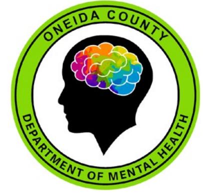
ONEIDA COUNTY
DEPARTMENT OF MENTAL HEALTH



ANTHONY J. PICENTE, JR.
County Executive

ASHLEE L. THOMPSON
Commissioner
Director of Community Services

ADULT SINGLE POINT OF ACCESS (ASPOA) REFERRAL FORM

EMAIL TO MENTALHEALTH@OCGOV.NET OR FAX TO (315) 768-3670

SUBMISSION OF A SEPARATE MENTAL HEALTH ASSESSMENT OR PSYCHIATRIC EVALUATION IS REQUIRED IN ADDITION TO THIS REFERRAL FORM.

DATE OF REFERAL: ________________________

SECTION 1 - DEMOGRAPHICS

FIRST NAME:	**LAST NAME:**
DOB:	**PHONE:**
SSN:	**GENDER:**

RESIDENTIAL ADDRESS:

RESIDENTIAL TYPE:

____ INDEPENDENT (ALONE) ____ INDEPENDENT (W/ FAMILY/FRIENDS)
____ CONGREGATE CARE ____ HALFWAY HOUSE
____ REHABILITATION FACILITY ____ SUPPORTIVE APARTMENT (PROGRAM)
____ CONGREGATE (GROUP HOME/RESIDENTIAL)
____ NURSING HOME ____ ASSISTED LIVING FACILITY
____ TRANSITIONAL LIVING PROGRAM: ____

____ HOMELESS SHELTER ____ STREET HOMELESS
ADDRESS PRIOR TO HOMELESSNESS: ____

CHRONICALLY HOMELESS? ____ YES ____ NO ____ UNKNOWN

"Chronically homeless" means:

(1) A "homeless individual with a disability" who:
  a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
  b. Has been homeless (as described above) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
    i. Occasion is defined by a break of at least seven nights not residing in an emergency shelter, safe haven, or residing in a place meant for human habitation (e.g., staying with a friend, in a hotel/motel paid for by a program participant)
    ii. Stays in institutions of fewer than 90 days do not constitute a break

(2) An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraphs (1) or (2) of this definition, including whose composition has fluctuated while the head of household has been homeless.

SPECIALTY TEMPORARY ADDRESS & TYPE:

____ HOSPITAL ____ CORRECTIONAL FACILITY ____ OTHER: ______________________

DETAILS OF SPECIALITY TEMPORARY ADDRESS: ____________________________________

DOES THE INDIVIDUAL HAVE ANY DEPENDENTS? ____ YES ____ # ____ NO

NAME, AGE, AND RELATIONSHIP: ____

IF THE INDIVIDUAL HAS DEPENDENTS, ARE RESIDENTIAL SERVICES BEING REQUESTED FOR BOTH CLIENT AND THEIR DEPENDENTS? ____ YES ____ NO

PRIMARY LANGUAGE:

LANGUAGE IF INTERPRETER IS NEEDED: ___________________

SECONDARY LANGUAGE:

ETHNICITY:
____ HISPANIC OR LATINO
____ NON-HISPANIC OR LATINO

MILITARY STATUS:
HAS CLIENT EVER SERVED IN THE UNITED STATES MILITARY? ____ YES ____ NO

BRANCH: ___________________
DISCHARGE STATUS: ______________________

RACE:
____ AMERICAN INDIAN OR ALASKAN NATIVE
____ ASIAN
____ BLACK OR AFRICAN AMERICAN
____ HISPANIC OR LATINO
____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____ WHITE
____ OTHER: ______________________________________

INSURANCE DETAILS
DOES CLIENT HAVE ACTIVE INSURANCE? ____ YES ____ NO ____ UNKOWN
MEDICAID CIN: MEDICARE #:

OTHER TYPE/#:

HIGHEST EDUCATION COMPLETED:

____ CURRENTLY IN SCHOOL

EMPLOYED: ____ YES ____ NO
____ PART-TIME ____ FULL-TIME
EMPLOYER NAME:
____

CURRENT BENEFITS RECEIVED:
____ NONE
____ PUBLIC ASSISTANCE
____ EARNED INCOME
____ CHILD SUPPORT
____ SUPPLEMENTAL SECURITY INCOME (SSI)
____ SOCIAL SECURITY DISABILITY INSURANCE (SSDI)
____ UNEMPLOYMENT
____ FAMILY
____ RESOURCES/ASSETTS: ____
____ OTHER: ____

CURRENT REPRESENTATIVE PAYEE SERVICES? ____ YES ____ NO ____ UNKNOWN
NAME/ORGANIZATION: ____________________________________ PHONE: __________________

EMERGENCY CONTACT (IF YES, PLEASE COMPLETE ADDITIONAL HIPAA AUTHORIZATION FOR THIS INDIVIDUAL):
NAME: ____________________________________ RELATIONSHIP: _______________
ADDRESS: PHONE:

SECTION 2 – REFERRAL SOURCE INFORMATION

NAME OF REFERENT:	RELATIONSHIP TO CLIENT:
AGENCY NAME:	EMAIL:
PHONE:	FAX:

SECTION 3 – SPOA ELIGIBILITY

To be eligible for services through the Adult Single Point of Access (ASPOA) Program, applicants must meet **all** of the following criteria. Please place a checkmark in each field where the answer is true.

_____ **The individual is 18+ years of age;**
_____ **The individual is willing to participate in these voluntary services;**
_____ **The individual has a primary DSM-5 diagnosis of a severe mental illness other than alcohol or substance use disorders, developmental disabilities, dementias, or mental disorders due to a general medical condition;**

1. Primary diagnosis: ____ ICD-10 Code: __________
2. Secondary diagnosis: ____ ICD-10 Code: __________
3. Other diagnosis: ____ ICD-10 Code: __________
4. Other diagnosis: ____ ICD-10 Code: __________
5. Other diagnosis: ____ ICD-10 Code: __________

-AND-

_____ **The individual is currently enrolled in SSI/SSDI due to a designated mental illness;**

-OR-

_____ **The individual must have documentation that they have experienced at least two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:**

_____ Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing healthcare, or complying with medical advice).
_____ Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
_____ Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
_____ Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete errors in tasks or require assistance in the completion of tasks).

-OR-

_____ **Reliance on Psychiatric Treatment, Rehabilitation, and Supports:** A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

ELIGIBILITY CERTIFICATION: I certify that this individual, who is eighteen years or older, is functionally disabled due to mental health needs, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the eligibility requirements listed above. I certify that I am the referent, and that this information is further justified in the attached mental health evaluation or other applicable assessment.

______________________________ ______________________________
Signature Date

SECTION 4 – REASON FOR REFERRAL

PLEASE GIVE AS MUCH DETAIL AS POSSIBLE

DESCRIBE THE INDIVIDUAL'S CURRENT CIRCUMSTANCES AND NEEDS (INCLUDING CURRENT PSYCHIATRIC SYMPTOMS):

____
____
____

DESCRIBE THE DESIRED OUTCOME OF THIS REFERRAL:

____
____
____

DESCRIBE THE INDIVIDUALS BASELINE FUNCTIONING:

____
____
____

DISCUSS THE INDIVIDUAL'S CURRENT AND PAST ADHERENCE WITH MENTAL HEALTH TREATMENT, INCLUDING ANY HISTORY OF NONCOMPLIANCE:

____
____
____
____

DISCUSS THE INDIVIDUALS REQUIRED LEVEL OF SUPERVISION:

____
____
____

DESCRIBE THE INDIVIDUAL'S TYPICAL INTERACTIONS WITH OTHERS (STAFF AND PEERS):

____
____
____

DESCRIBE THE INDIVIDUAL'S STRENGTHS AND SUPPORTS:

____
____
____

DESCRIBE THE INDIVIDUAL'S WEAKNESSES AND TRIGGERS (INCLUDING BEHAVIORS IF/WHEN THEY DECOMPENSATE):

____
____
____
____

OTHER INFORMATION:

____
____
____

SECTION 5 – CURRENT TREATMENT TEAM

LIST NAME OF WORKER, ORGANIZATION, AND PHONE NUMBER

MENTAL HEALTH TREATMENT

THERAPIST: ____________________

PRESCRIBER: ____________________

CARE MANAGER: ____________________

SUBSTANCE USE TREATMENT

COUNSELOR: ____________________

PRESCRIBER: ____________________

PEER ADVOCATE: ____________________

PRIMARY CARE: ____________________

PROBATION: ____________________

PAROLE/COMMUNITY SUPERVISION: ____________________

OTHER: ____________________

____

____

**SECTION 6 – MEDICAL AND BEHAVIORAL HEALTH HISTORY

FUNCTIONAL/MEDICAL LIMITATIONS:

____ IMPAIRED VISION
____ IMPAIRED HEARING
____ IMPAIRED ABILITY TO WALK
____ SPECIAL DIETARY NEEDS
____ REQUIRES SPECIAL MEDICAL EQUIPMENT
____ INTELLECTUAL OR DEVELOPMENTAL DISABILITY
____ TRAUMATIC BRAIN INJURY
____ LEARNING DISABILITY
____ DIABETES *(IF YES, SEE BELOW)*
REQUIRES INSULIN? ____ YES ____ NO
ABLE TO SELF-ADMINISTER INSULIN ____ YES ____ NO
____ ALLERGIES: ____________________
____
____
____ OTHER: ____________________
____
____

CURRENT MEDICAL CONDITIONS:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

COMMUNITY SURVIVAL SKILLS:

CAN APPLICANT EVACUATE A BUILDING INDEPENDENTLY WITHIN THREE MINUTES?
____ YES ____ NO

CAN APPLICANT BATHE & DRESS INDEPENDENTLY?
____ YES ____ NO

CURRENT MEDICAL MEDICATIONS:

____
____
____
____

<table>
<tr><td>CAN APPLICANT INDEPENDENTLY MAINTAIN THEIR HYGIENE/GROOMING?
____ YES ____ NO

IS APPLICANT AT RISK OF FALLING?
____ YES ____ NO

IS APPLICANT AT RISK OF WANDERING?
____ YES ____ NO

CAN APPLICANT COORDINATE THEIR OWN TRANSPORTATION?
____ YES ____ NO</td><td>____________________
____
____
____
____
____
____
____
____________________</td></tr>
<tr><td>PSYCHIATRIC MEDICATIONS (NAME, TYPE AND FREQUENCY):
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________
IF ANY OF THESE MEDICATIONS ARE LONG ACTING INJECTABLES, PLEASE SPECIFY.</td><td>APPLICANTS CAPABILITY TO ADMINISTER MEDICATIONS (CHOOSE ONE):
____ INDEPENDENTLY WITHOUT PROMPTS
____ INDEPENDENTLY WITH PROMPTS
____ IF ADMINISTERED TO THEM
____ UNABLE
____CURRENTLY REFUSING

IS THE INDIVIDUAL CURRENTLY MEDICATION COMPLIANT?
____ YES ____ NO

DATE OF LAST COMPLIANCE:

____________________</td></tr>
<tr><td colspan="2">HISTORY OF ASSISTED OUTPATIENT TREATMENT (AOT)?
____ YES ____ NO

IF YES, PROVIDE ADDITIONAL DETAILS SUCH AS WHICH COUNTY THEY WERE MONITORED IN, WHAT MEDICATIONS THEY WERE ON, THEIR SUCCESS OR FAILURE ON AOT, AND APPLICABLE DATES:
____
____
____
____
____</td></tr>
<tr><td colspan="2">SUBSTANCE USE HISTORY: HAS APPLICANT EVER USED, OR CURRENTLY USING, THE FOLLOWING SUBSTANCES?
➢ ALCOHOL …………………………………………… ____ PAST ____ CURRENT
LAST USE: ______________
➢ MARIJAUANA …………………………………… ____ PAST ____ CURRENT
LAST USE: ______________
➢ SYNTHETIC MARIJUANA …………………….. ____ PAST ____ CURRENT</td></tr>
</table>

LAST USE: ______________

- **METHAMPHETAMINE ……….……………….** ____ PAST ____ CURRENT
  LAST USE: ______________
- **AMPETAMINES …………………………………** ____ PAST ____ CURRENT
  LAST USE: ______________
- **OPIOIDS ……………………………………….** ____ PAST ____ CURRENT
  LAST USE: ______________
- **COCAINE/CRACK ………………………………** ____ PAST ____ CURRENT
  LAST USE: ______________
- **BENZODIAZEPINEs …………………………….** ____ PAST ____ CURRENT
  LAST USE: ______________
- **HALLUCINOGENS ………………………………** ____ PAST ____ CURRENT
  LAST USE: ______________
- **ABUSE OF PRESCRIBED MEDICATIONS …...** ____ PAST ____ CURRENT
  LAST USE: ______________
- **OTHER SUBSTANCES:**
  ____
  ____

____ **NO SUBSTANCE USE HISTORY IN THE APPLICANT'S LIFETIME**

PREVIOUS INPATIENT MENTAL HEALTH ADMISSIONS
(LIST FACILITY, DATES OF ADMISSION, AND REASON FOR ADMISSION:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

____ **NO INPATIENT MENTAL HEALTH ADMISSIONS**

PREVIOUS INPATIENT SUBSTANCE USE ADMISSIONS
(LIST FACILITY, DATES OF ADMISSION, AND REASON FOR ADMISSION:

1. ____
2. ____
3. ____
4. ____
5. ____

6. ______________________________

____ NO INPATIENT SUBSTANCE USE ADMISSIONS

PAST OUTPATIENT MENTAL HEALTH PROVIDERS: LIST NAME, DATES, AND PRIMARY DIAGNOSIS	**PAST OUTPATIENT SUBSTANCE USE PROVIDERS:** LIST NAME, DATES, AND PRIMARY DIAGNOSIS
1. ______________	1. ______________
2. ______________	2. ______________
3. ______________	3. ______________
4. ______________	4. ______________
5. ______________	5. ______________
____ NONE/NOT APPLICABLE	____ NONE/NOT APPLICABLE

SECTION 7 – FORENSIC HISTORY

IF YES, PLEASE PROVIDE DETAILS AND APPLICABLE DATES

RISK/CONCERN	CURRENT	PAST YR.	HISTORY	RISK/CONCERN	CURRENT	PAST YR.	HISTORY
PENDING CHARGES				SEXUAL OFFENSES			
MISDEMEANOR CHARGES				SEX OFFENDER REGISTRATION LEVEL: _____			
FELONY CHARGES				STRICT AND INTENSIVE SUPERVISION AND TREATMENT (SIST)			
VIOLENT FELONY CHARGES				MENTAL HEALTH COURT			
PROBATION				DRUG COURT			
PAROLE				HOPE COURT			
ARSON CHARGES				VETERANS TREATMENT COURT			

____ NO FORENSIC HISTORY

EXPLAIN ADDITIONAL INFORMATION REGARDING THE ABOVE FORENSIC HISTORY, IF APPLICABLE:

SECTION 8 – INDIVIDUAL'S RISKS & SAFETY CONCERNS

PLEASE MARK ANY APPLICABLE RISK/CONCERN IN THE CORRESPONDING TIME FRAME OF CURRENT, WITHIN THE PAST YEAR, OR HISTORY OF RISK/CONCERN

RISK/CONCERN	CURRENT	PAST YR.	HISTORY	RISK/CONCERN	CURRENT	PAST YR.	HISTORY
SUICIDAL IDEATION				ALCOHOL/SUBSTANCE USE			
SUICIDE ATTEMPT(S)				FIRE SETTING/ARSON			
SELF-INJURY				CRUELTY TO ANIMALS			
HOMICIDAL IDEATION				ACCESS TO WEAPONS			
HOMICIDE ATTEMPT				VIOLENCE/AGGRESSION			
HOMICIDE SUCCESS				IMPULSIVITY			
VICTIM OF ABUSE				POOR DECISION MAKING			
PERPETRATOR OF ABUSE				GANG INVOLVED/ACTIVITY			
PROPERTY DAMAGE				RUNNING AWAY/AWOL			
SEXUAL INAPPROPRIATENESS				OTHER: ___________________________			

____ NO RISK OR SAFETY CONCERN HISTORY

EXPLAIN ADDITIONAL INFORMATION REGARDING THE ABOVE RISK & SAFETY CONCERNS, IF APPLICABLE:

____
____
____
____
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____
____
____
____
____
____
____
____

SECTION 9 – PROGRAM GOALS

PLEASE MARK THE FOLLOWING GOALS YOU WOULD LIKE ASSISTANCE WITH OR WISH TO IMPROVE FROM SPOA SERVICES.

____ COMPLIANCE WITH MEDICATION/TREATMENT (MENTAL HEALTH, SUBSTANCE USE, MEDICAL
____ SOCIAL/COMMUNICATION SKILLS
____ JOB SKILLS/EDUCATION GOALS
____ MONEY MANAGEMENT/BUDGETING
____ COOKING/CLEANING
____ ACCESS TO COMMUNITY RESOURCES/TRANSPORTATION
____ ADVOCACY/ASSERTIVENESS
____ OTHER (PLEASE INDICATE): ____

SECTION 10 – SPOA SERVICES REQUESTED

PLEASE REVIEW THE ASPOA BROCHURE FOR DETAILS ON SERVICES BEFORE REQUESTING

CARE COORDINATION SERVICES:

____ HEALTH HOME CARE MANAGEMENT (HHCM)

____ INTENSIVE CASE MANAGEMENT (ICM)

____ ASSERTIVE COMMUNITY TREATMENT (ACT)

RESIDENTIAL SERVICES (GROUP SETTINGS WITH PROGRAMMING):

____ COMMUNITY RESIDENCE C/O CATHOLIC CHARITIES (CR)

____ ENRICHED LIVING CENTER (ELC) C/O RESCUE MISSION OF UTICA

____ STATE OPERATED COMMUNITY RESIDENCE (SOCR) C/O MOHAWK VALLEY PSYCHIATRIC CENTER

____ TRANSITIONAL LIVING CENTER (TLC) C/O MOHAWK VALLEY PSYCHIATRIC CENTER

RESIDENTIAL SERVICES (APARTMENT SETTINGS):

____ PATHWAYS APARTMENT PROGRAM (APT) C/O CATHOLIC CHARITIES ***Program***

____ SUPPORTED HOUSING (SH-CC) C/O CATHOLIC CHARITIES ***Rental stipend only***

____ SUPPORTED HOUSING (SH-UCP) C/O UPSTATE CARING PARTNERS

____ SUPPORTED HOUSING (SH-DP) C/O DEPAUL PROPERTIES ***SPECIFY: __ UTICA -or- __ ROME***

____ SUPPORTED HOUSING (SH-RMU) C/O RESCUE MISSION OF UTICA

____ LONG-TERM SUPPORTED HOUSING (LTSH) C/O CATHOLIC CHARITIES

____ MEDICAID RE-DESIGN TEAM (MRT) C/O CATHOLIC CHARITIES

____ TRANSFORMATION SUPPORTED HOUSING (TSH) C/O CATHOLIC CHARITIES

____ FORENSIC SUPPORTED HOUSING (FSH-HH) C/O HELIO HEALTH

____ FORENSIC SUPPORTED HOUSING PHASE 1 (FSH-CC1) C/O CATHOLIC CHARITIES

____ FORENSIC SUPPORTED HOUSING PHASE 2 (FSH-CC2) C/O CATHOLIC CHARITIES

SOCIAL EVENT SERVICES:

____ TRANSPORTATION SERVICES C/O CATHOLIC CHARITIES (TR-CC)

____ PSYCHOSOCIAL RECREATION SERVICES C/O CATHOLIC CHARITIES (PSR-CC)

**CLIENT FIRST NAME:	**CLIENT LAST NAME:

**SECTION 11 – HOMELESS VERIFICATION STATUS

CHOOSE ONE

ONLY COMPLETE THIS SECTION IF REFERRING TO **SUPPORTED HOUSING** PROGRAMS THROUGH DEPAUL, CATHOLIC CHARITIES, UPSTATE CARING PARTNERS, OR RESCUE MISSION OF UTICA.

	Individual has a primary nighttime residence that is a public or private place not meant for human habitation, such as a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground.
	Individual is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid by Federal, state or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing.
	Individual exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
	Individual is being released from a correctional facility or an inpatient hospitalization.

PROVIDE DETAILS OF HOMELESS STATUS:

____
____
____
____
____
____
____
____
____

CERTIFICATION:

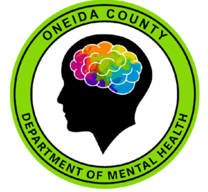
I verify, to the best of my knowledge, that the above information is true and accurate.

_______________________________ Print Name of Verifier

_______________________________ Signature of Verifier

_______________________________ Date of Verification

ONEIDA COUNTY
DEPARTMENT OF MENTAL HEALTH



ANTHONY J. PICENTE, JR.
County Executive

ASHLEE L. THOMPSON
Commissioner
Director of Community Services

HIPAA AUTHORIZATION FOR TWO-WAY EXCHANGE OF HEALTH INFORMATION
ADULT SINGLE POINT OF ACCESS (ASPOA)

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160; 45 CFR Parts 164; 42 CFR Part 2; 5 U.S.C. 552a; 38 U.S.C. 5701; and 38 U.S.C. 7332. Your disclosure of the information requested on this form is voluntary. The County of Oneida may disclose the information that you put on the form as permitted by law. Your signature on this form indicates you give the County of Oneida permission to use and/or disclose your Protected Health Information (PHI) identified below with authorized individual(s) and/or agencies. Disclosure of PHI may be written, electronic, or verbal. Authorization of this form includes the communication and disclose to/from/between all organizations that offer services through the Oneida County ASPOA Program to coordinate services on your behalf. These agencies include ACR Health, Building Blocks Learning Center, Catholic Charities Diocese of Syracuse - Oneida/Madison County, Central New York Health Home, Inc., County of Oneida (aka Oneida County Government), DePaul Properties, Inc., Helio Health, Inc., Integrated Community Alternatives Network (ICAN), Mohawk Valley Psychiatric Center, Neighborhood Center, Inc., Presbyterian Residential Community, Rescue Mission of Utica, Salvation Army and Upstate Cerebral Palsy dba Upstate Caring Partners.

**Asterix marked sections are required to be completed.

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**
****DATE OF BIRTH** ***(mm/dd/yyyy):***	****PHONE #:**
INDIVIDUAL'S MAILING ADDRESS ***(including City, State and Zip Code):***	

RECIPENT OF PROTECTED HEALTH INFORMATION (PRE-FILLED**):**
ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH (OCDMH)
800 PARK AVENUE, UTICA, NY 13501

****NAME OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	****PHONE # OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISLOSE PHI TO OCDMH:**
****ADDRESS OF AGENCY OR INDIVIDUAL BEING AUTHORIZED TO DISCLOSE PHI TO OCDMH:**	

THE PURPOSE FOR WHICH THIS INFORMATION MAY BE USED, DISCLOSED, OR REDISCLOSED INCLUDE (PRE-FILLED8**):**

- TO DETERMINE INITIAL AND CONTINUING HOME & COMMUNITY BASED SERVICES SUCH AS RESIDENTIAL, CASE MANAGEMENT, ASSERTIVE COMMUNITY TREATMENT, CRISIS, TRANSPORTATION, VOCATIONAL, AND/OR EDUCATIONAL RESOURCES;
- TO DETERMINE AND MAKE RECOMMENDATIONS FOR APPROPRIATE LEVELS OF CARE;
- TO ASSIGN APPROPRIATE SERVICES OFFERED THROUGH PARTNERSHIPS WITH SINGLE POINT OF ACCESS (SPOA) PROGRAMS;
- TO ACCESS DATA IN PSYCKES TO DETERMINE SERVICE ELIGIBILITY AND LEVEL OF SERVICE NEED; AND
- TO PLAN AND COORDINATE SERVICES AND TREATMENT.

****INFORMATION REQUESTED AND TO BE RELEASED (CHECK EACH APPLICABLE):**

_____ ENTIRE MEDICAL/SERVICE RECORD (INCLUDING PSYCHIATRIC & SUBSTANCE USE RECORDS)

-OR-

_____ BEHAVIORAL/MENTAL HEALTH/OTHER PSYCHIATRIC SCREENINGS/ASSESSMENTS/EVALUATIONS
_____ SUBSTANCE USE RECORDS

_____ FORENSIC HISTORY & RECORDS
_____ LEGAL HISTORY & RECORDS
_____ MEDICAL INFORMATION/HISTORY/CONCERNS (INCLUDING LABWORK/CLINICAL PROCEDURES)
_____ LETHALITY/RISK ASSESSMENTS/SCREENINGS/CONCERNS
_____ DIAGNOSIS/PROGNOSIS/PROGRESS IN TREATMENT/SERVICES
_____ HOUSING HISTORY
_____ MEDICATION HISTORY
_____ CASE MANAGEMENT RECORDS
_____ ADMISSION/INTAKE INFORMATION
_____ SERVICE PLAN(S)/IEP
_____ HIV/AIDS RELATED INFORMATION
(For HIV/AIDS disclosure: *I understand I also need to complete Form DOH 2557 found on the NYS Department of Health website.*

_____ OTHER: ____
____
____
____

AUTHORIZATION:
I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. This authorization is signed with the express understanding that the released information shall not be used for any purpose other than to provide and coordinate behavioral health services and shall be used in a confidential manner. I understand that I can receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the County of Oneida – Department of Mental Health. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. **I understand this disclosure includes future generated records 24 months after the date of my signature unless specified otherwise in the "expiration" section. Further, I understand that these records may be redisclosed amongst the providers who provide SPOA services in Oneida County, NY.**

EXPIRATION (IF NONE – SKIP THIS SECTION):
Only fill out this part if you are placing limitations on the expiration of permissions and/or limitations on permission)
UPON THE FOLLOWING DATE: ____
UPON THE FOLLOWING EVENT: ____

****SIGNATURE OF INDIVIDUAL:**

I am the person, or personal representative of the person, whose records will be used, disclosed and/or re-disclosed. I give permission to use, disclose and/or re-disclose my records as described in this document

DATE:

****FIRST NAME OF INDIVIDUAL**	****LAST NAME OF INDIVIDUAL:**