COUNTY OF WAYNE
DEPARTMENT OF MENTAL HYGIENE
WAYNE BEHAVIORAL HEALTH NETWORK

WAYNE BEHAVIORAL HEALTH NETWORK
ADULT SPOA REFERRAL PACKET

Packet must be completely filled out or committee cannot review it. The SPOA consent is mandatory unless the severity of the client's illness interferes with their ability to give consent (in this instance review will be done on an anonymous basis with no identifying information to be shared with SPOA Committee members).

1) Fill out the SPOA Referral
2) Fill out SPOA Determination check list and sign it
3) Explain SPOA Committee purpose and process to the client as noted below
4) Client then should sign the SPOA Consent for release of information
5) Pages 2, 3 and 4 and 5 of Notice of Privacy Practices for SPOA should be provided to each client referred to SPOA, page 6 to be signed by client and attached to referral
6) Please keep a copy of referral in the client's chart

Purpose: To review request for supportive services such as case management and residential options i.e.…Unity Forensic Housing, Lakeview (community residence, MICA independent housing, treatment apartments and independent housing.) and Elmira Psychiatric Centers, Family Care. Housing referrals require the approval of Wayne County SPOA Committee and admissions into these housing programs are reported to the Office of Mental Health on a quarterly basis, as are admissions to all levels of Case Management. OMH housing requires that the client meet SPMI criteria, so please review SPMI status to ensure that our priority population (SPMI) receive supportive services/residential services. (If the client is seeking independent housing ie…apartment, Section 8, or DSS housing then SPOA does not need to receive a referral).

Process: Once the SPOA Coordinator has received the completed referral packet, Coordinator and Mark Reynolds, PhD, SPOA Supervisor, will review the referral for completeness and readiness to present to committee. If more information is needed, the referring agent will be notified. If appropriate, the referral will be scheduled for SPOA Committee Meeting. Adult SPOA Committee meets twice monthly (unless otherwise indicated).

Committee agencies are noted on the consent form please point this out to your client.

The committee will offer recommendations and approve (if appropriate) CM and housing requests or identify other options. The referring agent and client will be informed of committee decisions/recommendations and we look for client feedback and comfort with these decisions/recommendations.

COUNTY OF WAYNE
DEPARTMENT OF MENTAL HYGIENE
WAYNE BEHAVIORAL HEALTH NETWORK

AUTHORIZATION FOR SINGLE POINT OF ACCESS

You have been asked to apply to the Wayne Behavioral Health Network's Single Point of Access (SPOA) in order to receive enhanced mental health services for yourself and/or your child. Use of the SPOA can help you obtain the most appropriate services for you and/or your child.

This notice describes how medical information about you may be used and disclosed and how you can get access to this Information. Please review it carefully

In order for the SPOA to determine what kinds of services will be most helpful to assist you and/or your child, it is necessary for the members of the SPOA to understand all of your and your family's needs, issues, and strengths. In order to evaluate your circumstances, the SPOA needs your consent to review medical, educational, and health records, including, if applicable, HIV status.

Individual clinical mental health records are confidential documents and there are specific rules in the Mental Hygiene Law (Sections 33.13 and 33.16) regarding the release of those records. Generally, the law does not allow release of a clinical mental health record to another party without the consent of the person, or for minor children, the consent of the parent. The clinical record contains material including reports, evaluations, case histories, notes, and possibly even photographs, which deal with the individual's mental health history. If you agree to release the records to SPOA, you should be aware that the SPOA has an obligation to preserve the confidentiality of the records, and cannot release information from the record to other third parties unless it contains your consent, or the release is allowed under Section 33.13 of the Mental Hygiene Law. The information used will be specifically for the purpose of serving the individual (e.g. assessment). Only persons with a need to know personally identifiable information will be allowed access to the materials. If the SPOA has received information from another source with restrictions or conditions, SPOA will use the information only under the conditions established by the other agency of organization.

There are also some specific laws you should know about. Article 27 -F of New York's Public Health Law imposes very stringent restrictions concerning the testing and safeguarding of HIV-related information and imposes severe penalties for any violation. School records (and those of similar educational institutions), are governed by the Family Educational Rights and Privacy Act, and referred to as FERPA. The Public Health Service Act, 42 USC 290ee-3 and 42 USC 290dd-3 are the Federal Laws which prescribe the requirements which must be met before disclosing information which identify, diagnose, or describe treatment of a person who abuses alcohol and/or drugs. These laws, too, provide substantial sanctions for violations of confidentiality.

The Federal Health Insurance Portability and Accountability Act requires that, generally, your written authorization be obtained before the SPOA can use your health information or share it with others who are not part of the SPOA. There are some situations, however, when we do not need your written authorization before using your health information or sharing it with others:

Treatment

- SPOA may share your health information with health service providers who are working with of you, and they may in turn use that information while providing services to you.

Business Operations

- SPOA may use your health information or share it with others in order to conduct normal business operations. For example, we may use your health information to evaluate the performance of the SPOA or to help educate our staff on how to improve the care they provide for you.

Appointment Reminders, Treatment Alternatives, Benefits and Services

- SPOA may use your health information when we contact you with a reminder that you have an appointment with the SPOA or a service provider.
- SPOA may use your health information for the purpose of assisting you to obtain treatments, or other services you need.

Emergencies

- SPOA may use or disclose your health information in an emergency.

Friends and Family

- If you do not object, SPOA may share your health information with a family member, relative or close personal friend who is involved in your care.

As Required by Law

- SPOA may use or disclose your health information if required by law to do so. We will notify you of these uses and disclosures if notice is required by law.

Victims of Abuse, Neglect or Domestic Violence

- We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities

- SPOA may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility.

Lawsuits and Disputes

- SPOA may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute.

Law Enforcement

- SPOA may disclose your health information to law enforcement officials for the following reasons:
    - To comply with court orders or laws;

- Identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime;
- Your death resulted from criminal conduct;
- To report a crime that occurred on our property; or
- To report a crime discovered during an offsite medical emergency.

To Avert a Serious Threat to Health or Safety

- SPOA may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

National Security and Intelligence Activities or Protective Services

- SPOA may disclose your health information to authorized deferral officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Inmate and Correctional Institutions

- If you are an inmate, or you are detained by a law enforcement officer, SPOA may disclose your health information, if necessary, to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors

- In the unfortunate event of your death, SPOA may disclose your health information to a coroner or medical examiner.

Exception if Information Does Not Identify You

- SPOA may use or disclose your health information if we have removed any information that might reveal who you are.

Research

- In most cases, SPOA will ask for your written authorization before using your health information or sharing it with others in order to conduct research.

How to Access Your Health Information

- You generally have the right to inspect and copy your health information.

How to Correct Your Health Information

- You have the right to request that SPOA amend your health information if you believe it is inaccurate or incomplete.

How to Keep Track of the Ways Your Health Information has been Shared with Others

- You have the right to receive a list from SPOA, called an "accounting list," which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on the list, but the list will identify non-routine disclosure of your information.

How to Request Additional Privacy Protections

- You have the right to request further restrictions on the way SPOA uses your health information or shares it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

How to Request More Confidential Communications

- You have the right to request that SPOA contact you in a way that is more confidential for you, such as at work instead of at home.

How to Obtain a Copy of This Notice

- You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically.

How to Obtain n a Copy of Revised Notices

- We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices.

How to File a Complaint

- If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health Human Services.

Your health information will not be used for the following by the SPOA:

Payment

- There is no charge to you for the SPOA.

Fundraising

- Your health information will not be used by the SPOA for fundraising purposes.

COUNTY OF WAYNE
DEPARTMENT OF MENTAL HYGIENE
WAYNE BEHAVIORAL HEALTH NETWORK

I have received a copy of the information entitled **Authorization For Single Point of Access** and have had an opportunity to read it or have it read to me. I have also had the opportunity to ask questions about it.

I want my needs and/or my child's needs, issues and strengths to be reviewed by SPOA, and understand that in order for SPOA to accurately assess those needs, mental health records, education records, and medical records may need to be reviewed by the SPOA.

SIGNATURE_____

RELATIONSHIP_____

DATE_____

Adult Residential Services Descriptions

Thank you for your interest in referring to the Mental Health residential programs of Wayne County. This referral form accesses several programs. The following information should assist you in choosing an appropriate level of care and with submitting the required information.

Wayne County offers three licensed agencies that operate residential programs certified by the Office of Mental Health (OMH). **Elmira Psychiatric Center's Family Care Program, Lakeview Mental Health Services and Unity House of Auburn**. For individuals to qualify for these programs they must meet the following initial criteria.

- They must be diagnosed with a primary mental illness.
- They must be at least 18 years old.
- They must be impaired in several areas of functioning and meet the **SPMI** eligibility requirements.
- They must be willing to participate in the services that are offered.
- They may have a **secondary** drug and alcohol diagnosis, if they are willing and motivated to work towards abstinence.

Community Residence: Lakeview offers a community residence program **providing 24-hour staffing** patterns to enrolled residents. Participants must be eligible for Medicaid and Cash Assistance or SSI/SSD. Participants receive support to work on rehabilitation plans to develop/maintain skills to live more independently. The community residence program is transitional with time-limited lengths of stay.

Treatment Apartment Programs: Lakeview offers a Treatment Apartment Program that provides a variety of staffing patterns; but **does not include 24 Hour supervision**. Participants must be eligible for Medicaid and Cash Assistance or SSI/SSD. These are single settings for one individual. Individuals work on rehabilitation plans to develop/maintain skills to live more independently. These programs are transitional with time-limited lengths of stay.

Supportive Housing: Lakeview offers a Supportive Housing Program providing assistance to eligible participants with obtaining **independent** affordable housing. Staff has contact with individuals on an at least monthly basis to support identified housing related needs. This program assists the individual in finding and maintaining independent housing for self and qualifying family members in the community. Rental and/or alternate approved financial assistance may be provided for eligible individuals. This is a long-term program for most individuals. Participants **must have an established income**, be eligible for Section 8 and be willing to apply for additional Federal/State subsidized housing programs as available/eligible.

MRT Housing (Medicaid Redesign Team): Lakeview offers Supportive Housing supports to individuals, for whom housing supports would avoid hospital, inpatient or long term residential stays: Identified participants must meet at least one (1) of the following eligibility criteria .

• Individuals with a serious mental illness identified as high users of Medicaid in need of supported housing who are referred by Health Homes.

• Individuals with a serious mental illness who are residents of NYS OMH Psychiatric Centers or OMH-operated residential programs.

• Individuals residing in NYS who have a mental illness and who are high users of Medicaid Services.

• Individuals with a serious mental illness who are being discharged from an Article 28 hospital or Article 31 hospital and in need of supported housing or for whom housing would assist in a hospital diversion

Family Care: Elmira Psychiatric Center offers family care services in Wayne and surrounding counties. This program is for individuals suffering from mental illness who benefit from daily oversight and smaller supportive settings. There are one to four residents per home. Homes cannot offer 24-hour supervision and participants must have ability to stay in the home without supervision for established periods of time. Participants must be eligible for Medicaid and Cash Assistance or SSI/SSD. The Office of Mental Health certifies family Care Providers; service recipients receive guidance and oversight with gaining/maintaining skills to function independently on a more regular basis. Participants are expected to attend some type of day program and must be medication compliant. There is no time limit on how long a resident may stay in the program.

Forensic Supported Housing:

Unity House of Auburn offers a Supported Housing Program serving individuals who are coming out of jail, have a Substance Abuse history or are not eligible for subsidized housing and section 8 due to legal/judicial status. Staff has contact with individuals on an at least monthly basis to support identified housing related needs. Participants must have an established income and be willing to apply for additional Federal/State subsidized housing programs as available/eligible.

Adult SPOA Referral Form

Wayne Behavioral Health Network

1519 Nye Road

Lyons, New York 14489

PHONE: 315-946-5722

FAX: 315-946-7066 ATTN: SPOA Coordinator

Date of Referral_____ Date Received by SPOA_____

Name_____ **Date of Birth**_____
Address_____ **SS#**_____
_____ **Sex M**____ **F**_____
Phone _____ **Medicaid #** _____

Marital Status

Single____ Married____ Divorced_____ Widowed____ Separated____ Unknown____

Emergency Contact

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

Referral Data Source

Name_____Title_____

Phone_____ Agency_____

County of Origin_____

Reason for Referral: Please provide a detailed description of the person's needs as they relate to the particular services requested below. If client has custody of children, please provide sex and age of each. This greatly impacts the housing that is required to house the client.

_____

_____

_____

_____

Please check services needed:

☐ **Care management** ☐ **Assertive Community Treatment (ACT)** ☐ **Residential Services**

If Residential: What level of care does the client require? See page 12 for ADL's

Please circle one: **LOW** **MEDIUM** **HIGH** **Meds dispensed** ____ **yes** ____ **no**

RISK INDICATORS

	YES	NO	UNKNOWN
Client is SPMI (see pg 11)	☐	☐	☐
Danger to Self	☐	☐	☐
Danger to Others	☐	☐	☐
Lacks Safe Secure Residence	☐	☐	☐
Victim of Neglect/Abuse	☐	☐	☐
Forensic/PINS	☐	☐	☐
Chemical Dependency	☐	☐	☐
Developmental/Learning Disabled	☐	☐	☐

PSYCHIATRIC HISTORY

Primary Diagnosis_____ **Code**_____

Secondary diagnosis(s) _____

Date Given_____ **By whom**_____

Primary Therapist _____ **Phone**_____

Present Psychiatrist _____ **Phone**_____

Present Care Manager _____ **Phone:**_____

Mental Health Service Utilization in Past 12 Months

#of Psych ED visits_____ #of Outpatient MH Admissions_____

#of Inpatient Psych. Admissions_____ #of days_____

Previous psychiatric treatment/hospitalizations **(Must provide facilities and dates)**_____

_____

_____

Behavior/circumstances precipitating most recent hospitalization_____

_____

_____

Signs/symptoms of decompensation (please be specific)_____

_____

_____

MEDICAL HISTORY

Primary Care Physician_____ **Phone**_____

_____

Current Medications **Dose** **Frequency** **Prescribing MD**

_____

_____

_____

_____

Allergies ____**Yes** ____**No** ____**Unknown** **If yes, please specify**_____

_____

Physical Diseases & Disabilities_____

_____

Functional Medical Problems (check all that apply)

( )None ( )Incontinent ( )Impaired ability to walk ( )Impaired vision

( )Hearing impairment ( )Requires special medical equipment ( )Other Medical

Please Explain_____

History of psychiatric inpatient/outpatient care:

Hospital/Agency **From (M/Y)** **To (M/Y)**

_____

_____

_____

Other Agencies Involved_____

_____

_____

Please note:

You must attach any available clinical information that will clearly show that the applicant meets the SPMI eligibility including:

Strength Assessment	**Health Assessment**	**Diagnosis/Mental Status**
Psychiatric Assessment	**Psychological Testing**	**History/psych social**
Education Records	**Current Treatment Plan**	

Client's Name _____ DOB _____

CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMONG ADULTS

In order to be considered an adult with a serious and persistent mental illness, "1" below must be met, in addition to either "2", "3", or "4":

1. **Designated Mental Illness**

___ **YES** ___ **NO** The individual is 18 years of age or older and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM-IV are also included mental illness diagnoses.

AND

2. **SSI or SSDI due to Mental Illness**

___ **YES** ___ **NO** The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

OR

3. **Extended Impairment in Functioning due to Mental Illness**
   a. Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:
      i. ___ **YES** ___ **NO** Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care or complying with medical advice).
      ii. ___ **YES** ___ **NO** Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
      iii. ___ **YES** ___ **NO** Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
      iv. ___ **YES** ___ **NO** Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

OR

4. **Reliance on Psychiatric Treatment, Rehabilitation and Supports**
   ___ **YES** ___ **NO** A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

Form completed by

Signature:_____ Date:_____

Wayne County Mental Health Adult SPOA Referral Packet

Community Survival Skills (Check appropriate response)

LEVEL OF CARE:	**LOW**Independent	**MED** Can do with help	**HIGH** Dependent
1. Activities of Daily Living			
Eating			
Dressing			
Grooming			
Toileting			
2. Personal Safety			
Crossing street safely			
Exit in emergency			
Smoking safely			
3. Community Living			
Using public transportation			
Shopping			
Cleaning			
Cooking			
Managing own money			

Provide explanations of the above choices when other than independent:

_____

_____

_____

Living Situation at time of Referral

( ) Lives Alone ( ) Lives with parents ( ) Lives with other relatives ( ) Psychiatric Center

( ) Homeless (street) ( ) Lives with spouse ( ) Assisted/supported living ( ) Correctional Facility

( ) Homeless (sheltered) ( ) Supervised Living ( ) Nursing home/medical setting ( ) Other _____

Length of time in current living situation (yrs/months)_____

Reasons for referral vs remaining in current living situation_____

_____

Does the client need 24-hour supervision? ( ) Yes ( ) No

Any adult history of homelessness? ( ) Yes ( ) No

Ability to tolerate group situations? ( ) Yes ( ) No (explain)_____

Previous residential history (include independent & supervised situations, be specific and provide reasons that those supports are no longer in place_____

_____

Interpersonal skills_____

Social supports_____

Family's interest in supporting this referral & becoming involved in the planning_____

_____

Effective counseling approaches to use with the client_____

_____

Cultural issues that may impact treatment & treatment planning_____

_____

Current Criminal Justice Status ( )Other

( )None ( )Currently incarcerated-prison ( )Currently incarcerated-jail ( )Alternatives to incarceration

( )CPL 330.20 ( )Parole ( )Probation ( )Released from jail/prison in the last 30 days

List of Convictions and dates: (**specific convictions required for housing applicants**)

_____

Contact: Probation/Parole Officer_____ Phone_____

(if applicant is on probation or parole this information is mandatory and must be included)

Current AOT? ( )Yes ( )No if yes, what are the conditions of the order?(treatment orders and effective dates.) _____

Ethnicity

( ) White (non-hispanic) ( ) Latino/Hispanic ( ) Black (non-hispanic) ( ) Native American

( ) Asian/Asian American ( ) Pacific Islander ( ) Other or dual (specify)_____

Current Educational Level ( ) Vocational, business training ( ) No formal education

( ) Some grade school 1-8th grade ( ) Some HS 9-12th, but no diploma ( ) GED ( ) HS Grad

( ) Some college, but no degree ( ) College Degree ( ) Masters Degree ( ) Ungraded

Current Employment Status

( ) Employed full-time ( ) Employed part-time ( ) Not Employed ( ) Training Program ( )Other_____

Primary Language

( )English ( )Spanish ( )Chinese ( )Creole ( )Hindi ( )No Language

( )French ( )Russian ( )Greek ( )Vietnamese ( )American Sign Language

( )Italian ( )German ( )Urdu ( )Other_____

English Proficiency (if primary language is other than English)

( )Does not speak English ( )Poor ( )Fair ( )Good ( )Excellent

Custody Status of Children (check all that apply)

( )No children ( )Have children all > 18 years old ( )Minor children currently in client's custody

( )Minor children not in client's custody but have access ( )Minor children not in client's custody-no access

Current or Last Services (check all that apply)

( )No prior service ( )MH residential ( )Case Management ( )Prison, Jail

( )State Psychiatric Center (Inpt) ( )MH outpatient ( )General hospital ( )Court

( )Emergency MH (nonresidential) ( )Local MH practitioner ( )CSP MH program

If no current services, specify date of last services_____

Use/Engagement with Mental Health Services (taking medications, making appointments, adherence to regimen/programs)

( )Independent-requires no assistance ( )Can do with help ( )Dependent ( )Rejects Services

Does the client understand and accept the need for prescribed medications? ( )Yes ( )No

Rate client compliance with medication regime:

( )Independent ( )with prompting ( )Needs assistance ( )Resistive

Rate client follow through with mental health appointments:

( )Independent ( )With prompting ( )Needs assistance ( )Resistive

Cognitive impairment? ( )Yes ( )No

Explain: _____

Details of compliance with treatment over the last 12 month period:(mandatory for housing applicants)

_____

_____

_____

Does The Client Have A History Of Any Of The Following?

			If Yes, Date
Fire setting	( )Yes	( )No	_____
Sexual offense (rape, pedophilia)	( )Yes	( )No	_____
Violent acts causing injury or using weapons	( )Yes	( )No	_____
Aggressive/assaultive behavior	( )Yes	( )No	_____
Suicidal ideation	( )Yes	( )No	_____
Suicide attempts/gestures	( )Yes	( )No	_____
Destruction of property	( )Yes	( )No	_____

If you answered **yes** to any of the above, please describe the circumstances_____

_____

_____

Outpatient Services Current or Planned (check all that apply)

	Current	Planned		Current	Planned
Health			Psychiatrist/Clinic		
Education			Alcohol/Drug Treatment		
Day Treatment Program			AA/NA		
Psychiatric Day Program			Case Management		
Vocational Services			ACT		
Community Residence			Family Support Services		
Halfway House			Children's ICM		
Adult Care Facility			Respite Services		
Child Preventative Services			Child Residential Treatment		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		

Indicate the client's willingness to participate in Day Program

( )Independent ( )With prompting ( )Needs to be taken to program ( )Rejects Services

Substance Abuse History

Does the client have a history of drug/alcohol abuse/dependency? ( )Yes ( )No

If yes, at what age did abuse begin? _____ Date of last chemical use_____

Drugs of choice (check all that apply)

( )None ( )Cocaine ( )Amphetamines ( )Prescription Drugs ( )Any IV drug use

( )Crack ( )PCP ( )Inhalant: sniffing glue ( )Alcohol ( )Heroin/Opiates

( )Sedative/hypnotic ( )Marijuana/Cannabis ( )Hallucinogens ( )Benzodiazepines ( )Other_____

Drug Use

( )None in the past month ( )1-3 times in past month ( )1-2 times/week ( )3-6 times/week ( )daily

Longest Period of Sobriety_____

Does the client smoke cigarettes? ( )Yes ( )No If yes, how many per day?_____

Chemical Dependency Treatment ( )Yes ( )No If yes, ( )Inpatient ( )Outpatient

Dates_____

_____

Chemical Dependency Service Utilization in past 12 Months

Number of Outpatient CD admissions _____ Number of Inpatient CD admissions _____

Number of out of County CD admissions _____ Number of days _____

If client is currently in a chemical dependency treatment program, do you know the anticipated date of discharge? _____

Current Provider for SA treatment. (Mandatory for housing application process; please notify applicant that information will be requested from providers as part of the eligibility process and additional releases of information will be requested as necessary.)

Provider Name:

Address:

Phone: **Fax:**

(Please attach a copy from the current SA treatment provider as available. (Psych- social, treatment plan and psychiatric evaluation.)

FUNDING VERIFICATION FORM

Client Name_____

	Case #	$$ Amount Received	Pending Application Submitted	Unknown
Social Security				
SSI				
SSD				
Public Assistance				
Veteran's Benefits				
Medicare				
Medicaid				
Food Stamps				
Pension				
Wages/Earned Income				
Unemployment				
Private Insurance				
Other 3rd Party Payer				
Trust Fund				
Medication Grant				

Court mandated expenses/debt (i.e. alimony, child support, student loans, utility bills). Please list all known and amounts_____

_____

Other resources (circle all that apply) Checking, Saving, Certificates of Deposit, Retirement Accounts, Mutual Funds, Burial Funds, Stocks, Bonds, Life Insurance, Motor Vehicle(s), Property, Other

SOCIAL SECURITY ADMINISTRATION

Consent for Release of Information

To: Social Security Administration

_____ _____ _____

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information about me to:

Name **Address**

_____

_____

_____

I want this information released because:_____

_____

_____

(There may be a charge for releasing information)

Please release the following information:

_____ Social Security Number

_____ Identifying Information (includes date and place of birth, parent's names)

_____ Monthly Social Security benefit amount

_____ Monthly Supplemental Security Income payment amount

_____ Information about benefits/payments I received from _____ to _____

_____ Medical Records

_____ Record(s) from my file (specify)_____

_____

_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation, which I know is false to obtain from Social Security records, I could be punished by a fine or imprisonment of both.

Signature_____

(Show signatures, names and addresses of two people if signed by mark.)

Date_____ Relationship_____

Wayne County Mental Health
Adult Single Point of Access (SPOA) Services
PERMISSION TO RELEASE INFORMATION

I hereby authorize the use or disclosure of my protected health information as follows:

Client Name_____

Social Security #_____ Date of Birth_____

The information that may be used or disclosed includes (check all that apply):

( ) Mental health records ( ) Alcohol/Drug records ( ) School or education records

( ) Health records ( ) All of the records listed above

The information may be disclosed by:

( ) Any person or organization that possesses the information to be disclosed

( ) Any persons from, Lakeview Mental Health, Unity House of Cayuga County, Elmira Family Care FLACRA or Health Homes of Upstate NY (HHUNY)

( ) East House Corporation

( ) The following persons or organizations:

_____ _____

The information may be disclosed to Wayne County Mental Health and its contract agencies providing residential or case management services or other community agencies that may contribute to planning for my care.

The purpose of disclosure is to assist in my care and to obtain payment for my care from insurance companies, government benefit programs and others participating in the residential or case management services.

This permission will be valid during the SPOA application and waiting list process and when receiving residential or case management services. This permission expires upon completion of services.

It is understood that this permission may be revoked. To revoke this permission, a written request should be made to the provider(s) listed above. Information disclosed before permission is revoked may be not retrieved. If action was taken in reliance on this permission, the person who relied on this permission may continue to use or disclose protected health information as needed to complete the work that began because this information was given.

Psychiatric and chemical dependency information is protected under Federal and State regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further release of information is prohibited by law. If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations the information indicated above could be re-disclosed. The release of HIV-related information requires additional authorization from the person whose records will be used or disclosed. I understand and agree to this authorization.

_____ _____ _____

Print Name Date Signature

_____ _____ _____

Witness Print Name Date Signature

SPOA CONSENT FOR RELEASE OF INFORMATION (Adult)	Patient's Name (Last, First, M.I.) …….. Sex…… Date of Birth…… **WAYNE BEHAVIORAL HEALTH NETWORK**

Part I – Consent To Release Information

Purpose or Need for Information

To enable Single Point of Access Committee members to collaborate in assisting me to develop a service plan and to access needed services.

Extent or Nature of Information to be Disclosed

Mental Health records of _____ maintained by the agencies named below. Records of services provided by the agencies named below to the extent they are relevant to mental health services provision.

From:	**To:**
Wayne Behavioral Health Network	Wayne Behavioral Health Network
Wayne County Dept. of Social Services	Wayne County Dept. of Social Services
NYS Office of Mental Health	NYS Office of Mental Health
Finger Lakes Addictions Counseling & Referral Agency	Finger Lakes Addictions Counseling & Referral Agency
Lakeview Mental Health Services	Lakeview Mental Health Services
Clifton Springs Hospital & Clinic	Clifton Springs Hospital & Clinic
ViaHealth of Wayne	ViaHealth of Wayne
Elmira Psychiatric Center	Elmira Psychiatric Center
DePaul Mental Health Services	DePaul Mental Health Services
Rochester Psychiatric Center	Rochester Psychiatric Center
Wayne County Compeer	Wayne County Compeer
Unity House	Unity House
Wayne County Action Program	Wayne County Action Program
Wayne ARC	Wayne ARC
Finger Lakes DDSO	Finger Lakes DDSO
HHUNY Health Homes of Upstate NY	HHUNY Health Homes of Upstate NY

I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. **I also understand that I have the right to cancel my permission to release information at any time.**

My consent to release information to the person/organization/facility/program identified above, will expire when I am no longer receiving services from such person/organization/facility/program, or one year from this date, whichever occurs first.

Signature of Patient/Person acting for patient	Relationship	Date Signed
Signature of Witness	Title	Date Signed

Wayne Behavioral Health Network
1519 Nye Road, Lyons, NY 14489
315-946-5722 315-946-7066 (Fax)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize that the requested information may be ☐ released to: ☐ received from: ☐ released to & received from:

Name of person/provider/organization or facility	**Contact name for provider/organization or facility**
Address	**City, State, Zip Code**
(_____)_____ Phone	**(_____)_____ Fax**

Purpose of the request: ☐ **Health Care Insurance Coverage** ☐ **Housing** ☐ **Disability Determination** ☐ **Coordination of Treatment** ☐ **Continuity of Care** ☐ **Discharge Planning** ☐ **Other: _____**

Specific Information Authorized for Release: ☐ **Assessments** ☐ **Psychiatric Evaluation** ☐ **Treatment Plans** ☐ **Discharge Summary** ☐ **Medical Records** ☐ **Physical Exam** ☐ **Laboratory tests and x-ray reports** ☐ **Diagnostic test reports** ☐ **School Reports** ☐ **Court Ordered Evaluation** ☐ **Other: _____**

ONE-TIME USE/DISCLOSURE: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility identified. **My authorization will expire:**

☐ When the requested information has been sent/received ☐ 90 days from this date of my signature

☐ Other: _____

OR

PERIODIC USE/DISCLOSURE: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire:**

☐ When I am no longer receiving services from WBHN ☐ One year from this date of my signature

☐ Other:_____

I (patient or representative) understand that:

- **I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.**
- **I may cancel this authorization at any time by submitting a *written* request to Wayne Behavioral Health Network, except where a disclosure has already been made in reliance on my prior authorization.**
- **If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.**
- **If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.**
- **Release of HIV-related information requires additional authorization.**
- **If the medical record information is not sent to another care provider, there may be a charge for the requested records.**

Signature of Patient or Representative_____ Date_____

Relationship to Patient (*if signed by other than patient)* ☐ Legal Guardian / Parent ☐ Other_____

Witness:_____ Date: _____

Relationship:_____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION:
I hereby withdraw authorization to release information effective: _____
Signature of Patient or Representative for revocation: _____