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:

SECONDARY LANGUAGE:

LANGUAGE IF INTERPRETER IS NEEDED: _____

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
___ RESOURCES/ASSETTS: _____
___ OTHER: _____
___ SUPPLEMENTAL SECURITY INCOME (SSI)
___ SOCIAL SECURITY DISABILITY INSURANCE (SSDI)
___ UNEMPLOYMENT
___ FAMILY

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 WORK
☐ 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:

_____
_____
_____
_____
_____
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_____
_____
_____
_____

COMMUNITY SURVIVAL SKILLS:

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

CAN APPLICANT BATHE & DRESS INDEPENDENTLY?
◯ YES ◯ NO

CURRENT MEDICAL MEDICATIONS:

_____
_____
_____
_____

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	_____ _____ _____ _____ _____ _____ _____ _____ _____
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.	**APPLICANTS CAPABILITY TO ADMINISTER MEDICATIONS (CHOOSE <u>ONE</u>):** ___ 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:** _____

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:

_____

_____

_____

_____

_____

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

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:

_____
_____
_____
_____
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_____
_____
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_____
_____

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

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:**