Updated on 10/19/21

Children's Single Point of Access Application

Instructions

Thank you for completing this application for the Children's Single Point of Access. When a child in our community is in need of assistance, we are always grateful to find out so that we can make sure that s/he is connected to the care and support that they and their family need.

The Children's Single Point of Access (C-SPOA) is operated by Clinton County government to enable families easy, streamlined access to the mental health service system regardless of their financial resources or insurance status. While C-SPOA does not provide any direct services, it can help a family to access the complete continuum of mental health services for a child. If you are in doubt as to whether the child about whom you are concerned should be referred to the C-SPOA, please make the referral.

The attached form requests information that will enable us to ascertain how best to begin serving this family.

- **Please complete this form no matter what kind of insurance the child has, or if the child has no insurance. C-SPOA services are available for all children in NYS, regardless of their insurance or immigration status.**
- **Please complete the form to the best of your ability – fields can remain incomplete if information is unavailable.**
  - **If you have documentation of the child's diagnosis, please provide it, but we do not want you to delay the application gathering documentation.**
  - **The C-SPOA will be able to help capture any missing information once you submit this form to them.**
  - **If you need help with this form, please call Erica Leonard at 518-565-4060.**
- **There are two consent forms attached to this application.**
  - **The Consent for Release of Information is REQUIRED in order for us to access the information we need to process this application. Therefore, we cannot process this application without appropriate consent signatures.**
  - **The Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent is OPTIONAL. This information will help us to coordinate services for the child, so it is helpful if the patient/guardian signs it, but it is NOT essential.**

When you have completed this form, please submit it by encrypted email to erica.leonard@clintoncountygov.com, by fax to 518-566-0168, or by mail to Clinton County Mental Health & Addiction Services 130 Arizona Ave, Suite 1500 Plattsburgh, NY 12903.

Clinton County

New York

CLINTON COUNTY SINGLE POINT OF ACCESS (SPOA) for CHILDRENS SERVICES

Check the box ☐ for the service you are referring the prospective recipient to:

☐ **NON-MEDICAID HEALTH HOME CARE MANAGEMENT (HHCM)**

Non-Medicaid Health Home Care Management Serves children/youth, up to the age of 21, with Serious Emotional Disturbance who need care management services and who are not eligible for Medicaid and therefore cannot enroll in Health Home.

☐ **COMMUNITY RESIDENCE (Adirondack Youth Lodge)**

The Adirondack Youth Lodge is a 24-hour 8-bed Community Residence serving youth who have serious and persistent symptoms caused by a designated mental illness diagnosis. The program is certified by the Office of Mental Health and provides local treatment options for at-risk males and females (ages 12-18). Youth and their families are engaged in improving their relationships by being provided with intensive services both in and out of the home. Restorative interventions are tailored to meet the child "where they're at", while remaining focused on empowering their entire network of support. Some services provided are behavior support, educational/vocational support, family support, health services, and medication management.

Additional documents required FOLLOWING SPOA Endorsement of the referral:

Adirondack Youth Lodge Referral And Admission Packet.

☐ **RESIDENTIAL TREATMENT FACILITY (RTF)**

A RTF is within the inpatient system of care that provides an extended level of care for children with serious emotional disturbances. Consideration for RTF may include the level in which the child/family has participated in or had access to less intensive services/supports to help the child function safely in home, school, and community environments. The SPOA Committee must endorse all RTF/PACC referrals. It is important that all local resources/services have been exhausted before a PACC referral is made.

Additional documents required FOLLOWING SPOA Endorsement:

Pre-Admission Certification Committee (PACC) Referral

Children's Single Point of Access Application

Today's date_____

Child's Information			
Full Name (Last, First MI)		People with the following immigration status may be eligible for Medicaid: • Citizen • Permanent resident (green card holder) • Refugee or asylee • U or T visa holder (for victims of crime or trafficking) • Employment authorization card holder • Deferred Action for Childhood Arrivals (DACA) recipient Does the child's immigration status fall into one of the above categories? YES NO	
Date of Birth	SSN		
Home Address			
Mailing Address (if different from home)			
Primary Language(s)	Does the child have health insurance? YES NO	Gender Identity	Fluent in English? YES NO
Insurance Plan	Insurance Policy Number	Medicaid/CIN#	
Is this child enrolled in Health Home Care Management? YES NO UNKNOWN		If yes, please indicate which Health Home/Care Management Agency	

Referral Information		
Date of Referral	Name/Title of Referrer	Referring Organization/Program
Address of Referrer		
Referrer Phone	Referrer Fax	Referrer Email
Reason for Referral (attach additional sheet if needed)		
Referrer Signature		

Caregiver Contact #1 Information		Caregiver Contact #2 Information	
Full Name		Full Name	
Address		Address	
Phone	Email	Phone	Email
Relationship to Child	Legal Guardian? YES NO	Relationship to Child	Legal Guardian? YES NO
Caregiver Primary Language	Fluent in English? YES NO	Caregiver Primary Language	Fluent in English? YES NO
Is this caregiver the primary contact? YES NO		Is this caregiver the primary contact? YES NO	
Is this caregiver enrolled in Health Home Care Management? YES NO UNKNOWN		Is this caregiver enrolled in Health Home Care Management? YES NO UNKNOWN	
If yes, please indicate which Health Home/Care Management Agency		If yes, please indicate which Health Home/Care Management Agency	

Children's Single Point of Access Application

Child's Name _____

Legal Custody Status	
Both parents together	Joint custody
Biological mother only	DSS
Biological father only	Adult Sibling
Other Legal Guardian (describe):	Emancipated Minor
	Adoptive Parent

Current Providers	
School and grade	Therapist/Therapist's agency
Psychiatrist/Psychiatrist's agency	Other service provider/agency

IQ Testing Scores (if available)		
Verbal	Full Scale	Test date

Additional Information	
Is child/youth currently admitted to an inpatient facility? ☐ YES ☐ NO	Number of hospitalizations in the previous 12 months
If yes, name of facility and expected discharge date:	Number of Emergency Department visits in the previous 12 months
Is child/youth currently receiving DSS preventive services? ☐ YES ☐ NO ☐ UNKNOWN	Other systems involvement (e.g. CPS, MST, etc.) – Please specify
If yes, name of provider	

Mental Health Diagnosis (if known)	
Does the child have a diagnosed serious emotional disturbance? ☐ YES ☒ NO	If so, what is it?
If yes, by whom was the diagnosis made?	If yes, when was the diagnosis made?

Preliminary Eligibility Screening	
Does the child have two or more chronic medical conditions (i.e. asthma, diabetes, substance use disorder)?	☐ YES ☐ NO ☐ UNKNOWN
Does the child have HIV/AIDS?	☐ YES ☐ NO ☐ UNKNOWN
Do you believe the child has a Serious Emotional Disturbance? (child meets one of the below criteria) • Difficulty with self-care, family life, social relationships, self-control, or learning • Suicidal symptoms • Psychotic symptoms (hallucinations, delusions, etc.) • Is at risk of causing personal injury or property damage • The child's behavior creates a risk of removal from the household	☐ YES ☐ NO ☐ UNKNOWN
Has the child been exposed to multiple traumatic events that have left a long-term and wide-ranging impact?	☐ YES ☐ NO ☐ UNKNOWN

If you have supporting documentation related to one of the above diagnoses/conditions, please attach it.

Please complete attached REQUIRED consent for release of information to process this SPOA application.

Child's Information	
Full Name (Last, First MI)	
Date of Birth	SSN

Symptom Checklist – current and leading to referral	Never	Rarely	Sometimes	Often	Always	Unknown
Psychotic symptoms	☐	☐	☐	☐	☐	☐
Attention Deficit/ Impulse Control	☐	☐	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Antisocial/ Unlawful Behaviors	☐	☐	☐	☐	☐	☐
Alcohol/ Substance Use/ Abuse	☐	☐	☐	☐	☐	☐
Self-Injurious Behaviors	☐	☐	☐	☐	☐	☐
Suicidal ideation/ Threats	☐	☐	☐	☐	☐	☐
Suicide Gestures/ Attempts	☐	☐	☐	☐	☐	☐
Fire Setting	☐	☐	☐	☐	☐	☐
Physical Aggression	☐	☐	☐	☐	☐	☐
Running Away	☐	☐	☐	☐	☐	☐
Sexually Inappropriate/ Aggressive Behavior	☐	☐	☐	☐	☐	☐
Difficulty in Peer Interactions	☐	☐	☐	☐	☐	☐
Low Self-Esteem	☐	☐	☐	☐	☐	☐
Truancy	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐

Current Educational Placement/ Program			
☐ Regular Class in age appropriate grade	☐ Special class for students with challenging social/emotional conditions	☐ Day Treatment Program	☐ GED
☐ Regular Class, above grade level	☐ Education, In-district program/services	☐ Part-time Vocational/ Educational	☐ Other (specify)
☐ Regular class but behind at least one grade	☐ Home Instruction	☐ Residential School Placement	☐ Not enrolled in school

BOCES	Home School District	Grade	Building

Alternate School Placement

Date of last IEP

Committee on Special Education Classification (CSE)		
☐ Emotional Impairment	☐ Sensory impairment (vision, hearing)	☐ Other Health Impairment
☐ Intellectual Impairment	☐ Autism	☐ Unknown
☐ Learning Impairment	☐ Physical Impairments	☐ Other (specify)
☐ Multiple Impairments	☐ Speech/ Language Impaired	

Diagnostic Information	
Diagnosis 1.	Date of Diagnosis
2.	Name & Credentials of Person Making Diagnosis
3.	
4.	Organization
5.	Phone
Medication for a Medical Condition	
Medication for a Psychiatric Condition	

Functional Limitation(s)	Moderate	Severe
Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries)	☐	☐
Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting)	☐	☐
Social relationships (e.g. 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)	☐	☐
Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability)	☐	☐
Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)	☐	☐

Child Strengths	
☐ Self-advocacy	☐ Family support
☐ Conflict resolution skills	☐ Good ability to establish rapport
☐ Sets goals/works	☐ Good personal hygiene and care in appearance
☐ Seeks outside assistance when needed	☐ Good physical health
☐ Follows through with recommendations/addresses needs	☐ Healthy social supports/peer group
	☐ Involvement in activities/community
☐ Open to/accepting of service/treatment	☐ Religious institution/spiritual involvement
☐ Capacity for openness	☐ Views self as belonging to a specific cultural group
☐ Interested in relationships with others	☐ Other (please specify) _____
☐ Capacity to tolerate painful emotions	_____

Caregiver Strengths	
☐ Ability to appropriately monitor and discipline	☐ Problem-solving skills
☐ Involved in seeking and supporting care to address the child's needs	☐ Ability to navigate other systems involved (e.g. legal, medical, developmental disabilities, etc.)
☐ Seeks additional information to advocate for the child	☐ Maintains safe, secure environment for the child
☐ Ability to organize and manage household	☐ Religious institution/spiritual involvement
☐ Presence of natural supports to help raise child	☐ Views self as belonging to a specific cultural group
☐ Provides stable housing	☐ Other (please specify)_____
☐ Healthy social supports/peer group	_____

Adverse Childhood Experiences (ACE)	
Has an ACE screening been conducted? ☐ YES ☐ NO ☐ UNKNOWN	If so, by whom? (please provide name and contact info)
If so, please provide the score:	

Complex Trauma Screening		
Prompts/Questions **If the answer to any question in one row is yes, please move on to the next row**	**Present? Y/N**	**> 6 mos ?**
• Was there a time when adults who were supposed to be taking care of the child didn't? • Has there ever been a time when the child did not have enough food to eat? • Did a parent or other adult in the household often … Swear at the child, insult the child, put the child down, or humiliate the child? Or act in a way that made the child afraid that the child might be physically hurt?	☐ **Yes** ☐ **No**	☐
• Has the child lived with someone other than the child's parents/caregiver while the child was growing up (because they couldn't take care of the child or the child was kicked out)? • Has the child ever been homeless? o This means the child ran away or was kicked out and lived on the street for more than a few days? Or the child and the child's family had no place to stay and lived on the street, or in a car, or in a shelter?	☐ **Yes** ☐ **No**	☐
• Has the child lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons? • Has the child been left in the care of different people due to parental incapacity or dysfunction, even if the child's primary place of residence did not change? • Has the child had two or more changes in primary caregiver or guardian, either formally (legally) or informally?	☐ **Yes** ☐ **No**	☐
• Has anyone ever made the child do sexual things the child didn't want to do, like touch the child, make the child touch them, or try to have any kind of sex with the child? • Has anyone ever *tried* to make the child do sexual things the child didn't want to do? • Has anyone ever forced the child (or tried to force the child) to have intercourse?	☐ **Yes** ☐ **No**	☐
• Has the child ever been hit or intentionally hurt by a family member? o If yes, did the child have bruises, marks or injuries?	☐ **Yes** ☐ **No**	☐
• Has the child ever *seen* or *heard* someone in the child's family/house being beaten up • Has the child ever *seen* or *heard* someone in the child's family/house get threatened with harm?	☐ **Yes** ☐ **No**	☐
• Has the child ever *seen or heard* someone being beaten, or who was badly hurt? • Has the child seen someone who was dead or dying, or *watched or heard* them being killed? • Has anyone ever hit anyone or beaten anyone up (physically assaulted anyone?) • Has anyone ever threatened to physically assault anyone (with or without a weapon)?	☐ **Yes** ☐ **No**	☐
• Did other children often tease or insult anyone, put anyone down, or threaten anyone physically? • Did they spread lies about anyone or turn other people against anyone?	☐ **Yes** ☐ **No**	☐
• Has anyone or anyone in the child's family been involved in, or *in direct danger* from a terrorist attack, war, or political violence?	☐ **Yes** ☐ **No**	☐
• Has anyone ever stalked the child? • Did anyone ever try to kidnap the child?	☐ **Yes** ☐ **No**	☐
• Is there anything else really scary or very upsetting that has happened to the child that I haven't asked about? Sometimes people have something in mind but they're not comfortable talking about the details. Is that true for you?	☐ **Yes** ☐ **No**	☐

Service Utilization History

History of Past and Present Services: (Please check all that apply)

- ☐ Intensive Case Management
- ☐ Service Coordination/Case Management
- ☐ Individualized Care Coordination
- ☐ Clinic Treatment
- ☐ Private/Individual Therapy
- ☐ Crisis Response Services
- ☐ Home Based Crisis Intervention
- ☐ Day Treatment
- ☐ Respite
- ☐ Medication Management
- ☐ Vocational Training
- ☐ ADL or Independent Living Skills
- ☐ Alcohol Abuse Treatment
- ☐ Substance Abuse Treatment
- ☐ Family Support Services
- ☐ Transportation
- ☐ After School/Weekend Program
- ☐ Specialized Summer Program
- ☐ Specialized Educational Services
- ☐ Speech & Language Therapy
- ☐ Mentoring
- ☐ Flexible Funding
- ☐ Foster Care
- ☐ State Psychiatric Facility
- ☐ Private Psychiatric Facility
- ☐ General Hospital Psychiatric Inpatient
- ☐ OPWDD Developmental Center
- ☐ Intensive in Home
- ☐ CCSI
- ☐ Supportive Case Manager
- ☐ Residential Treatment Facility
- ☐ Other (Specify) _____

Service Utilization Detail

Provider Name and Service Type	Date(s) of service

List of agencies with which the SPOA Committee is permitted

to exchange information

Clinton County Mental Health & Addiction Services

Behavioral Health Services North

Northern Rivers

University of Vermont Health Network/CVPH

Champlain Valley Family Center

Clinton County Department of Social Services

Clinton County Department of Probation

Champlain Valley Educational Services

NYS Office for People With Developmental Disabilities (OPWDD)

Champlain Valley Health Network

National Alliance for Mental Illness (NAMI)

St. Lawrence Psychiatric Center

UVHN/CVPH - Medical Home

Youth Advocacy Program (YAP)

CFTSS Agencies (Child and Family Treatment Support Services)

Adirondack Youth Lodge (Citizen Advocates, Inc.)

Berkshire Farms

School Districts' Office of Pupil Personnel Services/CSE

Office of Mental Health Mobile Integration Team (MIT)

C-Yes of Maximus (state designated independent entity)

_____

Child's Name _____

REQUIRED CONSENT FOR RELEASE OF INFORMATION
for Single Point of Access (SPOA), _____County ("County")

This authorization must be completed by the referred individual or his/her legal guardian/personal representative. This authorization permits the use, disclosure and re-disclosure of Protected Health Information (PHI) in accordance with State and Federal laws and regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records for the purposes of care coordination, delivery of services, payment for services, and health care operations.

I AUTHORIZE communication with, and an exchange of Personally Identifying Information (PII) and PHI between, the County Single Point of Access (SPOA) team (comprised of County and state employees as well as representatives of local service providers), Other Provider(s) (see attached list of Providers on page 2); **AND** the Referral Source (Person / Title / Agency / School or Correctional Facility):

_____

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

- ☐ Referral (including contact info)
- ☐ Psychiatric Evaluation/Assessment
- ☐ Mental Health/Psychosocial Assessment
- ☐ Psychological &/or Neurological Tests
- ☐ Documentation of Medical Necessity
- ☐ Psychosocial History and Assessment
- ☐ Family Planning Information
- ☐ Inpatient/Outpatient Treatment
- ☐ Financial &/or Insurance Info
- ☐ Discharge Summary/Treatment Plan
- ☐ Pre-Sentence Investigation Report
- ☐ HIV/AIDS-related Information
- ☐ Other (specify): _____
- ☐ Diagnosis
- ☐ Physical Health
- ☐ Medications (past & present)
- ☐ Substance Use
- ☐ School Records (including testing)

PURPOSE OR NEED FOR INFORMATION:
Allow SPOA to: make referrals to appropriate providers; consult regarding care; participate in care management services; provide discharge planning information to the providers listed on page 2; coordinate care among providers and through Health Homes; and facilitate participation in services accessed through SPOA.

I UNDERSTAND and ACKNOWLEDGE:

- This information must not be used, disclosed, or re-disclosed for any other purpose not covered under this authorization;
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of information related to HIV/AIDS-related, alcohol or drug treatment, or mental health treatment, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law or regulation;
- I am authorizing the re-disclosure of above-described information to the providers identified on page 2 of this form for the purposes identified on this form;
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on a form provided by **County.** I am aware that my revocation does not affect information disclosed while the authorization was in effect;
- I do not have to sign this authorization and that my refusal to sign will neither affect my ability to obtain treatment, nor my eligibility for benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524);

I HEREBY AUTHORIZE the use, disclosure, and re-disclosure of the indicated PHI by and to the parties identified on this release as often as necessary to fulfill the purpose(s) identified above, and this authorization will expire: (check one)

☐ When the individual named herein is no longer receiving services from County SPOA;

☐ One Year from the date of signature; ☐ Other: _____

I CERTIFY THAT I AUTHORIZE the use of the PHI as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
SIGNATURE of Individual, Parent or Legal Guardian **Printed Name of Individual signing** **Date**

_____
Description of Authority of Personal Representative

_____ _____ _____
SIGNATURE of WITNESS **Printed Name of Witness/Title** **Date**

Children's Single Point of Access Application Child's Name _

COMMUNICATION PREFERENCES

County SPOA wants to respect your wishes regarding Communication. Please indicate your preferences below.

US Mail

Can we send mail to your address with our return address on the envelope? ☐ Yes ☐ No

Telephone:

When calling, can we say we are County SPOA (Single Point of Access)? ☐ Yes ☐ No

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PERMISSION FOR ELECTRONIC COMMUNICATION

I understand the transmission of electronic information may not be secure. E-mails and cell phone communications are unencrypted, and other concerns may exist including but not limited to: email and faxes may accidently be sent to the wrong person; content may be changed without knowledge; copies may exist; some e-mails may contain harmful viruses; cell phone communications may be intercepted or heard by others; texting leaves a record of communication; and there is a risk of loss of device with information on it.

BY SIGNING BELOW, I HEREBY AUTHORIZE County Mental Health SPOA Team permission to correspond ***with me*** via *(check all that apply)*:

□ FAX	Fax Number:	_____
□ E-MAIL	Email Address:	_____
□ CELL PHONE	Phone Number:	_____
□ TEXT MESSAGE	Phone Number:	_____

I understand this permission may be cancelled by me at any time but cannot apply retroactively to communication that has already been sent.

_____ _____ _____

SIGNATURE of Individual, Parent or Legal Guardian **Printed Name of Individual signing** **Date**

_____

Description of Authority of Personal Representative

_____ _____ _____

SIGNATURE of WITNESS **Printed Name of Witness/Title** **Date**

Children's Single Point of Access Application

Child's Name _

Optional Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent

_____
Name of SPOA County

The SPOA Committee may get health information, including your child's health records, through a computer system run by_____, a Regional Health Information Organization (RHIO) A RHIO uses a computer system to collect and store health information, including medical records, from your child's doctors and health care providers who are part of the RHIO. The RHIO can only share your child's health information with people who you say can see or get such health information.

The SPOA Committee may also get health information, including your child's history of services reimbursed by Medicaid through a computer system called PSYCKES, which is run by the New York State Office of Mental Health. PSYCKES is a computer system maintained by the New York State Office of Mental Health that contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

If you agree and sign this form, SPOA Committee members are allowed to get, see, read and copy ALL of your child's health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your child's care, manage such care or study such care to make health care better for patients. The health information they may get, see, read and copy may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries your child had or may have had before; test results, like X-rays or blood tests; and the medicines your child is now taking or has taken before. Your child's health records may also have information on:

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

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your child's health information must obey all these laws. They cannot give your child's information to other people unless an appropriate guardian agrees or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your child's health information and the SPOA Committee must obey these laws and rules.

Please read all the information on this form before you sign it

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

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

_____
Print Name of Patient

Patient Date of Birth _____

Optional Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent

_____
Name of SPOA County

By signing this form, you agree to have your child's health information shared with the SPOA Committee. The goals of the SPOA Committee are to improve the integration of medical and behavioral health and to help healthcare providers improve quality of care. To support coordination of your child's care, health care providers and other people involved in such care need to be able to talk to each other about your child's care and share health information with each other to give your child better care. Your child will still be able to get health care and health insurance even if you do not sign this form.

The SPOA Committee may get health information, including your child's health records, through a computer system run by_____, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store health information, including medical records, from your child's doctors and health care providers who are part of the RHIO. The RHIO can only share your child's health information with people who you say can see or get such health information. PSYCKES is a computer system to collect and store health information from doctors and health care providers to help them plan and coordinate care.

If you agree and sign this form, the SPOA Committee members are allowed to get, see, read and copy, and share with each other, ALL of your child's health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your child's care, manage such care or study such care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries your child had or may have had before; test results, like X-rays or blood tests; and the medicines your child is now taking or has taken before. Your child's health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions;
6. Sexually-transmitted diseases (diseases you can get from having sex);
7. Social needs information (housing, food, clothing, etc..) and/or
8. Assessment results, care plans, or other information you or your treatment provider enter into PSYCKES.

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your child's health information must obey all these laws. They cannot give your child's information to other people unless an appropriate guardian agrees or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your child's health information and the SPOA Committee must obey these laws and rules.

Please read all the information on this form before you sign it.

☐ **I AGREE** that the SPOA Committee can get ALL my child's health information through the RHIO and/or through PSYCKES to give my child care or manage my child's care, to check if my child is in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the SPOA Committee and the health provider agencies may share my child's health information with each other. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the SPOA participating providers.

_____ _____
Print Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____

Children's Single Point of Access (C-SPOA)
Patient Information Sharing Consent

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**

   If you agree, SPOA providers will use your health information to:
   - Coordinate your health care and manage your care;
   - Check if you have health insurance and what it pays for; and
   - Study and make health care for patients better.

   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. **Where does my health information come from?**

   Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

3. **What laws and rules cover how my health information can be shared?**

   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

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

   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients.

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

   If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at_____, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **How long does my consent last?**

   Your consent will last until the day you take back your consent, or if the SPOA stops working, or three years after the last date of service from the SPOA, whichever comes first.

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

   You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the SPOA. You can get this form by calling_____. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

8. **How do I get a copy of this form?**

   You can have a copy of this form after you sign it.