How do I get a copy of this form?
A copy of this form will be provided to you after you sign it.