Children's Single Point of Access Application Part 1

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Directions: Complete this form and submit to the youth applicant's C-SPOA of origin to apply for C-SPOA Coordination.
Note: To apply for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF), submit this completed form and the C-SPOA Application Part 2 to C-SPOA.

☐ Check this box if submitting this application with the C-SPOA Part 2 Application for Youth ACT, CCR and RTF.

Youth Applicant Information

Youth's Name in Use

Pronouns in Use

Sex assigned on youth's birth certificate
☐ Male
☐ Female

Gender Identity
☐ Agender ☐ Nonbinary/Genderqueer
☐ Female ☐ X
☐ Male ☐ Other: _____

Youth's Race – select all that apply
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American

Primary Language/Means of Communication:

Is the youth fluent in English? ☐ Yes ☐ No

Youth's Ethnicity ☐ Hispanic ☐ Non-Hispanic

SSN

County of Origin

Permanent Home Address, if applicable

Current Location (if different from home)

Does the youth have Medicaid coverage? ☐ Yes ☐ No

Medicaid/CIN#

Check if the youth is eligible for any of the following:
☐ Title IV-E ☐ SSI ☐ SSDI

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 youth's immigration status fall into one of the above categories? ☐ Yes ☐ No

Is documentation available to confirm the youth's immigration status falls into one of the above categories? ☐ Yes ☐ No

Does youth have private health insurance? ☐ Yes ☐ No

Insurance Plan

Insurance Policy Number

Is youth enrolled in Health Home Care Management/Coordination?
☐ Yes ☐ No ☐ Unknown

If the child is enrolled in Health Homes Serving Children or Health Homes Serving Individuals with ID and/or DD, provide contact info.:
Agency & HHCM/CCO Name:_____
Phone Number:_____ Email:_____

Referrer Contact information (if other than caregiver)

Name/Title of Referrer

Referring Organization/Program

Address of Referrer

Referrer Phone

Referrer Fax

Referrer Email

Children's Single Point of Access Application Part 1

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Caregiver Contact #1 Information		Caregiver Contact #2 Information	
Full Name Primary Contact? ☐		**Full Name** Primary Contact? ☐	
Address		**Address**	
Phone	**Email**	**Phone**	**Email**
Relationship to Youth	**Legal Guardian?** ☐ Yes ☐ No	**Relationship to Youth**	**Legal Guardian?** ☐ Yes ☐ No
Caregiver Primary Language	**Fluent in English?** ☐ Yes ☐ No	**Caregiver Primary Language**	**Fluent in English?** ☐ Yes ☐ No

Legal /Custody Status

- ☐ Both parents together
- ☐ Biological father only
- ☐ Biological mother only
- ☐ Joint custody
- ☐ Adoptive Parent(s)
- ☐ OCFS and Family Court. Identify Status
  - ☐ Case Pending
  - ☐ Person In Need of Supervision (PINS)
  - ☐ Youthful Offender
  - ☐ Juvenile Offender
  - ☐ Juvenile Delinquent
  - ☐ Restrictive Placement
- ☐ Other, Relative
- ☐ Emancipated Minor
- ☐ DSS. Identify locality:
- ☐ ACS. Identify Case Planning agency:

Please note any details about custody status (e.g. restricted access):

Reason for C-SPOA Coordination Referral

Reason for referral (Identify service needs and interests. Attach additional sheet if needed.)

Mental Health Diagnosis (if known)

Does the child have a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown	**If so, what is the primary diagnosis?**
	When was the diagnosis made?
Has a Licensed Practitioner of the Healing Arts determined that the youth meets criteria for serious emotional disturbance? ☐ Yes ☐ No ☐ Unknown	**If so, when was the determination made?**

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Intellectual and Developmental Disability Diagnosis (if known)	
Does the child have an intellectual and/ or developmental disability diagnosis? ☐ Yes ☐ No ☐ Unknown	**If so, what is the diagnosis?**
	When was the diagnosis made?

IQ Testing Scores (if available)			
Full Scale	**Verbal Subscale,** as applicable	**Non-Verbal Subscale,** as applicable	**Test date**

Current Providers	
School and grade	**Therapist/Therapist's agency**
Psychiatric Medication Prescriber/agency	**Other service provider/agency**

Additional Service Information	
Number of psychiatric hospitalizations in the previous 12 months	**Number of Emergency Department visits in the previous 12 months**
Is the youth currently eligible for Home and Community Based Services? ☐ Yes ☐ No ☐ Application Pending ☐ Unknown	
Is youth currently receiving preventive services through DSS or ACS? ☐ Yes ☐ No ☐ Unknown	**If yes, name of Prevention provider**
Is the youth currently in foster care? ☐ Yes ☐ No ☐ Unknown	**Is the youth freed for adoption?** ☐ Yes ☐ No ☐ Unknown
Is the youth currently OPWDD eligible? ☐ Yes ☐ No ☐ Application Pending	**Is the youth currently eligible for OPWDD Home and Community Based Services?** ☐ Yes ☐ No ☐ Application Pending
Other systems involvement (e.g., child welfare, etc.) – Please specify	

Preliminary Eligibility for Health Home Case Management	check here if the youth has HHCM		
Does the youth have two or more chronic conditions (e.g., asthma, diabetes, substance use disorder)?	☐ Yes	☐ No	☐ Unknown
Does the youth have HIV/AIDS?	☐ Yes	☐ No	☐ Unknown
Do you believe the youth has a Serious Emotional Disturbance? (Youth 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 youth's behavior creates a risk of removal from the household	☐ Yes	☐ No	☐ Unknown
Has the youth been exposed to multiple traumatic events that have left a long-term and wide- ranging impact?	☐ Yes	☐ No	☐ Unknown

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

REQUIRED CONSENT FOR RELEASE OF INFORMATION
for Single Point of Access (SPOA), Niagara **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 5); **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
- ☐ Financial &/or Insurance Info
- ☐ Discharge Summary/Treatment Plan
- ☐ Pre-Sentence Investigation Report
- ☐ HIV/AIDS-related Information
- ☐ Inpatient/Outpatient Treatment
- ☐ 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 5; 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 5 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);

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

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**

List of agencies with which the SPOA Committee is permitted to exchange information

Please list in this section. Please also see Attachment A (or remove / cross out this reference to attachment A only if authorization is NOT being given)

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

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

Are we able to leave a voicemail at the telephone number(s) provided? ☐ Yes ☐ No

---

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**

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

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

Niagara
Name of SPOA County

The SPOA Committee may get health information, including your youth's health records, through a computer system run by HEALTHeLINK , a Regional Health Information Organization (RHIO) A RHIO uses a computer system to collect and store health information, including medical records, from your youth's doctors and health care providers who are part of the RHIO. The RHIO can only share your youth'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 youth'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 youth's health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your youth'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 youth had or may have had before; test results, like X-rays or blood tests; and the medicines your youth is now taking or has taken before. Your youth'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 youth's health information must obey all these laws. They cannot give your youth'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 youth'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 youth's health information through the RHIO and/or through PSYCKES to provide my youth care or manage my youth's care, to check if my youth is in a health plan and what the plan covers.

☐ **I DENY CONSENT** for the SPOA Committee to access ALL of my youth'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.

SIGNATURE of PARENT or LEGAL GUARDIAN	**Printed Name of Parent/Legal Guardian**	**Date**
SIGNATURE of WITNESS	**Printed Name of Witness**	**Date**

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 (716) 438-3071, 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 (716) 438-3071. 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.

List of agencies with which the Niagara County C-SPOA Program and Committee is permitted to exchange information - Attachment A

This permission to use, disclose and/or re-disclose records applies to the following organizations and people who work at those organizations as appropriate. These organizations work together to deliver services to residents of Niagara County.

• **Beacon Center**	• **Monroe Plan**
• **Best Self Behavioral Health** • **BestSelf Health Home** *(includes all associated care management agencies)*	• **New Directions Youth & Family Services, Inc.**
• **BryLin Hospitals, Inc.**	• **Niagara County Department of Mental Health & Substance Abuse Services**
• **Buffalo Federation of Neighborhood Centers (BFNC)**	• **Niagara County Department of Social Services**
• **Buffalo Psychiatric Center**	• **Niagara County Office for the Aging**
• **Cattaraugus Rehabilitation Center Community Residence**	• **Niagara County Probation Department**
• **Catholic Charities of WNY**	• **Niagara Falls Memorial Medical Center (NFMMC)**
• **Catholic Health System**	• **NFMMC Health Home Care Management**
• **Cazenovia Recovery Systems**	• **Northpointe Council, Inc.**
• **Central NY Psychiatric Centers and satellite offices**	• **NYS Department of Corrections and Community Supervision (includes Parole)**
• **Child & Family Services**	• **NYS Council on Children and Families – Interagency Resolution Unit** *(formerly Hard to Place / Serve Committee)*
• **Children's Health Home of Upstate New York (CHHUNY)** *(includes all associated care management providers)*	• **OISHEI Healthy Kids and Women & Children's Hospital** *(includes all associated care management providers)*
• **Children's Health Home of WNY (dba OISHEI Healthy Kids)** *(includes all associated care management agencies)*	• **Orleans Niagara BOCES**
• **Community Health Center of Buffalo (CHCOB)** • **Community Health Center of Niagara (CHCON)**	• **Our Lady of Victory (OLV)** *formerly Baker Victory Services)*
• **Community Services for Every1**	• **Pathways, Inc. Community Residence**
• **Community Missions of Niagara Frontier, Inc.**	• **Person Centered Services**
• **Dale Association**	• **Pinnacle Community Services (***formerly Family & Children's Services of Niagara)*
• **DePaul Community Services** • **DePaul Properties** • **Living Opportunities of DePaul**	• **Prime Care Inc.**
• **DePaul Community Services** • **DePaul Properties** • **Living Opportunities of DePaul** • **Dr. Joshua Russell, MD**	• **Prime Care Medical, Inc at the Niagara County Jail** • **Psychotherapy Associates of Niagara**
• **East Amherst Psychology Group**	• **Recovery Center of Niagara**
• **Eastern Niagara Hospital**	• **Recovery Options Made Easy, Inc.** *(formerly Housing Options Made Easy, Inc.)*
• **Encompass Health Home** *(includes all associated care management agencies)*	• **Rochester Psychiatric Center (inpatient and children's Community Residence)**
• **Endeavor Human Services**	• **Save the Michaels of the World**
• **Empower (formally Niagara Cerebral Palsy)** • **Erie County Department of Mental Health** *(including Single Point of Entry / Access– SPOE / SPOA– Program)*	• **School Districts within Niagara County (Barker, Lewiston-Porter, Lockport, Newfane, Niagara Falls, Niagara-Wheatfield, North Tonawanda, Royalton-Hartland, Starpoint, Wilson)**
• **Erie County Medical Center (ECMC)**	• **Specialty / Treatment Courts within Niagara County**
• **Evergreen Health Services**	• **Spectrum Health and Human Services**
• **Gateway-Longview**	• **Strong Memorial Hospital**
• **Glove House Community Residence**	• **Suburban Psychiatric Associates**
• **Greater Buffalo United Healthcare Network (GBUHN)**	• **Transitional Services Inc.**
• **Harmonia Collaborative Care**	• **Venture Forthe**
• **Health Homes of Upstate NY (HHUNY)** *(includes all associated care management agencies)*	• **Villa of Hope**
• **Hillside Family of Agencies (Hillside Children's Center)**	• **UBMD Physicians Group**
• **Horizon Health Services**	• **WNY Developmental Disabilities Regional Office**
• **Intandem** • **Jewish Family Services**	• **WNYIL - Independent Living Project / Independent Living of Niagara County**
• **Kaleida Health**	• **WNY Office of Mental Health Field Office**
• **Living Opportunities of DePaul and DePaul Properties**	• **WNY Office of Addiction Services & Supports**
• **Mental Health Association in Niagara County (MHA)**	• **WNY Children's Psychiatric Center**
• **Mental Health Advocates of WNY**	• **YWCA of Western NY**

updated 5.2023 mcgd

Please ensure this page is included with the completed Part I application as authorized

Verification of Meeting Serious Emotional Disturbance (SED) Criteria

Instructions:

A child or adolescent (under the age of 21) has Serious Emotional Disturbance (SED) if they have a designated mental illness diagnosis in the Diagnostic and Statistical Manual (DSM) categories below as defined by the most recent version of the DSM of Mental Health Disorders AND have experienced functional limitations listed below due to emotional disturbance over the past 12 months from the date of assessment on a continuous or intermittent basis as determined by the treating or assessing *Licensed Practitioner of the Healing Arts (LPHA).

This verification form is to be filled-out by a LPHA who has the ability to diagnose within their scope of practice under New York State law. The LPHA must verify that the applicant meets SED criteria based on primary diagnosis and functional impairments.

The form should be completed by a LPHA who has diagnosed or is actively treating the child.

The LPHA verification is required component of a referral for eligibility determination and access to the following services offered through Niagara County CSPOA referral: Non-Medicaid Care Management, Community Crisis Intervention (CCI), and Family Support Services (non-Medicaid eligible individuals or individuals with Medicaid who do not meet medical necessity criteria).

NOTE: *This form is not required if verification of SED by an LPHA is explicitly present in the youth's clinical documentation submitted with the application.*

Child's Information			
Last Name	First Name	MI	Date of birth

Verification of Meeting Serious Emotional Disturbance Criteria				
Diagnostic Criteria				
☐ **As a Licensed Practitioner of the Healing Arts I verify that the child/youth has at least one primary DSM diagnosis in the following Qualifying Mental Health Categories**				
Select at least one DSM Qualifying Mental Health Category	**Current Diagnosis**	**Select Primary Diagnosis**	**Select Severity Indicator**	**Date of Diagnosis**
Anxiety Disorders		◉	Low ☐ Medium ☐ High ☐	
Bipolar and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Depressive Disorders		○	Low ☐ Medium ☐ High ☐	
Disruptive, Impulse-Control, and Conduct Disorders		○	Low ☐ Medium ☐ High ☐	
Dissociative Disorders		○	Low ☐ Medium ☐ High ☐	
Obsessive-Compulsive and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Feeding and Eating Disorders		○	Low ☐ Medium ☐ High ☐	
Gender Dysphoria		○	Low ☐ Medium ☐ High ☐	
Paraphilic Disorders		○	Low ☐ Medium ☐ High ☐	
Personality Disorders		○	Low ☐ Medium ☐ High ☐	
Schizophrenia Spectrum and Other Psychotic Disorders		○	Low ☐ Medium ☐ High ☐	
Somatic Symptom and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Trauma- and Stressor-Related Disorders		○	Low ☐ Medium ☐ High ☐	
Attention Deficit/Hyperactivity Disorder		○	Low ☐ Medium ☐ High ☐	

Functional Criteria		
☐ **As a Licensed Practitioner of the Healing Arts I verify that the child/youth has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations have been moderate in at least two of the following areas or severe in at least one of the following areas:**		
Moderate	**Severe**	
☐	☐	Ability to care for self (e.g,. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
☐	☐	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); or
☐	☐	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); or
☐	☐	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); or
☐	☐	Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
☐ Supporting documentation (psychosocial, psychological, psychiatric and education documentation) supports this verification.		
☐ I hereby verify, as a Licensed Practitioner of the Healing Arts that this child/youth meets the clinical standards for SED determination as indicated above.		

LPHA Name	**LPHA Signature**	**Date**

Credentials Of LPHA:

- ☐ Registered Professional Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Psychiatrist
- ☐ Licensed Psychologist
- ☐ Licensed Psychoanalyst
- ☐ Licensed Master Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage & Family Therapist
- ☐ Licensed Mental Health Counselor
- ☐ Licensed Creative Arts Therapist

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1B

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Directions: This form is to be completed by the C-SPOA with the guardian and youth's assistance to gain a better understanding of the youth and family needs. This information will assist the C-SPOA in coordinating and matching the youth and family with services and supports.

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	☐ High school graduate/GED
☐ Regular class, above grade level	☐ Vocational training only	☐ Part-time Vocational/Educational	☐ Not enrolled in a school program
☐ Regular class, but behind at least one grade	☐ BOCES	☐ Residential School for students with challenging social/emotional conditions	☐ College
☐ Home instruction	☐ Other (specify)		

Home School District	Grade	Date of last IEP

Committee on Special Education Classification (CSE)- If Applicable		
☐ Autism	☐ Deafness	☐ Deaf-Blindness
☐ Emotional Disability	☐ Hearing Impairment	☐ Intellectual Disability
☐ Learning Disability	☐ Multiple Disabilities	☐ Orthopedic Impairment
☐ Other Health Impairment	☐ Speech or Language Impairment	☐ Traumatic Brain Injury
☐ Visual Impairment		

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1B

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

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 interactionswith 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 oftime 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)	☐	☐

Youth Strengths

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

Caregiver Strengths

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

Children's Single Point of Access Application Part 1B

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Adverse Childhood Experiences (ACE)	
Has an ACE screening been conducted? ☐ Yes ☐ No ☐ Unknown	If so, please provide the score:
If so, by whom? (please provide name and contact information)	

Complex Trauma Screening (Direct questions about the youth to the caregiver)			
Questions (suggested prompts/questions for assessing trauma exposure within each category)	**Trauma Type**	**Currently Present?**	**Present for >6 months?**

• Was there a time when adults were supposed to be taking care of the youth but did not?
• Has there ever been a time when the youth did not have enough food to eat?
• Did a parent or other adult in the household often:
  ○ Swear at the youth, insult the youth, put the youth down, or humiliate the youth?
  ○ Or act in a way that made the youth afraid that the youth might get physically hurt?
	Physical/ Emotional Neglect
	
	OR
	
	Emotional Maltreatment
		☐ Yes
		☐ No
			☐ Yes
			☐ No

• Has the youth lived with someone other than the youth's parents/caregiver when the youth was growing up (because they could not take care of the youth or the youth was kicked out)? • Has the youth ever been homeless? (i.e. Has the youth ran away or was kicked out and lived on the street for more than a few days? Or the youth and the youth's family had no place to stay and lived on the street, in a car, or in a shelter?)	Displacement	☐ Yes ☐ No	☐ Yes ☐ No
• Has the youth lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons? • Has the youth been left in the care of different people due to parental incapacity or dysfunction, even if the youth's primary place of residence did not change?	Attachment Disruption	☐ Yes ☐ No	☐ Yes ☐ No
• Has anyone ever made the youth do sexual things the youth didn't want to do, like touch the youth, make the youth touch them, or try to have any kind of sex with the youth? • Has anyone ever *tried* to make the youth do sexual things the youth didn't want to do? • Has anyone ever forced the youth (or tried to force the youth) to have intercourse?	Sexual abuse OR Sexual assault/rape	☐ Yes ☐ No	☐ Yes ☐ No

NEW YORK STATE | Office of Mental Health

NYS Conference of Local Mental Hygiene Directors, Inc.

Children's Single Point of Access Application Part 1B

Youth Applicant's Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Questions (suggested prompts/questions for assessing trauma	Trauma Type	Currently Present?	Present for >6 months?
• Has the youth ever been hit or intentionally hurt by a family member? ○ If yes, did the youth have bruises, marks, or injuries?	Physical abuse	☐ Yes ☐ No	☐ Yes ☐ No
• Has the youth ever *seen* or *heard* someone in the youth's family/house being beaten up? • Has the youth ever *seen* or *heard* someone in the youth's family/house get threatened with harm?	Domestic violence	☐ Yes ☐ No	☐ Yes ☐ No
• Has the youth ever *seen* or *heard* someone being beaten, or who was badly hurt? • Has the youth seen someone who was dead or dying, or watched or heard them being killed? • Has the anyone ever hit the youth or beaten the youth up (physically assaulted the youth?) • Has anyone ever threatened to physically assault the youth (with or without a weapon)?	Community violence OR Interpersonal violence	☐ Yes ☐ No	☐ Yes ☐ No
• Did other youth often tease or insult the youth, put the youth down, or threaten the youth physically? • Did they spread lies about the youth or turn other people against the youth?	Bullying	☐ Yes ☐ No	☐ Yes ☐ No
• Has the youth or anyone in the youth's family been involved in, or *in direct danger* from a terrorist attack, war, or political violence?	Terrorism/ War/Political Violence	☐ Yes ☐ No	☐ Yes ☐ No
• Has anyone ever stalked the youth? • Did anyone ever try to kidnap the youth?	Stalking/ Kidnapping	☐ Yes ☐ No	☐ Yes ☐ No
• Is there anything else really scary or very upsetting that has happened to the youth 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?	Other Trauma	☐ Yes ☐ No	☐ Yes ☐ No