OFFICE OF COMMUNITY SERVICES
FOR WARREN AND WASHINGTON COUNTIES
230 Maple Street, Suite 1, Glens Falls, NY 12801
Telephone: (518) 792-7143
FAX: (518) 792-7166

Dear Community Partners:

Please find attached a revised application for the Children and Youth Care Management and Respite Services operated by Parsons Child and Family Center, the Glens Falls Hospital, the Warren-Washington Association for Mental Health, Community Maternity Services, Hudson Headwaters Health Network, Health Homes (AHI and CHHUNY), Northeast Parent and Child Society and coordinated locally in collaboration with the Office of Community Services for Warren and Washington Counties.

The primary objective of these services is to provide linkage and referral services for children with serious emotional disturbances and their families in order to improve functioning in their homes, schools, communities, thus reducing the need for hospitalization or placement outside of the home.

The Care Coordination services facilitate mental health and medical service delivery by helping children, youth, and families make and **keep appointments, advocating on their behalf, and assisting children, youth, and families with gaining access to entitlements and health care services. The *Home and Community-Based Waiver Services* program is designed for children and youth who might otherwise be admitted to hospital or institutional levels of care. Services include individualized care coordination, crisis response, intensive in-home, respite care, family support and skill-building. *Respite services* provided needed breaks for parent or guardians and children**

A child or youth may qualify for these services if he or she is:

- **experiencing a serious emotional disturbance or behavioral disorder;**
- **at risk of being hospitalized, re-hospitalized, or placed outside the home;**
- **having difficulty functioning in the home, school and community;**
- **involved in multiple systems (mental health, special education, family court, etc.);**
- **engaged in clinical treatment or services which have not been successful; and**
- **living with parents or guardians who are able and willing to participate in services.**

Eligibility for admission to these programs is determined by the *Single Point of Entry (SPOE) Committee*. Provider agencies participate with the assessment and monitoring of services through this committee. Their input helps to ensure that each applicant receives the appropriate level of care to meet his or her needs. Availability for some services may be limited. It is the goal of this committee to provide some level of support when applicable or link to more appropriate support as needed. There may be a delay in receiving services even after an applicant has been determined eligible. If the referring agent or parent/guardian is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and participating programs reserve the right to make the final determination.

The attached referral should be filled out completely. In addition, the referring agent should attach copies of:

- **Signed release of information;**
- **Psychiatric evaluation,**
- **Relevant admission and discharge summaries *(most recent);* and**
- **Copies of Medicaid or other health insurance benefit card and social security card.**

The referral and any pertinent information should be forwarded to:

SPOE Coordinator
Office of Community Services
230 Maple Street, Glens Falls, NY 12801
Telephone: (518) 792-7143 Fax: (518) 792-7166

After receiving and reviewing the completed referral, we will contact you as soon as possible regarding the next step in the process. Thank you for your interest in our programs.

Never Give UP
Child-Centered/ Family-Focused/ Community Based/ Multi-System/ Culturally & Linguistically Competent/
Least Restricted/Least Intrusive

CHILDREN AND YOUTH SPOA REFERRAL

Respite ☐ Health Home ☐ Care Management ☐ HBCS Waiver ☐

Referral Date_____

Child's Name: DOB: Gender: Male ☐ Female ☐ Child's Current Address: Medicaid #: Social Security #: Other Insurance: Race: Hispanic ☐ Caucasian ☐ African American ☐ Native American ☐ Other ☐	**Referral Source Name:** **Relationship:** Agency (if appropriate): Address: Phone:
Parent/Guardian Name: **Mother**: Address: Phone: **Father:** Address: Phone: **Guardian:** Address: Phone:	**Medical Consent:** (if Different or only one parents or guardian) Name: **Custody status:** Bio Parents ☐ Mother ☐ Father ☐ Adoptive Parents ☐ Step Parent ☐ Grandparents ☐ Local DSS ☐ Other: **Lives with: Parent(s) ☐ Guardian ☐ Other: ☐_____**

Assessments:

Is the child/youth interested in services? Yes ☐ No ☐ Is the family interested in services? Yes ☐ No ☐

Reason for Referral for Care Management:(Brief narrative, please include any details on events, behaviors, etc. that prompted the referral)

Respite requested, goal of service for applicant :(Brief narrative; please include goal, developmental needs and behavioral strengths).

If respite requested: Overnight ☐ Hourly ☐ Weekdays ☐ Weekends ☐

Health Home Eligibility

☐Complex Trauma: Trauma is defined as exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, and exposure to violence, and physical and sexual abuse. **Date of Screening: _____**

☐Serious Emotional Disturbance (SED): A child or adolescent (under the age of 21) that has a designated mental illness diagnosis as defined by the most recent version of the DSM, chronic condition and has experienced functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis.

☐Health Home Eligible: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is: 1) At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement) –2)Has inadequate social/family/housing support, or serious disruptions in family relationships;--3)Has inadequate connectivity with healthcare system; --4)Does not adhere to treatments or has difficulty managing medications;--5)Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;--6)Has deficits in activities of daily living, learning or cognition issues, or--Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Current Functioning:

Living Arrangement, including risk of homelessness:

Social Service Needs: **(Public Assistance, SNAP, HEAP, etc….)**

Please note child/youth and family strengths, skills, and interests:

Risk Factors: including legal, and substance abuse history:

If symptoms/behaviors exist and its impairment on daily functioning

Behavior	No Evidence	Mild	Moderate	Severe	Unknown	Behavior	No Evidence	Mild	Moderate	Severe	Unknown
Suicide Risk						Depression					
Self-Injurious Behavior						Impulsive					
Danger to Others						Anxiety					
Sexual Aggression						Oppositional					
Fire Setting						Psychotic Symptoms					
Aggressive Behavior						Anger Control					
Intentional Misbehavior						Attachment					
Sleep Problems						School Attendance					
Runaway						School Suspension					
Enuresis/Encopresis						Phobia					
Substance Use						Physical Limitations					

Hospitalizations:

History of inpatient admissions? Yes □ No □

Dates and sites of past admissions, if known:

Currently inpatient? Yes □ No □

Current Inpatient Hospital:

Admit date:

Anticipated D/C date:

Diagnosis:

Date of Evaluation:

Medications and dosage:

Take medications as prescribed? Yes □ No □

Other chronic health conditions:

Financial:

Does the child have any income of his or her own? Yes ☐ No ☐

If yes, list total amount: SSI ☐ SSDI ☐ Veteran Benefit ☐

Does the child have any financial resources, i.e. savings, trusts? Yes ☐ No☐ If yes, list total value:

Current School Attended Name: Address: Phone: Contact Person: Classified: IEP ☐ 504Plan ☐ Full Scale IQ: Last grade completed: School District:	**Behavioral Health** Provider Name: Address: Phone: Contact Person: Last Appointment:
Foster Care / DCYF County / Agency Name: Address: Phone: Contact Person	**Other Collateral** Provider Name: Address: Phone: Contact Person:
Primary Care / Pediatrician Name: Address: Phone:	**Other Collateral** Provider Name: Address: Phone: Contact Person:
******Required Attached Documentations****** ***Psychiatric Evaluation and/or** ***Psychological Evaluation or** ***Psycho-Social Assessment and** ***Copy of Insurance Card**	Additional Attached Documentations if available: Medical / Physical School Information (IEP, 504,FBA) Treatment Plan/Service Plan Safety Plan Other:
Person Referring Child to SPOA: Signature: Date:	

Required parental signature: Attached: Authorization for Release

Please Fax form and accompanying documents to: SPOA Coordinator, Office of Community Services Fax: (518)792-7166

SINGLE POINT OF ENTRY AUTHORIZATION FOR RELEASE OF INFORMATION	**Name (Last, First):** **DOB:**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Description of Information to be Used/Disclosed: General medical reports, social histories, psychosocial reports, psychiatric assessments, Individualized Educational Plans, psychological testing, other:

Purpose or Need for Information: The purpose of this disclosure is for determination of eligibility for residential, case management, respite, and psychosocial/vocational programs licensed and/or funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties.

From: Name, Address & Title of Person/Organization/ Facility/Program Disclosing Information	**To:** Name, Address & Title of Person/Organization/ Facility/Program to Which this Disclosure is to be Made The Single Point of Entry Committee (SPOE), comprised of representatives of community agencies including the Office of Community Services for Warren and Washington Counties, the Warren-Washington Association for Mental Health, Behavioral Health Services of The Glens Falls Hospital, Parsons Child and Family Center, Northeast Parent and Child Society, Community Maternity Services, Hudson Headwaters Health Network, Adirondack Health Institute Health Home, Children Health Home of Upstate New York, Berkshire Farm Center, the Office for Persons with Developmental Disabilities and the Departments of Social Services for Warren and Washington Counties.

I hereby authorize the use or disclosure of the above information to the Person/Organization/Facility identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my 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).

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

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

☐ When acted upon; or ☐ 90 Days from this Date.

B-2. Periodic Use/Disclosure: I hereby permit 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: ☐ One year from this date;

If neither B-1 nor B-2 is selected, this authorization will expire one year from this date.

Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

Individual (or Child or Youth) (Name) Date	Individual (or Child or Youth) (Signature) Date
If applicable, Parent or Guardian (Signature) Date	Witness (Signature) Date

Please print to complete this form
Licensed Professional

Complex Trauma Eligibility Determination Form

Please print to complete this form only if Health Home Eligible and unable to determine SED Eligibility

Children's Eligibility for Health Home Care Management services on the basis of Complex Trauma is based on three criteria. All three must be present in order for a child to be determined eligible. In addition to eligibility, the child must separately be determined *appropriate* for Health Home Care Management in accordance with current DOH guidance.

Child Name _____ DOB: _____ Medicaid#: _____

CMA: _____ Health Home: _____ Date: _____

I. Complex Trauma Exposure

Based on the Complex Trauma Exposure Assessment (CTEA), has the child been exposed to multiple interpersonal traumatic events, or at least one chronic interpersonal trauma lasting 18 months or more?* Yes No

** For young children (ages 0-5) a determination of "chronic" exposure can be made for periods less than 18 months*

Exposure Category	Present? Y/N	Chronic? Y/N	Comments (onset, duration, description)
Psychological Maltreatment (emotional abuse/neglect)			
Neglect			
Displacement			
Attachment Disruption			
Sex Abuse			
Sex Assault			
Trafficking/Commercial Sexual Exploitation			
Physical Abuse			
Domestic Violence			
Physical Assault/ Interpersonal Violence			
Community Violence			
War / Political Violence			
Stalking / Kidnapping			
Bullying			
Other			

II. Functional Impairments

Based on the use of validated assessment instruments in accordance with the process developed by DOH, and based on at least one face-to-face interview, is the child experiencing functional impairments in at least two of the following categories, or acute impairment in at least one category? Yes No

Impairment Category	Present? Y/N	Acute? Y/N	Instrument / Method	Comments (onset, duration, description)
Physiology / Neurodevelopment				
Emotional Response				
Cognitive Processes				
Impulse Control / Self-Regulation				
Self-Image				
Relationships with Others				

Please print to complete this form
Licensed Professional

III. Links between Traumatic Exposure and Experience of Functional Impairments

- *In your professional opinion, are the Functional Impairments listed in Section II resulting from, or linked to, the Trauma Exposure described in Section I?* Yes No
- *Are these Functional Impairments best explained as being a result of, or exacerbated by, Complex Trauma, and not as the result of some other diagnosis or developmental delay?** Yes No

**As long as complex trauma is present, the addition of a co-morbid disorder or diagnosis does not disqualify the child.*

Comments:

IV. Eligibility Determination

As a licensed professional acting within my scope of practice, I find that the child referenced herein

- ❑ ***IS***
- ❑ ***IS NOT***

experiencing Complex Trauma in accordance with the definition approved by CMS for Health Home eligibility purposes.

Print Name: Credential: License #:

Signature: Date:

Attachments:

- ○ Referral Cover Sheet
- ○ Medical Consent
- ○ Trauma Exposure Assessment
- ○ Functional Impairment Assessment Materials (list)
- ○ Collateral / Background Materials Provided (list)