CHENANGO COUNTY ADULT SPOA

Please complete this form attaching the Consent for Release of Information. Additionally, please provide supporting documents (e.g. current psychiatric evaluation) when possible.

Date of Referral:_____

Client's Name:_____ DOB: _____Age:_____

Address:_____

Phone Number: _____ Social Security Number:_____

Medicaid Number or Insurance Provider:_____

Referral Source:_____ Relation to Client:_____

Name of Therapist:_____ Phone Number:_____

Name of Psychiatrist:_____Phone Number:_____

DSM 5 Diagnosis:

_____

_____

Psychosocial Stressors:

_____

_____

Medical Conditions:

_____

_____

High Risk Behaviors (i.e. history of aggression, substance use, etc.):

_____

_____

Additional Comments or Concerns

_____

_____

Services Needed:

- ☐ Mental Health Treatment (Individual Therapy, Med Management)
- ☐ Care Coordination Services (case management services to link individual with resources)
- ☐ Non-Medicaid Care Coordination (case management services to link individuals with resources who do not have Medicaid)
- ☐ Chenango Social Club (Drop in center for individuals in MH or substance abuse Recovery)
- ☐ Peer Engagement Services (Support services provided by Peers)
- ☐ Supported Housing (Financial Assistance for individuals with a MH diagnosis)
- ☐ Chenango House ATP program (Chenango House programming in client's own apartment)

Please note that making a referral is not a guarantee of acceptance in to certain programming

Eligibility Determination (check all that apply):

- ☐ Is the person high risk or heavy user of mental health services?
- ☐ Two or more face to face psychiatric crisis intervention contacts in 6 month period
- ☐ Admission to an inpatient psychiatric service two or more times within the past 12 months or an extensive history of multiple psychiatric admissions
- ☐ Isolated from mental health services but with symptoms that interfere with appropriate community or personal functioning
- ☐ Responsive to services but requires special assistance in order to maintain level of functioning
- ☐ Client is mentally ill and is homeless or in danger of becoming so
- ☐ The client has multiple disabilities including mental illness, substance abuse and/or intellectual disability
- ☐ Client is seriously mentally ill and currently or recently incarcerated

Please have release of information on next page signed and dated by client

Please submit referral to: Liz Warneck, LCSW-R, CSS Program Coordinator

5 Court St. Norwich, NY 13815

***Phone**: (607) 337-1600 **Fax** (607) 334-4519*

Chenango County Single Point of Access Committee- Adult

Request for Screening and Consent for Exchange of Information

Name of Adult:_____ DOB:_____

Current Address:_____Phone: _____

I am requesting that my referral packet be submitted to the Single Point of Access Committee (SPOA) to determine eligibility for Care Coordination, Clinical and Housing services. I understand the screening committee includes representatives from Chenango County Behavioral Health, Department of Social Services, Public Health, Catholic Charities, GBHC Mobile Integration Team, Southern Tier Care Coordination, Bassett Care Coordination, OPWDD, Southern Tier Connect, The Addiction Center of Broome County and Chenango Health Network. I understand that the referral packet will be checked for completeness and someone from the committee may need to contact me or the referral source for further clarification, or to request additional documentation. Only this information may be used and/or disclosed as a result of this authorization. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected. To revoke this authorization, a written request should be made to the Contact Person (Administrative Assistant). Information disclosed before an authorization is revoked may not be retrieved. If action was taken in reliance on the authorization,the person who relied on the authorization may continue to use or disclose protected health information as needed to complete the work that began because the authorization was given. It is understood that information used or disclosed pursuant to this authorization may not be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans must follow federal rules protecting the privacy of health information. But those rules do not apply to other organizations.

Signature:_____Date:_____

Witness Signature_____Date:_____