

Livingston County Adult Single Point of Access (A-SPOA) - APPLICATION

Applicant's NAME: _____ Applicant's DOB: _____

INSTRUCTIONS: To access services available through A-SPOA, complete both: (1) A-SPOA Application and (2) Universal Consent for Release of Information. For detailed instructions on how to complete forms, please refer to Instructions for Application and/or the Instructions for Universal Consent for Release of Information located at: www.livingstoncountyny.gov/898/Referral-Forms

SUBMISSION: Submit completed Application and Universal Consent for Release of Information to: amberhaaney@livingstoncountyny.gov

QUESTIONS: Contact A-SPOA Coordinator at: Phone: (585) 243-7811 · Fax: (585) 243-7264 · Email: amberhaaney@livingstoncountyny.gov

----- This document is best suited for Adobe Acrobat Reader. Download here: <https://get.adobe.com/reader/otherversions/> -----
Use **TAB** button to toggle forward through Application. Use **SHIFT + TAB** to toggle backwards.

PROGRAM SELECTION – Programs and/or Services the Applicant is Requesting (select all that apply)

<p style="text-align: center;"><u>CARE MANAGEMENT</u></p> <p><input type="checkbox"/> Medicaid Care Management</p> <p><input type="checkbox"/> Non-Medicaid Care Management</p>	<p style="text-align: center;"><u>RESIDENTIAL</u></p> <p><input type="checkbox"/> OMH Certified Apartment Treatment Program (CAP)</p> <p><input type="checkbox"/> OMH Supportive Housing – Apartment Program</p> <p><input type="checkbox"/> Empire State Supportive Housing Initiative (ESSHI)</p>
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SECTION 1 – APPLICANT INFORMATION

1. Full Name		2. Date of Birth (MM/DD/YYYY)		3. Gender Identity	
4. Currently Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Eviction	5. Current Residence				
		<input type="checkbox"/> Private Home/Apartment	<input type="checkbox"/> Emergency Housing	<input type="checkbox"/> Inpatient Setting	
		<input type="checkbox"/> Community Residence	<input type="checkbox"/> Substance Use Facility	<input type="checkbox"/> Couch Surfing	
		<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Other (describe): _____		
6. Physical Address			7. Mailing Address (if different from physical address)		
8. Phone [(area code) xxx-xxxx]		9. Do you have full custody of at least one (1) child under the age of 18? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		10. Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Primary Language(s)
12. Financial Status/Income Status <i>Check all that apply</i> <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> SSD \$ _____ <input type="checkbox"/> VA \$ _____ <input type="checkbox"/> Public Assistance \$ _____ <input type="checkbox"/> Other \$ (Source) _____		13. Health Insurance <i>Check all that apply</i> <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid CIN #: _____ <input type="checkbox"/> Veteran's <input type="checkbox"/> Medicare #: _____ <input type="checkbox"/> Uninsured <input type="checkbox"/> Other _____		14. Ethnicity <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> African American / Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Native American <input type="checkbox"/> Other, Specify: _____	
15. Current Representative Payee <input type="checkbox"/> Yes. If so, who? _____ <input type="checkbox"/> No			16. Alternative Contact (Name, Phone Number with Area Code, Relationship)		
17. Applicant's Reason for Applying for Services:					

SECTION 2 – REFERRER'S INFORMATION

18. Referrer Name		19. Referrer Title	
		20. Referrer Agency	
21. Referrer Mailing Address		22. Referrer Email	
		23. Referrer Phone	24. Referrer Fax

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25. Referrer's Reason for Applying for Services:

SECTION 3 – DIAGNOSTIC AND CURRENT TREATMENT INFORMATION

26. Diagnosis(es) (Mental Health, Substance Use Disorder, Medical, Intellectual)

27. Current MENTAL HEALTH Treatment Provider(s)

None/Not Applicable

Name of Provider _____

Agency _____

Address _____

Phone _____

Email _____

28. Current SUBSTANCE USE Treatment Provider(s)

None/Not Applicable

Name of Provider _____

Agency _____

Address _____

Phone _____

Email _____

SECTION 4 – OTHER SERVICE PROVIDERS

29. Primary Care Physician

None/Not Applicable

Name of Provider _____

Agency _____

Address _____

Phone _____

Email _____

30. Current Care Management Services

None/Not Applicable

Name of Provider _____

Agency _____

Address _____

Phone _____

Email _____

SECTION 5 – HIGH RISK ALERTS

31. Check all that apply

- Suicide Attempt(s) Medication non-compliance Chronic Physical Health Conditions
- Suicidal Threats Appointment attendance non-compliance Homelessness - current
- Fire Setting Frequent Crisis Requiring Readmission Homelessness – historic
- Violent History / Assault Inappropriate sexual behaviors Victim of Physical / Sexual Abuse
- Self-Injurious Behavior Other (specify): _____

For any items checked, please provide details (dates and brief explanation, if available): _____

32. Assisted Outpatient Treatment (AOT) Status

- Current AOT Order / Recipient Yes No Unknown
- AOT Candidate (in process) Yes No Unknown

SECTION 6 – CRIMINAL JUSTICE STATUS

33. Indicate if any current - or past - history – check all that apply:

- Probation – Expires: _____ No Legal History
- PO Name: _____ CPL Status (\$330.90)
- Parole – Expires: _____ Order of Protection
- PO Name: _____ Conviction of a Crime
- Charges Pending (active)

For any items checked, please provide details (dates and brief explanation, if available): _____

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SECTION 7 – TREATMENT HISTORY	
<p>34. Mental Health Treatment</p> <p><input type="checkbox"/> None/Not Applicable</p> <p>Inpatient Treatment History <i>(include dates, facility names)</i></p> <p>Outpatient Treatment History <i>(include dates, facility names)</i></p>	<p>35. Substance Use Treatment</p> <p><input type="checkbox"/> None/Not Applicable</p> <p>Inpatient Treatment History <i>(include dates, facility names)</i></p> <p>Outpatient Treatment History <i>(include dates, facility names)</i></p>
<p>36. Number of Emergency Department visits in 12 months prior to referral:</p>	
SECTION 8 – ADDITIONAL INFORMATION	
<p>37. Please include any additional information, pertinent to this application for SPOA services, not otherwise specified:</p>	
SECTION 9 – CARE MANAGEMENT SERVICE SELECTION	
<ul style="list-style-type: none"> ❖ Medicaid Health Home & Health Home Plus ❖ Non-Medicaid Care Management 	
<p>38. What does Care Management do for you?</p> <p>Once enrolled, you will be assigned a Care Manager who will work with you to create a personal care plan based on your needs. Some of the services may include:</p> <ul style="list-style-type: none"> A. Connecting to health care, mental health, and/or substance use treatment providers B. Connecting to needed medications, social services, and/or other community programs 	
<p>39. Do I qualify?</p> <p>Medicaid-eligible adults and children with a chronic medical and/or behavioral health condition(s):</p> <ul style="list-style-type: none"> A. Two or more chronic conditions <i>(e.g., Substance Use Disorder, Asthma, etc.)</i> OR B. One single qualifying condition <ul style="list-style-type: none"> i. HIV/AIDS OR ii. Serious Mental Illness (SMI) (Adults) OR iii. Serious Emotional Disturbance (SED) or Complex Trauma(Children) <p>Substance Use Disorders (SUD) do not, by themselves, qualify an individual for Medicaid Health Home services and can be used to qualify individuals in conjunction with another chronic condition.</p> <p>For more detailed information: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf</p>	
<p>40. Housing Programs Options <i>(Select ONE, if applicable)</i></p> <p>Housing Services:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Lakeview Health Services Supportive Housing <input type="checkbox"/> Arbor Housing and Development Supportive Housing <input type="checkbox"/> DePaul Support Housing <input type="checkbox"/> Sky Bird Landing Supportive Housing </div> <div style="width: 45%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Lakeview Treatment Apartment Program <input type="checkbox"/> No Preference (A-SPOA will select based on availability) <input type="checkbox"/> None / Not applicable <input type="checkbox"/> Other: </div> </div>	
<p>41. Care Management Options <i>(Select ONE, if applicable)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Health Homes of Upstate New York <input type="checkbox"/> None/ Not applicable 	
<p>----- Signature is not required on this document ----- End of Application ----- Submit to: amberhainey@livingstoncountyny.gov-----</p>	

Livingston County Adult Single Point of Access (A-SPOA) – UNIVERSAL CONSENT for RELEASE OF INFORMATION

Individual's NAME: _____

Individual's DOB: _____

This authorization must be completed by the referred individual or their legal guardian/personal representative.

This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42, Part 2 of the *Code of Federal Regulations (42 CFR Part 2)* that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and Protected Health Information (PHI) between, Livingston County Single Point of Access (SPOA) Team (comprised of Livingston County Mental Health Department staff), **Other Providers** (see attached list of Providers on page 2) which comprise the **SPOA Committee; AND the Referral**

Name & Address of Referral Source: _____

DESCRIPTION OF INFORMATION to be used / disclosed and re-disclosed **(check ALL that apply):**

- ALL listed below**
- Mental Health/Psychosocial Assessment
- Psychiatric Evaluation/Assessment/ Consultation
- Discharge Summary/Treatment Plan
- Psychological &/or Neurological Tests
- Documentation of Medical Necessity
- Referral (including contact info)- required**
- Inpatient/Outpatient Treatment
- Financial &/or Insurance Info
- Medications (past & present)
- Pre-Sentence Investigation Report
- Physical Health (including family planning if applicable)
- Other (specify): _____
- Diagnosis(es)
- HIV/AIDS-related Information
- School Records (including testing)
- Substance Use Evaluation
- Substance Use Diagnosis
- Substance Use Treatment Plan
- Substance Use Medication(s)
- Substance Use Discharge

PURPOSE OR NEED FOR INFORMATION:

Allow SPOA to: consult with and make referrals to appropriate providers; collect and provide documentation (e.g.: discharge planning information) and coordinate care among providers (listed on page 2 of this document); and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- I am applying for services and programs, appropriate to my wants and needs, accessible via the SPOA process.
- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization.
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- I authorize the re-disclosure and digital storage, including Cloud-based services, of the above-described information to the providers identified on page 2 of this document for the purposes identified on this form.
- I have the right to revoke (*take back*) this authorization at any time. My revocation must be in writing on a form provided by Livingston County. I am aware that my revocation does not affect information disclosed while the authorization was in effect.
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain medical treatment nor access to benefits to which I may be eligible.
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524).
- I have been offered a copy of the *Notice of Privacy Practices* and I have the right to request and receive a copy at any time.

I HEREBY PERMIT the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified in this *Universal Consent for Release of Information* as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire:

(Check one)

- When the individual named herein is no longer receiving services accessed through Livingston County SPOA.
- One year from the date of signature.
- Other: _____

I CERTIFY THAT BY SIGNING THIS AUTHORIZATION I acknowledge I have read, understand, and consent to use of the PII and PHI as set forth in this document. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE of Individual or Personal Representative

Printed Name of Individual

Date

Printed Name of Personal Representative (if applicable)

Description of Authority of Personal Representative (e.g. Parent/ Legal Guardian)

SIGNATURE of WITNESS

Printed Name of Witness/Title

Date

Livingston County Adult Single Point of Access (A-SPOA) – UNIVERSAL CONSENT for RELEASE OF INFORMATION

Individual's NAME: _____

Individual's DOB: _____

List of PROVIDERS with which Adult Single Point of Access (A-SPOA) is permitted to exchange information.

- | | |
|---|--|
| Arbor Housing and Development | Rochester Psychiatric Center |
| CASA Trinity | University of Rochester Medical Center |
| Catholic Charities of Steuben/Livingston | VESID |
| Center for Dispute Settlement | Wyoming County Community Health System |
| Chances and Changes Inc. | |
| Compeer West | |
| Community Action of Wyoming County | |
| Depaul Community Services | |
| Genesee Valley BOCES | |
| Health Homes of Upstate New York | |
| Hillside | |
| Lakeview Health Services Inc. | |
| Livingston County Department of Health | |
| Livingston County Department of Social Services | |
| Livingston County Family Court | |
| Livingston County Mental Health Services | |
| Livingston County Office for the Aging | |
| Livingston County Probation | |
| Livingston County Sheriff's Department | |
| Livingston County Youth Advocacy | |
| Livingston/Wyoming Arc | |
| Mental Health Association of Rochester | |
| Noyes Mental Health | |
| NYS Office of Mental Health | |
| Office of Addiction Services and Supports (OASAS) | |
| Office of Housing/Section 8 | |

If not listed above - include AGENCY NAME, ADDRESS AND PHONE NUMBER for:

Mental Health Treatment/Psychiatric Records:

Substance Use Treatment/Records:

Primary Care Practitioner:

Other (***include Alternative Contact***):

Livingston County Adult Single Point of Access (A-SPOA) – UNIVERSAL CONSENT for RELEASE OF INFORMATION

Individual's NAME: _____

Individual's DOB: _____

Livingston County Adult Single Point of Access (A-SPOA) Patient Information Retrieval Consent

The SPOA Committee may get health information, including your health records, through a computer system operated by *HealthConnections*, a Regional Health Information Organization (RHIO). 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.

The SPOA Team and Committee may also get health information through a NYS Office of Mental Health database called *PSYCKES* (Psychiatric Services and Clinical Knowledge Enhancement System). It can contain health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in *PSYCKES*, visit www.psyckes.org.

If you agree and sign this form, SPOA Team and Committee members can access, read, and copy your health information - including all of the health information obtained from the RHIO and/or from *PSYCKES* – needed to arrange your care, manage such care or study such care to make health care better for patients. The health information they see, read and copy 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:

- Alcohol or drug use problems
- Sexually transmitted diseases
- Discharge summaries
- Birth control and abortion (family planning)
- Medication and dosages
- Employment Information
- Genetic (inherited) diseases or tests
- Diagnostic Information
- Living Situation
- HIV/AIDS
- Allergies
- Social Supports
- Mental health conditions
- Substance use history summaries
- Claims Encounter Data
- Clinical notes
- Lab tests

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 you, an appropriate personal representative 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. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your health information and the SPOA Team and Committee must obey these laws and rules.

Please read all of the information on this form before signing it.

I GIVE CONSENT for the SPOA Committee to access ALL of my health information through the RHIO and/or through *PSYCKES* to provide me care or manage my care, to check if I am in a health plan and what the plan covers.

I DENY CONSENT for the SPOA Committee to access ALL of my health information through the RHIO and/or through *PSYCKES*; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

SIGNATURE of Individual or Personal Representative

Printed Name of Individual

Date

Printed Name of Personal Representative (if applicable)

Description of Authority of Personal Representative (e.g. Parent / Legal Guardian)

SIGNATURE of Witness

Printed Name of Witness/Title

Date

Individual's NAME: _____

Individual's DOB: _____

Details About Patient Information and the Consent Process

1. How will SPOA providers use my information?

By signing the *Universal Consent for Release of Information*, SPOA providers can use your health information to coordinate and manage your health care; check if you have health insurance and what it pays for; and study and make health care better for patients. The choice you make does not allow health insurers to see your information, decide whether to give you health insurance, or pay your bills.

2. Where does my health information come from?

Your health information comes from places and people that gave you 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. An example of where this information is accessed is Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). If you have any questions, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider.

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 the HIPAA Privacy Rule – or – "HIPAA" – *Health Information Portability and Accountability Act*).

4. How does SPOA protect health information?

The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose Protected Health Information about them, as well as their rights and the covered entity's obligations with respect to that information.

5. If I agree, who can get and see my information?

Only individuals whom you have authorized are permitted to access and view your health information. For the purposes of SPOA, this may include treatment and services providers who work for SPOA or for a SPOA provider.

6. What if a person uses my information and I didn't agree to let them use it?

If you think someone used your information, and you did not agree to give the person your information, you can contact: Livingston County Mental Health at (585) 243-7250; the NYS Office of Mental Health Customer Relations at (800) 597-8481; or the United States Attorney's Office at (212) 637-2800.

7. How long does the *Universal Consent for Release of Information* last?

The *Universal Consent for Release of Information* is valid until you are no longer receiving/being connected to services accessed through Livingston County SPOA, you revoke (take back) permissions, or as otherwise specified on page 1 of this document.

8. What if I change my mind later and want to take back my consent?

You have the right to revoke (take back) the written consent at any time. The revocation must be in writing on a form provided by Livingston County located here: www.livingstoncountyny.gov/898/Referral-Forms. The revocation of consent does not affect information disclosed while the authorization was in effect. 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.

9. How do I get a copy of this form?

You can request to have a copy of this form after you sign it from: amberhainey@livingstoncountyny.gov.