2018 Onondaga County Adult SPOA Application

Send with **Records** and signed **SPOA Permission Form to SPOA Fax: 315-435-3279**

Referral Information

Referral is for: *See OMH SMI High Priority Eligibility Criteria	☐ OMH Residential Services; Congregate or Apartment Treatment ☐ OMH Supported Housing ☐ Non Medicaid CM for SMI* Eligible ☐ Forensic Case Management ☐ ACT Team ☐ SRO ☐ To be determined ☐ Other_____		
Date of Referral:		**Applicant Gender:**	☐ **Male** ☐ **Female**
Applicant Name:		**AKA:**	
Social Security Number, last 4 digits:	**Applicant DOB:**		
Home Street Address:			
(City, State, Zip)			
Current Location:			

If inpatient, anticipated release date:_____

Alternate Contact, Address and/or Phone # for Client when in the community:	Emergency Contact Name, Address & Phone #:
May we leave a message? ☐ Yes ☐ No	

Referring person contact information: **Provider Type:** _____

Name: _____ **Role**_____

Agency: _____

Address: _____

Phone: _____ **Fax:** _____

Email Address: _____

Legal Status

Involved with: **If incarcerated, anticipated release date**_____

☐ Parole ☐ County Probation ☐ Federal Probation/history

PO name and phone: _____

Reason/charges/convictions_____ Restrictions? _____

☐ CPL _____ ☐ Court Order or Diversion ☐ Town Court ☐ Treatment Court

☐Adult Protective Services ☐Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other: _____

Medicaid Status

Client Medicaid #: _ _ _ _ _ _ _ _ _ _

Managed Care Company:_____

Medicaid active? Yes_____ **No**_____ **HARP eligible? Yes** ____ **NO**_____ **Not known** _____

Name_____

Personal And Demographic Information

Race / Ethnicity	Primary Language	English Proficiency (If primary language is not English)
☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian ☐ American Indian or Native ☐ Other (specify) _____	☐ English ☐ Spanish ☐ American Sign Language ☐ Other (specify) _____	☐ Does Not Speak English. ☐ Poor ☐ Fair ☐ Good - Does Not Need Translator ☐ Literacy level:

Veteran Status

Veteran or served in military? ☐ Yes ☐ No Branch/ type of discharge: _____

Service Connected Disability? ☐ Yes ☐ No If Service Connected _____%

Current Marital Status	Custody Status of Children
☐ Single, never married ☐ Currently married ☐ Divorced/separated ☐ Widowed	☐ No children ☐ Minor children in clients custody, ages:_____ ☐ Have children - older than 18 years ☐ Minor children not in client's custody but have access ☐ Minor children no custody - no access

Prior Living Situations: **Section 8 Status:**

If planning to live with family/friend, please list other members of the household:

Current Educational Level	Employment/Vocational
☐ No formal education ☐ Some grade school (1-8th grade) ☐ Completed grade school ☐ Some HS (9-12th grade, but no diploma) ☐ HS diploma or GED ☐ Vocational, business training ☐ Some college, no degree ☐ College degree ☐ Master's degree ☐ Other:_____	☐ If has employment history, describe: ☐ Other vocational training, describe: Recommendations: ☐ Access-VR involvement ☐ Other:

Representative payee history?	☐ No ☐ Yes ☐ Recommended? Debts, if any: _____
Representative Payee Name:	
Agency:	
Phone:	**Address:**

Name_____

Clinical Information

	Diagnoses	CODE
DSM 5 MH		
DSM 5 SUD		
DSM 5 other		
Disability level		
Chronic health conditions		
Other health conditions		
BH Treatment type:		
Clinician:		
Psychiatrist:		
Other behavioral health supports:		

Number of ER Visits For Psychiatric Reasons in the in last 12 Months:_____
Number of Psychiatric Hospitalizations in the last 24 Months:_____

Date	Hospital	Length of Stay

Substance Use

Drugs of Choice:

☐ None ☐ Any IV Drug Use ☐ Alcohol ☐ Marijuana/Cannabis
☐ Crack ☐ Heroin/Opiates ☐ PCP ☐ Hallucinogens
☐ Cocaine ☐ Sedative/Hypnotic ☐ Benzodiazapines ☐ Spike, Synthetic Marijuana
☐ Prescription drugs ☐ Amphetamines ☐ Inhalant: Sniffing Glue/Other Household Product
☐ Other:_____Inpatient Rehab?_____

Physical Health/Wellness

Check off any of the following that apply:

☐ Incontinent ☐ Impaired Walking ☐ Requires Special Medical Equipment
☐ Hard of Hearing/Deaf ☐ Impaired Vision/Blind ☐ Lung Problems
☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure
☐ Chronic Pain ☐ Weight Concern ☐ Cognitive Impairment
☐ Speech Impairment ☐ Developmental Disorder ☐ Traumatic Brain Injury
☐ Learning Disability ☐ Other: _____

Financial Section: Income And Insurance Status

Income and Insurance	Now Receives	Income and Insurance	Now Receives
No Income	☐	Wages/Earned Income	☐
SSI	☐	Unemployment/Amount_____	☐
SSD	☐	Child Support Owed or Received $_____	☐
Temporary Assistance	☐	Worker's Comp	☐
Veterans benefits	☐	Social Security Retirement	☐
Medicare	☐	Pension/Amount:_____ Source _____	
Medicaid	☐	Trust Fund	☐
Food Stamps	☐	Special Needs Trust	☐
Other, Describe:_____		Private Insurance/Third Party Payer	☐

Name_____

Alerts Related To Risk To Self Or Others

	Yes	No	Date of most recent episode
History of Homelessness			
Victim of Physical/Sexual Abuse			
History of Domestic Violence in Home			
Chronic Self-Harm/Self-Mutilation			
History of Suicidal Ideation			
History of Suicide Attempts /Self Harm			
Elaborate on Other Serious Attempts			
Arson			
Physically Abusive and/or Assaultive of Another			
Sexually Assaultive Behavior			
Destruction of Property			
Current Access to Firearms			
Criminal Justice Involvement			
AOT Order			
AOT Enhanced			

Reason For Referral

Precipitating Events Leading up to Referral:

_____

_____

Current Symptoms:

_____

Desired Outcome of Care Coordination or Residential Services:

_____

_____

Strengths:

_____

_____

Please Specify Discharge Linkages:

_____

_____

Please Note Anything You Have Questions About Regarding Your Plan:

The individual requesting services agreed to submit this application □ **YES** □ **NO**

The individual requesting services agreed to review by the SPOA Team and Potential Providers. □ **YES** □ **NO**

Individual, i.e. Applicant's Signature: _____

Date: _____

Onondaga County SPOA Team

Call: 315-435-3355 x4695;

Valerie Flanagan, x4695, Jennifer Feliciano x4997, Jan Moag x4696

Name_____

County of Onondaga
Department of Adult & Long Term Care Services
Aging • Mental Health • NY Connects • Protective Services for Adults • Veterans
John H. Mulroy Civic Center, 10th Floor
421 Montgomery Street, Syracuse, NY 13202
www.ongov.net

Joanne M. Mahoney
County Executive

Lisa D. Alford, MA
Commissioner

Onondaga County Mental Health SPOA (Adults)
2018 Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.
2. The person whose information may be used or disclosed is:

   Name: _____ **Date of Birth:** _____
3. The information that may be used or disclosed includes: Mental Health/Alcohol Drug/Health Treatment Records
4. This information may be disclosed by: The persons or organizations listed in **Attachment A** and/or the following persons/ organizations that provide services to me:_____
5. This information may be disclosed to: Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.

   ☐ The persons or organizations listed in bold in Attachment A or ☐ the following persons or organizations: _____
6. The purposes for which this information may be used and disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Onondaga County Mental Health;
   - Delivery of services, including care coordination, case management and OMH (Office of Mental Health Residential& Housing Services
   - Payment for services; and Health Care Operations such as quality assurance.

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that

not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. This permission expires (check applicable box):

☐ One year from today on _____ ☐ Upon the acceptance for services on _____

9. I specify permission for the following time period:

☐ Permission only applies to records for the following time period: _____ to _____

☐ Other limitation: _____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as des this document.

_____ _____

Signature **Date**

If applicant is under the age of 18 and/or has a legal guardian: I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is: _____.

I give permission to use and disclose my records as described in this document.

Signature_____ Date_____

Print Name_____