

Niagara County Department of Mental Health Children's Single Point of Access (CSPOA) Program Application

APPLICATION GUIDE

Dear Parent/Guardian and/or Referral Source,

Thank you for your interest in the Niagara County Department of Mental Health Children's Single Point of Access (CSPOA) Program. Following this page you will find information on CSPOA description of services, criteria for referral, and application for services.

If you are a parent/guardian completing the application, please do your best to complete all sections. If you are uncertain of the diagnostic section, you may leave this blank, but be sure to write in on the consent form your child's mental health counselor's, therapist's, doctor's and/or psychiatrist's name and/or agency he/she attends so we may obtain this information.

For other referral sources, please complete all applicable sections of the application (see application guide on cover of this packet). Please note that the application and requirements have changed.

○ Please complete the following sections of this application:

- CSPOA Eligibility Determination (pages 4 &5)
- CSPOA Application (pages 6-9)
- CSPOA Consent to Release and Obtain Information -add additional providers to Box E as needed (page 10 and 11)
- CSPOA Family/Collateral Consent -add family members or other collateral contact information in box provided (pages 12 & 13)
- ONLY COMPLETE CANS-NY if you have completed the CANS-NY training and are certified (pages 13 & 14). (You may complete the CANS-NY Online training free of charge at <http://www.canstraining.com>.)
- ONLY COMPLETE pages 15 and 16 if individual applying has Medicaid or Medicaid Managed Care
- Please attach all necessary documentation to the application
 - Supporting documentation of child's CURRENT/ MOST RECENT mental health diagnosis. Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing child's current / most recent diagnosis given or signed off by a psychiatrist, psychologist, psychiatric nurse practitioner, LCSW-R or LCSW.
 - A Current Copy of the Individual's Health Insurance Card(s)
 - Signed consent forms (per client/parent/guardian willingness) for all mental health treatment providers (I.E. outpatient mental health provider, any psychiatric hospitals where the child has been treated in the past year, etc) so information can be requested as appropriate to obtain necessary/additional information to determine eligibility for services.
 - ***If child is in the custody of a person other than the biological parent, legal documentation must accompany the application stating legal guardianship; applications cannot be formally reviewed until this is received.*

Please mail or fax the completed application and supporting documentation as noted above to the following:

By Mail: Niagara County Dept. of Mental Health SPOA Program
5467 Upper Mountain Rd. Suite 200
Lockport, NY 14094

By Fax: (716) 439-7418

Should you have questions, concerns and/or would like more information, please contact us at (716) 439-7410. We are happy to assist you.

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

Niagara County Children’s Single Point of Access (CSPOA)
Description of Services

- CSPOA was created for the purpose of identifying Niagara County’s most at-risk children and youth and developing strategies to maintain them in their homes and communities. CSPOA will also assess need for mental health placement (Residential Treatment Facility and Community Residence) and refer to those services after home based services and community treatments have been tried.
- CSPOA will assess the strengths and needs of children referred and will develop plans to link those children to the most appropriate services. CSPOA will also monitor and track children as they move through the continuum of care.
- CSPOA is available to families and service providers who are seeking help for a child with an emotional disability and who are at risk of hospitalization or placement.
- The following provides a brief description of the services available to eligible children and youth referred to CSPOA. It is the responsibility of CSPOA to determine if / what services a child and family is eligible for and to refer them to the appropriate service, agency or committee for consideration.
- The following programs are designed to meet the common goal of prevention and out of home placement and / or psychiatric hospitalization. Participation is voluntary and provided at no cost to families.

Home and Community Based Waiver Services (HCBS Waiver): (Hillside Children’s Center)

An Individual Care Coordinator (ICC) provides intensive services (6 or more times per month) to families with children at high risk of placement. Linkage and advocacy are offered, families can access respite care, family support, skill building, crisis response and intensive in home services.

Mobile Integration Team (MIT): (Western New York Children’s Psychiatric Center)

Short Term Services to bridge service gaps. Offers brief therapeutic support, skill building, crisis assessment and intervention (not 24/7), consultation and information, peer support and skills training, family and caregiver support and skill building, behavioral support and consultation, and in home and community based respite.

Home Based Crisis Intervention (HBCI): (New Directions Youth and Family Services)

Case managers provide direct services to children / youth that are at imminent risk of hospitalization or have had a recent crisis and their families. Services include at least 2 face to face contacts in the home per week for a 6-10 week period, 24 hour availability for crisis intervention and stabilization, child and family assessments, linkages, referrals and advocacy.

Care Management Services (Formerly ICM and SCM Services) : Intake and Screening; Assessment and Reassessment of functional impairments, needs and strengths; Development and Implementation of Case Management Plan, which includes linkage and referral to services and advocacy; Coordination of Services; Crisis Intervention; Support Building; Monitoring and Follow up of Case Management Services; Verbal intervention and Discharge Planning. (Family and Children’s Services and New Directions Youth and Family Services)

Other Services and programs available for families in the community and not required through referral to CSPOA:

- **Catholic Charities MST program:** MST (Multi-Systemic Therapy) is a program that provides intensive home based services (2-3 visits per week) to families for an average of 3-5 months. This program is targeted for families and caregivers with a youth age 12-17 that are at risk of PINS, probation or out of home placement and who exhibit aggressive, delinquent, or criminal behavior.
- **Respite Services:** Time away for Families, caregivers and children who are in need of break to nourish themselves and prevent a crisis.
In Home Respite: The Mental Health Association of Niagara County will provide in home respite to children and their siblings receiving mental health services in Niagara County
- **Family Support:** Parent led support groups offered in a variety of community sites in Niagara County for caregivers raising children with emotional and behavioral problems. Childcare and transportation is available. Advocacy, referrals, linkage, recreational activities and home visits are also available.

CHILDREN'S SINGLE POINT OF ACCESS (CSPOA) PROGRAM
For Children ages 5-20

Mandatory: Please complete this section for persons under the age of 20 (2 PAGES)

ELIGIBILITY DETERMINATION

CHILD NAME: _____

DATE OF BIRTH: _____

Meets Criteria for Serious Emotional Disturbance Among Children And Adolescents
According to New York State Office of Mental Health

To be considered a child or adolescent with serious emotional disturbance **A and B must be met.**

Please check all that apply and fill in information requested in provided spaces:

A. Serious Emotional Disturbance Diagnosis. The child or adolescent is younger than 21 years of age and has a *designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM), other than alcohol or drug disorders, delirium, dementia, and amnesic and other cognitive disorders; developmental disabilities; or social conditions. ICD-10 categories that do not have an equivalent in DSM are also not included as designated diagnoses.

***Please list current diagnoses:** _____

If diagnosis includes ADHD, please check if the child has utilized psychiatric inpatient, Residential Treatment Facility, Day Treatment, Community Residence, Mental Health HCBS Waiver, OCFS B2H Waiver or OMH Targeted Case Management in the PAST 3 YEARS

***Please attach supporting documentation of child's CURRENT/ MOST RECENT mental illness diagnosis.** Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing child's current / most recent diagnosis given or signed off by a psychiatrist, psychologist, psychiatric nurse practitioner, LCSW-R or LCSW.

Date diagnoses given or determined to be current / continuing (list most recent date): _____

^Name AND credentials of professional making diagnostic determination: _____

(if professional is not a psychiatrist, Ph.D. level psychologist, psychiatric nurse practitioner or LCSW / LCSW-R, the diagnosis must be signed off as being verified / supported by one of the above credentialed professionals).

^Signature of professional if available: _____

Name AND credentials of professional verifying / supporting diagnosis if applicable: _____

^Signature of professional if available: _____

AND

B. Extended impairment in functioning due to Emotional Disturbance. The child or adolescent has experienced functional limitations due to emotional disturbance **over the past 12 months on a continuous or intermittent basis.** The functional limitations **must be moderate in at least (2)** of the following areas **OR severe in at least (1)** of the following areas: *(If the functional limitation area applies, check M for moderate or S for severe)*

M or **S Self-care** (personal hygiene; obtaining and eating food; dressing; avoiding injuries).

M or **S Family life** (capacity to live in a family or family-like environment; relationships with parents or substitute parents, siblings, and other relatives; behavior in family setting).

M or **S Social relationships** (establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time).

M or **S Self-direction/self-control** (ability to sustain focused attention for long enough periods of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability).

M or **S Learning ability** (school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

Additionally, in order to be eligible for services through the CSPOA Program, applicants must *(Please check all that apply)*:

- Between the **age 5 – 20** (including age 5 and 20)
- Willing to participate
- Qualify as a high risk/high need child/adolescent** as defined by the following criteria below: **“Criteria A” must be met. In addition, at least (1) area in each Criteria B1, B2, C and D must be identified.** *(Please check all that apply)*:
- Criteria A: Designated Serious Emotional Disturbance Diagnosis** *(see previous page for criteria)*

AND

Criteria B: Severity of Problem Presentation

The youngster must meet 1 and 2 below:

- 1. Demonstrates a need for immediate or intensive intervention in (1) or more of the following:
 - Psychosis
 - Attention Deficit/Impulse Control
 - Depression/Anxiety
 - Oppositional Behavior
 - Antisocial Behavior
 - Substance Abuse
 - Adjustment to Trauma
- 2. Displays at least (1) of the following:
 - Attachment (only for children less than 6 years old)
 - Situational Consistency of Problems
 - Temporal (over time) Consistency of Problems

AND

Criteria C: Risk Behaviors

The youngster demonstrates a need for a safety plan for at least (1) of the following:

- Danger to self
- Danger to others: frequent dangerous (significant harm) level of aggression to others. Any fire setting within the past year. Child is an immediate risk to others.
- Elopement
- Sexually Abusive Behavior
- Social Behavior
- Crime/Delinquency

AND

Criteria D: Caregiver Strengths and Needs

Caregiver lacks strengths and resources to support the child in the present home placement in at least (1) of the following areas:

- Physical/Behavioral health (medical, physical, mental health, substance abuse)
- Supervision (monitoring and discipline)
- Involvement with care
- Knowledge
- Organization
- Resources
- Residential stability
- Safety

CSPOA Level of Service recommended (refer to CSPOA Description of Services):

- OMH Residential Treatment Facility** (must include both SPOA application AND RTF application packet; please contact SPOA Program to obtain RTF application packet and RTF description of services as needed)
- OMH Community Residence** (must include both SPOA application AND a Western Region Community Residence program application packet; please contact SPOA Program to obtain the Community Residence application)
- Home & Community Based Waiver Services**
- Mobile Integration Team**
- Home Based Crisis Intervention**
- Care Management**

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

CSPOA PROGRAM APPLICATION

Please remember to complete and submit the appropriate forms above along with this portion of the application.
Please complete each section of the application; do not leave any blanks—place a line through or write N/A for any area that does not apply.

REFERRED CHILD'S INFORMATION

For NCDMH use—client ID #					
First Name		Middle Initial		Last Name	
Social Security #		Date of Birth		Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
Current Street Address			Town		Zip
Home Phone #		Cell Phone #		Work / Other Phone #	

Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Application Pending for: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Managed Care <input type="checkbox"/> Other			
If Medicaid – provide #		Medicaid Active? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No Unknown	
Other Insurance Type:			Policy Holder:		
Policy #					
Current child benefits received <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> SSI <input type="checkbox"/> SSD <input type="checkbox"/> Survivor's <input type="checkbox"/> Veteran's Earned Income (work)					
<input type="checkbox"/> Child Support <input type="checkbox"/> Resources/Assets (savings bonds, savings account, trust fund, etc) <input type="checkbox"/> Other (<i>specify</i>)					

Ethnicity (check all that apply) <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian					
<input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Unknown <input type="checkbox"/> Other (<i>specify</i>):					

Brief physical description (approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.)
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Are services required in a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, specify language:</i>
--

Special Needs & Preferences (physical, medical, visual, hearing, cultural/religious, language, writing, reading, developmental disability) (<i>specify</i>):

Child's Custody Status <input type="checkbox"/> Biological Parent(s) <input type="checkbox"/> *Adoptive Parent(s) <input type="checkbox"/> *Grandparent(s) <input type="checkbox"/> *Local DSS <input type="checkbox"/> *OCFS					
<input type="checkbox"/> *Other Family/Legal Guardians <input type="checkbox"/> Emancipated Minor <input type="checkbox"/> Other (<i>please specify</i>):					
<i>*If child is in the custody of a person other than the biological parent, legal documentation(e.g. custody decree, adoption certificate) must accompany the application stating legal guardianship; applications cannot be formally reviewed until this is received.</i>					

Living Situation <input type="checkbox"/> unknown <input type="checkbox"/> alone <input type="checkbox"/> with child <input type="checkbox"/> one parent family <input type="checkbox"/> two parent family					
<input type="checkbox"/> one parent adoptive family		<input type="checkbox"/> two parent adoptive family		<input type="checkbox"/> grandparent(s)	
<input type="checkbox"/> jail/ correctional facility		<input type="checkbox"/> homeless / streets		<input type="checkbox"/> emergency shelter	
<input type="checkbox"/> OMH Facility (<i>specify</i>)		<input type="checkbox"/> hospital (<i>specify type</i>)		<input type="checkbox"/> OASAS Facility (<i>specify type</i>)	
<input type="checkbox"/> OCFS Facility (<i>specify</i>)		<input type="checkbox"/> Other (<i>specify</i>)			

Names of persons living in home with child	Ages	Relationships of persons living with child	Names of persons living in home with child	Ages	Relationships of persons living with child

Is child currently pregnant <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does child have children <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, custody status:</i>

OTHER SIGNIFICANT CONTACTS NOT LISTED ABOVE

Name (First, MI, Last)		Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Child:		<i>If yes, please complete pages 11 - 12</i>			
Address, City, State, Zip		Phone #			

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

BACKGROUND INFORMATION

Current Grade Level (Specify Grade)	<input type="checkbox"/> GED	<input type="checkbox"/> BOCES	<input type="checkbox"/> Not enrolled in School	<input type="checkbox"/> Unknown
Current School District	Current School Name			

Educational Placement Status (<i>Check all that apply</i>)				
<input type="checkbox"/> Age appropriate grade level	<input type="checkbox"/> Above grade level	<input type="checkbox"/> Behind at least one grade	<input type="checkbox"/> Special Education	<input type="checkbox"/> Unknown
<input type="checkbox"/> Residential School	<input type="checkbox"/> Day School / Treatment	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> BOCES	<input type="checkbox"/> Home Instruction
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Vocational Training Only			

Committee on Special Education Status				
<input type="checkbox"/> None	<input type="checkbox"/> Unknown	<input type="checkbox"/> Emotionally Disturbed	<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Sensory Impaired
<input type="checkbox"/> Physically impaired	<input type="checkbox"/> Multiple handicapped	<input type="checkbox"/> Other health impaired	<input type="checkbox"/> Other (<i>specify</i>)	

IEP <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No	504 Plan <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No
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IQ Scores	Unknown	Full Scale Score	Date Of Test	Name of Test Given
Current Legal Status				
<input type="checkbox"/> None	<input type="checkbox"/> Unknown	<input type="checkbox"/> PINS Diversion	<input type="checkbox"/> PINS	<input type="checkbox"/> Juvenile Delinquent
<input type="checkbox"/> Probation	<input type="checkbox"/> Incarcerated (Jail / Detention)	<input type="checkbox"/> Released from jail within 30 days	<input type="checkbox"/> Bailed/ROR	<input type="checkbox"/> Juvenile Offender
<input type="checkbox"/> Conditional Discharge	<input type="checkbox"/> Involved in Treatment Court	<input type="checkbox"/> Family Court Involvement	<input type="checkbox"/> Other (<i>specify</i>)	

Legal History <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, briefly explain:</i>
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Employment Status <input type="checkbox"/> N/A due to age <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed, with work history <input type="checkbox"/> Unemployed, no work history
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CURRENT SERVICE PROVIDERS

	Agency / Name	Address	Phone
Primary Medical Doctor <input type="checkbox"/> None <input type="checkbox"/> Unknown			
Mental Health Provider <input type="checkbox"/> None <input type="checkbox"/> Unknown			
Psychiatrist / Psychiatric Nurse Practitioner <input type="checkbox"/> None <input type="checkbox"/> Unknown			
Probation <input type="checkbox"/> None <input type="checkbox"/> Unknown			
DSS Worker <input type="checkbox"/> None <input type="checkbox"/> Unknown			
Substance Abuse Provider <input type="checkbox"/> None <input type="checkbox"/> Unknown			
Other (<i>specify</i>)			

Has child/family been referred for other services? Yes No *If yes, please list services:*

Medication Prescribed Yes No Unknown

Child's Adherence to Medication Regimen Independently With assistance Unknown

Takes medication: As prescribed Most of the time Sometimes Rarely or Never Unknown

TYPES OF SERVICES / SUPPORT CHILD IS IN NEED OF & NOT CURRENTLY RECEIVING

(Check all that apply)				
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Day Treatment
<input type="checkbox"/> Alcohol/Substance Abuse Treatment	<input type="checkbox"/> Mentoring	<input type="checkbox"/> Respite	<input type="checkbox"/> Family Support	<input type="checkbox"/> Educational
<input type="checkbox"/> Speech & Language Therapy	<input type="checkbox"/> Literacy Services	<input type="checkbox"/> Vocational Training	<input type="checkbox"/> Employment	<input type="checkbox"/> After school/weekend program
<input type="checkbox"/> Social/Recreational/Community Activities	<input type="checkbox"/> Transportation	<input type="checkbox"/> Skill building	<input type="checkbox"/> Benefits/Entitlements	<input type="checkbox"/> Housing
<input type="checkbox"/> Advocacy	<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Monitoring safety / behavioral plan	<input type="checkbox"/> Coordination of services	<input type="checkbox"/> Other (<i>please specify</i>):

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

CHILD'S TREATMENT, SERVICES AND HISTORY				
Services	Past 30 days (√)	Past 12 months (√)	Prior to 1 year ago (√)	No History (√)
Psychiatric Inpatient <i>(list # of times if known)</i> _____				
Hospital Psychiatric Emergency Room, NO ADMISSION <i>(list # of times if known)</i> _____				
Emergency Mental Health / Crisis Services				
Mental Health Outpatient Treatment				
Alcohol/Substance Abuse Outpatient				
Case Management / Waiver Services				
Residential Program <i>(specify)</i>				
Developmental Disability				
Work/Vocational				
Parenting Services				
Foster Care				
Mentoring / ComPeer				
ADL or Independent Living Skills				
Other <i>(specify)</i>				

CHILD'S ALCOHOL / SUBSTANCE ABUSE HISTORY	
<input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Current (past 30 days) <input type="checkbox"/> History – list clean/sober time frame _____	Drug(s) of choice (specify) _____

CHILD'S SYMPTOMS and RISKS				
Symptoms and Risk Behaviors	Past 30 days (√) Or Ongoing	Past 12 months (√)	Prior to 1 year ago (√)	No History (√)
Psychotic Symptoms				
Anxiety				
Depression				
Suicidal Thoughts				
Self-Harm Behavior				
Suicide Attempts				
Danger / Violence towards others				
Verbal Aggression				
Physical Aggression				
**Sexual Aggression toward others				
**Sexually Inappropriate				
Victim of abuse				
Mistreatment of Children/CPS involvement				
Property Destruction				
** <input type="checkbox"/> Fire setting / Arson				
**Cruelty to Animals				
Sleep Disorder				
Enuresis (e.g. bed wetting)				
Encopresis (e.g. soiling undergarments)				
Physical complaints				
Cognitive Functioning				
Eating Disorders				
Peer/Social Interactions & Functioning				
Impulsivity				
Running Away/AWOL				
Gang involvement / activity				
Bullying <input type="checkbox"/> victim of aggressor				
Truancy				

****Provide further details in the "additional information section on the next page**

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

Weapons in the home? Unknown Yes No *If yes, specify type:*

Individual identified as high risk by: N/A Behavioral Health Organization (BHO) Health Home

**LEVEL OF FUNCTIONING
INDEPENDENT / DAILY LIVING SKILLS**

- Unknown
- Independent
- Functioning at age appropriate level
- Needs additional support , *specify areas:*
 - personal hygiene
 - home environment
 - recognizing danger
 - shopping
 - budgeting
 - traveling in community
 - Other (*specify*)
- understanding instructions
- completing tasks
- communicating clearly/appropriately
- social functioning
- self-direction
- appointment / treatment follow through

HEALTH HOME APPROPRIATENESS CRITERIA

- Is at risk for an adverse event (I.E. death, disability, inpatient admission, mandated preventative service, or out of home placement)
- Has inadequate social/family/housing support, or serious disruptions in family relationships
- Has inadequate connectivity with healthcare system
- Does not adhere to treatments or has difficulty managing medications
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- Has deficits in activities of daily living, learning, or cognition issues
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

CHILD'S STRENGTHS (Please check all that apply):

- Unknown None Self-Advocacy Family/Primary Support Group Support Has healthy social supports/peer group
- Involved in Clubs, Activities, Community Church/Spiritual Involvement Sets Goals/Works Toward them
- Open to/Accepting of support services/treatment Seeks out assistance when needed Compliant with treatment
- Follows through with recommendations & addresses needs Other (*briefly explain*):

CAREGIVER'S STRENGTHS (Please check all that apply):

- Unknown None Briefly explain:

REFERRAL SOURCE INFORMATION

Referral Source Name (Please Print):	Relationship to individual:
Referral Source Signature: Date:	
Agency / Program:	
Complete Address and Phone Number:	

ADDITIONAL INFORMATION AS APPROPRIATE:

Niagara County Department of Mental Health Children's Single Point of Access (CSPOA) Program Application

**AUTHORIZATION TO OBTAIN, USE, DISCLOSE AND RE-DISCLOSE
PROTECTED HEALTH INFORMATION (PHI) / CONFIDENTIAL INFORMATION (2 pages)**

Please complete with appropriate signatures and forward with SPOA application

This authorization must be completed by the child's personal representative to obtain, use, disclose and re-disclose protected health information (PHI) / confidential related information, in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Child (18 and older may sign for themselves) / legal guardian (for child under age of 18) consents to the following:

As it pertains to my / my child's application to and services through the Single Point of Access Program (SPOA), SPOA is hereby granted permission to obtain, use, disclose, and re-disclose identifying information, health, mental health, alcohol and drug, and education records / information (orally, in print and electronically) to and from the following agencies that are represented on the SPOA committee (**in Box A**), other agencies listed in **Box B** (that are not already listed in Box A) that may be referred to through SPOA for residential consideration; other agencies listed in **Box C**(that are not already listed in Box A or Box B) that may be referred to through SPOA for adult services if applicable; other agencies listed in **Box D** in order to make a referral to the Children's Health Homes; and to any agency listed below in **Box E**:

BOX A

- | | |
|---|---|
| <ul style="list-style-type: none"> • Niagara County Department of Mental Health • Niagara County Department of Health • Niagara County Department of Probation • Niagara County Department of Social Services • Niagara Falls Memorial Medical Center • Catholic Charities • Community Missions of Niagara Frontier, Inc. • Eastern Niagara Hospital • Family and Children's Services of Niagara, Inc. | <ul style="list-style-type: none"> • Hillside Family of Agencies (Hillside Children's Center) • Lockport City Schools / District • Mental Health Association of Niagara County, Inc. • New Directions Youth & Family Services, Inc. • Northpointe Council, Inc. • Orleans Niagara BOCES • WNY CPC (Children's Psychiatric Center) • WNY DDRO (Developmental Disabilities Regional Office) • WNY OMH Field Office |
|---|---|

BOX B Residential Treatment Facilities (RTFs) and Community Residences (CRs)

- | | |
|---|---|
| <ul style="list-style-type: none"> • Baker Victory Services RTF • Child & Family Services RTF and CR • St. Joseph's Villa RTF and CR | <ul style="list-style-type: none"> • Cattaraugus Rehabilitation Center CR • Glove House CR • Pathways, Inc. CRs • Rochester Psychiatric Center CR |
|---|---|

BOX C For individuals between the ages of 18 and 20 only

- | | |
|--|---|
| <ul style="list-style-type: none"> • Buffalo Psychiatric Center • Dale Association • Health Home Partners of WNY • Horizon Health Services | <ul style="list-style-type: none"> • Housing Options Made Easy, Inc. (HOME) • Living Opportunities of DePaul • Prime Care Medical at the Niagara County Jail |
|--|---|

BOX D For Individuals with Medicaid and/or Medicaid Managed Care

- | | |
|---|---|
| <ul style="list-style-type: none"> • NY State Medicaid Analytic Performance Portal (MAPP) • Encompass Health Home (Catholic Charities of Broome County) | <ul style="list-style-type: none"> • Children's Health Home of Western New York (Kaleida Health) • Children's Health Home of Upstate New York |
|---|---|

I understand that the members of this committee have agreed to be bound by the highest standards defined by law, which includes federal alcohol and drug record privacy regulations 42 C.F.R. Part 2, federal law governing privacy of educational records (FERPA)(20 USC 1232g), and New York State Mental Hygiene Law 33.13, to maintain the confidentiality of the information presented to the committee and to not discuss that information outside the scope of the committee.

Purpose or need for information: I understand the only information obtained, used, disclosed, and re-disclosed will be pertinent and necessary to allow the SPOA committee:

- To determine initial and continuing residential and case/care management eligibility, level of service / care, and needs;
- To make recommendations for appropriate services;
- To assign to appropriate services offered through, or in partnership with, SPOA;
- To plan and coordinate services, and for service delivery;
- To complete utilization review of my/my child's progress in the assigned service(s);
- To facilitate a referral/enrollment in a Health Home via the Medicaid Analytic Performance Portal (MAPP) if appropriate.
- For payment of services.

I further understand that:

- Only this information may be obtained, used, disclosed and re-disclosed as a result of this authorization.
- I have the right to participate in the SPOA committee discussion regarding the appropriate level of service for my / my child's needs.
- This information is confidential and cannot be legally disclosed without my permission.

Consenter's Initials: _____

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

AUTHORIZATION TO OBTAIN, USE, DISCLOSE AND RE-DISCLOSE

PROTECTED HEALTH INFORMATION (PHI) / CONFIDENTIAL INFORMATION continued

- It is the role of the committee to oversee the use of case/care management and residential services in Niagara County and to decide what level of service is most appropriate for each client in light of the demands for those services. The committee's decision will be based on information about me / my child.
- I may withdraw this permission to share information at any time without jeopardizing my current treatment / services or any future application for these services. My revocation must be in writing on the form provided to me by **Niagara County Dept. of Mental Health**, shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- 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).

Periodic Use / Disclosure: Unless my permission is withdrawn in writing I understand that this consent / authorization **will remain in effect as long as I continue to receive the services covered by this committee** for the purposes described above as often as necessary to fulfill the purposes identified above.

BOX E: I certify that I authorize the use of my/my child's protected health information / confidential information as set forth in this document.

CHILD NAME:	Date of Birth:
--------------------	-----------------------

BOX E: Agency (Name & Address) <u>Releasing / Obtaining</u> Information to / from SPOA: 	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; border-top: 1px solid black; border-bottom: 1px solid black;">Legal Guardian's Signature</td> <td style="width:20%; border-top: 1px solid black; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; border-bottom: 1px solid black;">Legal Guardian's Printed Name</td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">Witness</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; border-bottom: 1px solid black;">Witness's Printed Name</td> </tr> </table>	Legal Guardian's Signature	Date	Legal Guardian's Printed Name		Witness	Date	Witness's Printed Name	
Legal Guardian's Signature	Date								
Legal Guardian's Printed Name									
Witness	Date								
Witness's Printed Name									

DO NOT COMPLETE BELOW THIS LINE ON THIS PAGE UNLESS CONSENT /AUTHORIZATION IS BEING WITHDRAWN

Request / Authorization to Withdrawal Consent:

I voluntarily withdraw my request for case/care management or residential services and in so doing withdraw my authorization for the Niagara County Single Point of Access Committee to continue to share information regarding me/my child. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Legal Guardian's Signature: _	Date _____
Witness _____	Date _____

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

FAMILY / COLLATERAL CONSENT FORM (2 pages):

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.)
	Sex Date of Birth
	Facility/Agency Name: Niagara County Dept of Mental Health Children's Single Point of Access (CSPOA) Program & Committee Agency Representatives

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):

- Identifying Information
 Presence in treatment/services
 Information necessary to engage in services
 Medical Information/Concerns
 Lethality/Risk Concerns
 Diagnosis/Prognosis/Progress in Treatment/Services
 Behavioral/Mental Health Information
 Substance use/abuse Information
 Legal/Criminal Justice Status
 Other (identify): _____

Purpose or Need for Information

1. This information is being requested: (PLEASE CHECK ONE)

- by the individual or his/her personal representative; or
 By Other (please describe) _____
1. The purpose of the disclosure is (PLEASE DESCRIBE):
 Continuity of Care
 Coordination of Services
 Facilitate Referrals/Linkage with Needed Services
 Other (identify): _____

From/To: Name, Address, & Title of Person/Organization/Facility/Program Disclosing Information and To which 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.

Name:
Niagara County Dept. of Mental Health CSPOA Program &
 Assigned Case Management or Residential Agency
 5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094;
 Phone: (716) 439-7410; Fax: (716) 439-7418

To/From: Name, Address, & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information.

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.

Family / Collateral Contact(s):

A. 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 redisclosed 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 (**Niagara County Dept. of Mental Health**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524.

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

Facility/Agency Name: Niagara County Dept of Mental Health Children's Single Point of Access (CSPOA) Program & Committee Agency Representatives	Patient's Name (Last, First, MI)	ID #
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B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

When I am no longer receiving services from **Niagara County Dept. of Mental Health SPOA Program and agency assigned that is providing case management and/or residential services**

Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my 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 patient's personal representative.

WITNESSED BY: _____
 Staff person's name and title

Authorization provided to: _____ Date: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information : _____

Title: _____

Date Released: _____

PART 2: Revocation of Authorization to Release Information

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

I hereby refuse to authorize the use/disclosure indicated in Part I, 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 Revocation of Authorization)*

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

ONLY COMPLETE THIS PAGE IF YOU ARE CERTIFIED TO COMPLETE THE CANS-NY

CANS - NY Ratings Sheet

Child/Youth's Name (print):

DOB: Gender: male female transgender Race/Ethnicity:

Client ID Number (CIN): Primary Language: English Spanish Other, specify:

Address:

City State: NY Other, specify: Zip

Is this the initial CANS: (check one) Yes No CANS Completion Date:

CANS Administrator (print):

Phone number: Agency:

DOMAINS

CHILD/YOUTH STRENGTHS DOMAIN: Note: 0=Strength

	0	1	2	3		0	1	2	3	N/A
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual/Religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Interpersonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Relationship Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Talents/Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Optimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vocational	<input type="checkbox"/>				
Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resiliency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STRENGTHS AND NEEDS DOMAIN FOR PRIMARY CAREGIVER

Caregiver type:

STRENGTHS and NEEDS DOMAIN

Note: In this category, 0= no evidence of need

	0	1	2	3		0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acculturation: Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

STRENGTHS AND NEEDS DOMAIN FOR SECOND CAREGIVER INVOLVEMENT (SI)

Caregiver type:

STRENGTHS and NEEDS DOMAIN

Note: In this category, 0= no evidence of need

	0	1	2	3		0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acculturation: Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Niagara County Department of Mental Health Children Single Point of Access (CSPOA) Program Application

CHILD/YOUTH LIFE FUNCTIONING DOMAIN

	0	1	2	3	NA		0	1	2	3	NA
Primary Caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		School Achievement	<input type="checkbox"/>				
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		School Attendance	<input type="checkbox"/>				
Acculturation: Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		JJ/Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	go to DD Domain
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Medical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	go to Med Domain
Sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	go to BH Domain
Knowledge of Sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Adj. to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	go to AT Domain
Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Substance Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	go to SU Domain
Job Functioning	<input type="checkbox"/>										
School Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

CHILD/YOUTH RISK BEHAVIORS DOMAIN

	0	1	2	3		0	1	2	3
Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runaway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger to Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delinquent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

CHILD/YOUTH BEHAVIORAL HEALTH DOMAIN

	0	1	2	3		0	1	2	3
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive/Hyper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHILD/YOUTH DEVELOPMENTAL DOMAIN

	0	1	2	3		0	1	2	3
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Care/Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHILD/YOUTH MEDICAL HEALTH DOMAIN

	0	1	2	3		0	1	2	3
Life Threatening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intensity of Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Complexity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organized Complexity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impairment in Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

CHILD/YOUTH ADJUSTMENT TO TRAUMA

	0	1	2	3		0	1	2	3
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness or Victim of Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Affect Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Verbal Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Re-experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Disaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witness to Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witness to Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHILD/YOUTH SUBSTANCE USE DOMAIN

	0	1	2	3		0	1	2	3
Severity of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Influence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stage of Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*****Please ONLY complete the following page if the individual has Medicaid Or Medicaid Managed Care*****

Health Home Chronic Condition Eligibility Criteria

- Currently Enrolled in Medicaid or Medicaid Managed Care
- Two or More Chronic Conditions (i.e.: Substance Use Disorders, Asthma, Diabetes, etc)

Please List: _____

OR

- One Single Qualifying Chronic Condition
 - HIV/AIDS or
 - Serious Emotional Disturbance (SED in Children) (see Health Home Criteria Below) or
 - Complex Trauma (please complete the Complex Trauma Screening Tool on page 16)
 - Please attach documentation for the Qualifying Conditions identified above

SED Definition for Health Home- DSM Qualifying Mental Health Categories

- Schizophrenia Spectrum and Other Psychotic Disorder
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma-and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptoms and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD *(with restrictions)

*With an ADHD diagnosis, the individual must have also utilized the following services in the past 3 years: Psychiatric inpatient; Residential Treatment Facility (RTF); Day Treatment; Community Residence (CR); Mental Health HCBS Waiver; OCFS B2H Waiver; or OMH Targets Case Management.

