

SPOA Universal Referral Form

Bolded – CAIRS Core Elements

Non-Bold – CAIRS Optional Elements

Italic type – Paper Transfer

Client Information

Child's First Name		Middle Initial	Last Name
Date Of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's Social Security Number	Phone
Medicaid ID 1 (Required for referral to Health Home Care Management)		Medicaid ID 2	Primary Language
Child's Race <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other (Specify) _____			
County of SPOA (Fiscal) Responsibility		County of Residence	
Current Address			

Parents

Mother's Name (First, MI, Last)		Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	County
Address, City, State, Zip		Home Phone	Work Phone
		Primary Language	
Father's Name (First, MI, Last)		Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	County
Address, City, State, Zip		Home Phone	Work Phone
		Primary Language	
Has family been referred for other services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please list services:	
Are parents legal guardians? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list guardian in "Other Significant Contacts".		Is either parent/legal guardian enrolled in a Health Home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which Health Home? _____	

Other Significant Contacts — Please list other significant contacts

First Name, MI, Last Name		Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	County
Address, City, State, Zip		Home Phone	Work Phone
First Name, MI, Last Name		Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	County
Address, City, State, Zip		Home Phone	Work Phone

Current Providers

First Name, MI, Last Name		Relationship	County
Address, City, State, Zip		Home Phone	Work Phone
First Name, MI, Last Name		Relationship	County
Address, City, State, Zip		Home Phone	Work Phone
First Name, MI, Last Name		Relationship	County
Address, City, State, Zip		Home Phone	Work Phone

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Background Information

Child's living situation: (Check one box only)

- | | | |
|--|--|---|
| 01 <input type="checkbox"/> Independent living | 11 <input type="checkbox"/> DFY Community Group Home | 21 <input type="checkbox"/> Jail |
| 02 <input type="checkbox"/> Two parent family | 12 <input type="checkbox"/> Family Based Treatment | 22 <input type="checkbox"/> Homeless/streets |
| 03 <input type="checkbox"/> One parent family | 13 <input type="checkbox"/> OCFS Therapeutic Foster Care | 24 <input type="checkbox"/> Grandparent(s) |
| 04 <input type="checkbox"/> Two parent adoptive family | 14 <input type="checkbox"/> Crisis Residence | 25 <input type="checkbox"/> Private psychiatric inpatient- Article 31 |
| 05 <input type="checkbox"/> One parent adoptive family | 15 <input type="checkbox"/> Runaway shelter | 26 <input type="checkbox"/> Gen. hospital psych inpatient- Article 28 |
| 06 <input type="checkbox"/> Other relatives' home | 16 <input type="checkbox"/> Residential school (SED) | 27 <input type="checkbox"/> State psychiatric inpatient |
| 07 <input type="checkbox"/> OCFS Family Foster Care | 17 <input type="checkbox"/> Residential Treatment Center (OCFS) | 88 <input type="checkbox"/> Other (specify) _____ |
| 08 <input type="checkbox"/> OMH CY Community Residence | 18 <input type="checkbox"/> Residential Treatment Facility (OMH) | 99 <input type="checkbox"/> Unknown |
| 09 <input type="checkbox"/> Teaching Family Home | 19 <input type="checkbox"/> Psychiatric inpatient care - unspecified | |
| 10 <input type="checkbox"/> OCFS Group Home | 20 <input type="checkbox"/> OCFS/DRS Facility | |

Child's custody status: (Check one box only)

- | | | |
|--|--|---|
| 01 <input type="checkbox"/> Biological Parents | 04 <input type="checkbox"/> Other Family/Legal Guardians | 06 <input type="checkbox"/> Emancipated Minor |
| 02 <input type="checkbox"/> Adoptive Parents | 05 <input type="checkbox"/> Local DSS | 88 <input type="checkbox"/> Other |
| 03 <input type="checkbox"/> Grandparent(s) | | |

Highest level of education completed: (Check one box only)

- | | | |
|--|---|--|
| 01 <input type="checkbox"/> Kindergarten | 08 <input type="checkbox"/> Seventh | 15 <input type="checkbox"/> Ungraded – Middle School |
| 02 <input type="checkbox"/> First | 09 <input type="checkbox"/> Eighth | 16 <input type="checkbox"/> Ungraded – High School |
| 03 <input type="checkbox"/> Second | 10 <input type="checkbox"/> Ninth | 17 <input type="checkbox"/> College |
| 04 <input type="checkbox"/> Third | 11 <input type="checkbox"/> Tenth | 18 <input type="checkbox"/> Graduate |
| 05 <input type="checkbox"/> Fourth | 12 <input type="checkbox"/> Eleventh | 19 <input type="checkbox"/> Post Graduate |
| 06 <input type="checkbox"/> Fifth | 14 <input type="checkbox"/> Ungraded – Elementary | 99 <input type="checkbox"/> Unknown |
| 07 <input type="checkbox"/> Sixth | | |

School District:

Child's Educational Placement: (Check one box only)

- | | |
|--|--|
| 01 <input type="checkbox"/> Regular class in age-appropriate grade | 10 <input type="checkbox"/> Day Treatment |
| 02 <input type="checkbox"/> Regular class, above grade level | 11 <input type="checkbox"/> Home instruction |
| 03 <input type="checkbox"/> Regular class, but behind at least one grade | 12 <input type="checkbox"/> BOCES |
| 04 <input type="checkbox"/> Special class for students with handicapped conditions | 13 <input type="checkbox"/> College |
| 05 <input type="checkbox"/> Residential school for the educationally (emotionally) handicapped | 77 <input type="checkbox"/> Not enrolled in school |
| 06 <input type="checkbox"/> Vocational training only | 88 <input type="checkbox"/> Other (specify) _____ |
| 07 <input type="checkbox"/> Part time vocational/educational | 99 <input type="checkbox"/> Unknown |
| 09 <input type="checkbox"/> High school graduate/GED | |

Home School Name:

Current School Name:

Date of Last IEP:

Committee on Special Education Status:

- | | | |
|---|---|--|
| 02 <input type="checkbox"/> Emotional Disturbance | 07 <input type="checkbox"/> Multiple Disability | 12 <input type="checkbox"/> Speech or Language Impairment |
| 03 <input type="checkbox"/> Learning Disability | 08 <input type="checkbox"/> Autism | 13 <input type="checkbox"/> Visual Impairment (includes blindness) |
| 04 <input type="checkbox"/> Sensory Impaired | 09 <input type="checkbox"/> Intellectual Disability | 77 <input type="checkbox"/> None |
| 05 <input type="checkbox"/> Physical Disability | 10 <input type="checkbox"/> Deafness | 99 <input type="checkbox"/> Unknown |
| 06 <input type="checkbox"/> Other Health Impaired | 11 <input type="checkbox"/> Hearing Impairments | |

Child's IQ:

Verbal Score– Performance Score:

Full Scale Score:

Date:

Child's Legal Status: (Check one box only)

- | | | |
|---|--|---|
| 01 <input type="checkbox"/> PINS | 04 <input type="checkbox"/> Juvenile Delinquent - restricted | 88 <input type="checkbox"/> Other (specify) _____ |
| 02 <input type="checkbox"/> PINS Diversion | 05 <input type="checkbox"/> Juvenile Offender | 99 <input type="checkbox"/> Unknown |
| 03 <input type="checkbox"/> Juvenile Delinquent | 77 <input type="checkbox"/> None | |

Income or benefits child is currently receiving: (Check all that apply)

- | | |
|---|--|
| 01 <input type="checkbox"/> Supplemental Security Income (SSI) | 06 <input type="checkbox"/> Medicaid |
| 02 <input type="checkbox"/> Social Security Disability Income (SSDI) | 07 <input type="checkbox"/> Medicare |
| 03 <input type="checkbox"/> Veteran Benefit | 08 <input type="checkbox"/> Medication Grant |
| 04 <input type="checkbox"/> Social Security Retirement, survivor or dependent (SSA) | 09 <input type="checkbox"/> Private insurance, employer coverage, no third party insurance |
| 05 <input type="checkbox"/> Any public assistance cash program:
Family Assistance (TANF), Safety Net, Temporary Disability | 10 <input type="checkbox"/> Other (please specify) _____ |

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Using the scale below, indicate the level that most accurately reflects the frequency with the child engaged in the following behaviors in the past 18 months.

SCALE		Never	Rarely	Some-times	Often	Always	Unknown
		0	1	2	3	4	9
0 NEVER This behavior not observed or reported.							
1 RARELY The child has engaged in behavior once in the past 18 months.							
2 SOMETIMES The child has engaged in behavior two times in the past 18 months.	44 Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 OFTEN The child has engaged in behavior five times in the past 18 months.	45 Destruction of Property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 ALWAYS The child has routinely engaged in behavior more than five times in the past 18 months.	46 Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 UNKNOWN	47 Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Functioning

SCALE	
0 NOT EVIDENT Child does not display this symptom/behavior	
1 MILD This symptom/behavior exists, but there is no impairment (lost of effectiveness) in carrying out daily activities or in meeting major role requirements.	
2 MODERATE This symptom/behavior exists. This child maintains an appropriate level of functioning in daily activities and major roles only with difficulty and increased effort and support.	
3 MARGINALLY SEVERE This symptom/behavior exists There is definite impairment in carrying out daily activities and/or performing major roles. Major roles are able to be perform.	
4 SEVERE This symptom/behavior exists Definite impairment exists in daily activities. The child is unable to perform one or more major role at any level. The child may not be allowed to remain in one or more major roles due to severity of symptom/behavior	
9 UNKNOWN	

	Not Evident	Mild	Moderate	Marginally Severe	Severe	Unknown
	0	1	2	3	4	9
55 Self Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56 Social Relationships/Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57 Cognitive Functioning/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58 Self Direction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59 Motor Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Health Information

Current Medical Conditions:	Any Medical Alerts:
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Drugs for Medical Conditions:

Is child taking medications for psych condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Name: (If yes is checked)
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Child's Treatment and Services History

SCALE	(Enter number. Please enter 0 for none.)
0 Never	Psychiatric Hospitalization in last 12 months _____
1 Not at all in past six months	Psychiatric Hospitalization in last 6 months _____
2 One or more times in the past 6 months, but not in the past 3 months	Emergency Room visits in last 12 months-NYC only _____
3 One or more times in the past 3 months, but not in the past month	Emergency Room visits in last 6 months _____
4 One or more times in the past month, but not in the past week	Arrests in last 6 months _____
5 One or more times in the past week	Incarceration in last 6 months _____

How frequently was this recipient a victim of sexual or physical abuse?

History of Past and Present Services: (Check all that apply)		
01 <input type="checkbox"/> Intensive Case Management	11 <input type="checkbox"/> Vocational Training	22 <input type="checkbox"/> Flexible Funding
02 <input type="checkbox"/> Service Coordination/Case Management	12 <input type="checkbox"/> ADL or Independent Living Skills	23 <input type="checkbox"/> Foster Care
03 <input type="checkbox"/> Individualized Care Coordination	13 <input type="checkbox"/> Alcohol Abuse Treatment	24 <input type="checkbox"/> State Psychiatric Facility
04 <input type="checkbox"/> Clinic Treatment	14 <input type="checkbox"/> Substance Abuse Treatment	25 <input type="checkbox"/> Private Psychiatric Facility
05 <input type="checkbox"/> Private/Individual Therapy	15 <input type="checkbox"/> Family Support Services	26 <input type="checkbox"/> General Hospital Psychiatric Inpatient
06 <input type="checkbox"/> Crisis Response Services	16 <input type="checkbox"/> Transportation	27 <input type="checkbox"/> OPWDD Developmental Center
07 <input type="checkbox"/> Home Based Crisis Intervention	17 <input type="checkbox"/> After School/Weekend Program	28 <input type="checkbox"/> Intensive in Home
08 <input type="checkbox"/> Day Treatment	18 <input type="checkbox"/> Specialized Summer Program	29 <input type="checkbox"/> CCSI
09 <input type="checkbox"/> Respite	19 <input type="checkbox"/> Specialized Educational Services	30 <input type="checkbox"/> Supportive Case Manager
10 <input type="checkbox"/> Medication Management	20 <input type="checkbox"/> Speech & Language Therapy	31 <input type="checkbox"/> Residential Treatment Facility
	21 <input type="checkbox"/> Mentoring	88 <input type="checkbox"/> Other (Specify) _____

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Referral

Referral Source to SPOA:

- | | | |
|---|--|--|
| 01 <input type="checkbox"/> Family/Legal Guardian | 07 <input type="checkbox"/> Social Services | 13 <input type="checkbox"/> Residential Treatment Facility |
| 02 <input type="checkbox"/> Self | 08 <input type="checkbox"/> Other Mental Health Program | 14 <input type="checkbox"/> Community Residence |
| 03 <input type="checkbox"/> School/Education System | 09 <input type="checkbox"/> Physician | 15 <input type="checkbox"/> Intensive Case Management |
| 04 <input type="checkbox"/> State-Operated Inpatient Program | 11 <input type="checkbox"/> Emergency Room
(Psychiatric & General Hospital) | 16 <input type="checkbox"/> OPWDD |
| 05 <input type="checkbox"/> Local Hospital Acute Inpatient Unit | 12 <input type="checkbox"/> Private Psychiatric Inpatient Hospital | 88 <input type="checkbox"/> Other
(Specify) _____ |
| 06 <input type="checkbox"/> Juvenile Justice System | | |

Services Child referred to SPOA for: (Check all that apply.) *Services availability varies by county, referral does not guarantee acceptance.

- | | | |
|--|--|--|
| 01 <input type="checkbox"/> Health Home Care Management | 11 <input type="checkbox"/> Vocational Training | 22 <input type="checkbox"/> Flexible Funding |
| 02 <input type="checkbox"/> Service Coordination/Case Management | 12 <input type="checkbox"/> ADL or Independent Living Skills | 23 <input type="checkbox"/> Foster Care |
| 03 <input type="checkbox"/> Individualized Care Coordination | 13 <input type="checkbox"/> Alcohol Abuse Treatment | 24 <input type="checkbox"/> State Psychiatric Facility |
| 04 <input type="checkbox"/> Clinic Treatment | 14 <input type="checkbox"/> Substance Abuse Treatment | 25 <input type="checkbox"/> Private Psychiatric Facility |
| 05 <input type="checkbox"/> Private/Individual Therapy | 15 <input type="checkbox"/> Family Support Services | 26 <input type="checkbox"/> General Hospital Psychiatric Inpatient |
| 06 <input type="checkbox"/> Crisis Response Services | 16 <input type="checkbox"/> Transportation | 27 <input type="checkbox"/> OPWDD Developmental Center |
| 07 <input type="checkbox"/> Home Based Crisis Intervention | 17 <input type="checkbox"/> After School/Weekend Program | 28 <input type="checkbox"/> Intensive in Home |
| 08 <input type="checkbox"/> Day Treatment | 18 <input type="checkbox"/> Specialized Summer Program | 29 <input type="checkbox"/> CCSI |
| 09 <input type="checkbox"/> Respite | 19 <input type="checkbox"/> Specialized Educational Services | 30 <input type="checkbox"/> Residential Treatment Facility |
| 10 <input type="checkbox"/> Medication Management | 20 <input type="checkbox"/> Speech & Language Therapy | 88 <input type="checkbox"/> Other (Specify) _____ |
| | 21 <input type="checkbox"/> Mentoring | |

Please describe why child requires the highest level of service that SPOA provides:

List Child's Strengths: (Enter as many as desired)

List of Family/Caregiver Strengths: (Enter as many as desired)

Name of Person Referring Child to SPOA:

Title:

Signature of Person Referring Child to SPOA:

Phone:

Date of Referral to SPOA:

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AUTHORIZATION FOR RELEASE OF INFORMATION

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. A separate authorization is required to use or disclose confidential related information.

PART 1: Authorization for Release of Information

Description of Information to be Used/Disclosed:

I, *(insert Parent/legal Guardian/ACS/Foster Care)* _____, consent to release clinical information to the Single Point of Access (SPOA). I understand that the SPOA will review and evaluate the information to determine eligibility for services in Home and Community Based Services Waiver, Health Home Care Management, Family Based Treatment or Community Residence.

Purpose or Need for Information:

1. This information is being requested by:
 - The individual or his/her personal representative; or
 - Other *(please describe)* _____
2. The purpose of the disclosure is *(please describe)*:

It is understood that this information will be used to evaluate *(Insert Child's Name)* _____ for possible placement with HCBS Wavier, Case Management, Family Based Treatment or Community Residence. Upon acceptance, my child will be receiving services from one of the above.

It is understood that this information will be used to evaluate *(Insert Child's Name)* _____ for possible placement with HCBS Wavier, Health Home Care Management, Family Based Treatment or Community Residence. Upon acceptance, my child will be receiving services from one of the above.

To: Name, Address, & Title of Person/Organization/Facility Program to Which this Disclosure is to be Made

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

A. I authorize the SPOA to release clinical information and make recommendations for the appropriate program for possible enrollment. I also understand that the SPOA may recommend other appropriate programs/services, such as Residential Treatment Facility, the Coordinated Children's Services Initiative, or the Parent Resource Center. 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 this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
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 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 ability 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).

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Please select one choice from either B-1 or B-2:

B-1. One-time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:

- When acted upon;
- 90 Days from this Date;

B-2. Periodic Use/Disclosure: I hereby permit the periodic use or 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 one of the intensive high end mental health services;
- One Year from this Date;
- Other _____

C. Patient Signature: I certify that I authorize the use of my medical/mental 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 Personal Representative

WITNESSED BY: _____

Staff person's name and title

Date

Authorization Provided To: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information

Date Released

Title

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility Program whose name and address is:

I hereby revoke my authorization to use/disclose information indicated in Part 1, 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)*