Tioga County Adult Single Point Of Accessibility
Application & Instructions

Individuals must be 18 years or older. Please clearly indicate which services you are requesting. The SPOA Committee for adults receives referrals for:

- CARE MANAGEMENT (formerly known as Case Management Services)
- HOUSING SERVICES through Rehabilitation Support Services (RSS)
- SOCIAL CLUB through RSS

Process for Completing a Referral:

1. Complete the attached **Community Referral Application on** p. 2 & 3 and have the consumer sign the **Consent for Disclosure Form** on page 5.
2. Have the consumer sign the attached **SPOA Release of Information** and **PSYCKES Consent Form**
3. Check below the Program(s) you are referring to:

____ACT Care Management OR **_____ RSS Care Management**

OR

____Finger Lakes Care Management (EPC)

____ Must have Medicaid **AND**

____ SPMI Criteria **OR**

____ Mental Health Diagnosis **and** One Chronic Medical Condition **OR**

___ Substance Abuse **and** One Chronic Medical Condition **OR**

_____Two Chronic Medical Conditions

___ Finger Lakes Non-Medicaid Care Mgmt (EPC) OR ____RSS Non-Medicaid Care Mgmt

___ Must meet SPMI Criteria and NOT have Medicaid

____ Housing

___The Front Street Residence (Must meet SPMI Criteria and have Medicaid)

___Tioga Apartment Program (Must meet SPMI Criteria and have Medicaid)

___Tioga Supported Housing (Must meet SPMI Criteria)

Tioga Social Club (Must have Mental Health Diagnosis)

4. Send the completed **Referral Form/Consent, PSYCKES Consent and SPOA Release,** to Sue Graves:

a. Confidential Fax (607) 687-0248
b. Mail Tioga County Department of Mental Hygiene
Attn: Susan Graves
PO Box 177, Owego, NY 13827

If you have any questions, please contact Cathy Healy (SPOA Coordinator) at 607-689-8126.

*Please complete all information thoroughly *and* completely. Missing information may result in delays. Incomplete or incorrectly completed Releases of Information are not valid and will not be able to be utilized.

HHUNY Health Home Care Management - Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell Phone:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information — Check All that Apply
Must meet either A only or B only or two C to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness (Complete Page 4)	
	B	HIV/AIDS & the risk of developing another chronic condition	
	C	Mental Health condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
	Lack of or inadequate social/family/housing support	
	Lack of or inadequate connectivity with healthcare system	
	Non-adherence to treatments or medication(s) or difficulty managing medications	
	Recent release from incarceration	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative

Provide any additional information that may be helpful in assignment to a care management agency:

Specify Preferred or Recommended Care Management Agency, if any: _____ _____ _____ _____

Contact Information for Person Completing Referral:

Name:	**Title:**
Organization:	
Phone:	**Email:**

Verification of Eligibility of a Serious Mental Illness for Health Home

- ☐ The individual currently meets the criteria for a DSM (Diagnostic and Statistical Manual of Mental Disorders) psychiatric diagnosis other than alcohol or drug disorders (291.xx, 303.xx, 305.xx), organic brain syndromes (290.xx-294.xx, 310.xx), developmental disabilities (299m, 315.xx, 317.xx-319.xx) or social conditions (Vxx.xx). ICD-CM psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.

AND

- ☐ The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

OR

- ☐ Documentation that the individual has experienced **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 health care 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 simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

OR

- ☐ A documented history shows that the individual at some prior time met the threshold for 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.

Axis I Mental Health Diagnosis:

_____ _____

_____ _____

_____ (Enter Name) is disabled due to a mental health condition, and this individual's ability to remain in the community would be seriously jeopardized without the provision of care management and meets the eligibility criteria noted above.

_____ _____

Print Name of Individual Completing This Form | Title

_____ _____

Signature | Date

PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of health care services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION

1. The person whose information may be used or disclosed is:

Name: _____

Date of Birth: _____

2. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
3. This information may be disclosed to the persons or organizations listed in Attachment A.
4. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
5. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
6. This permission expires on (date).
7. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal **representative.** (If personal representative, please enter relationship _____.)

I give permission to use and disclose my records as described in this document.

_____ _____

Signature Date

CONSENT TO DISCLOSE HEALTH RECORDS — ATTACHMENT A

HHUNY CENTRAL

Health information may be disclosed for purposes of treatment to the people and organizations listed below.

AIDS Community Resources, Inc. Catholic Charities of Cortland County Catholic Charities of Oswego County Cayuga County Community Mental Health Center

- Coordinated Care Services, Inc.

Elmira Psych Center

- Excellus Health Plans

Family Services of Chemung

Fidelis Care

- Finger Lakes Community Health
- Hillside Family of Agencies
- Liberty Resources & Behavioral Health Care
- Monroe Plan for Medical Care
- New York Care Coordination Program, Inc.

New York State Office of Mental Health

- New York State Office of Alcohol and Substance Abuse Services

Onondaga Case Management Services

- Rehabilitation Support Services
- Southern Tier Care Coordination

Total Care

Tioga County Department of Mental Health

Tompkins County Mental Health Services

- VNA
- United Healthcare

Tioga County Department of Mental Hygiene
Single Point of Accessibility (SPOA) Release of Information
PO Box 177 - 1062 State Route 38
Owego, NY 13827

Owego (607) 687-4000
Waverly (607) 565-9594/2800

Owego Fax (607) 687-6396
Waverly fax (607) 565-7194

Consent for Release of Information

Client Name: _____ **DOB:** _____

Concerning: (choose only one) _____**Alcohol/Drug Records** _____**Mental Health Records**

Grants permission to the **Tioga County Single Point of Accessibility Committee**, or a representative thereof, to obtain information from and/or release information to the following:

Name of Organization/Agency or person: Tioga County Department of Mental Hygiene
(A separate consent form must be completed and signed for each individual or group exchanging information with SPOA and/or attending the SPOA meeting.)

Extent or Nature of Information to be disclosed:

X Any Assessments, Evaluations, Discharge summaries or other information regarding history, treatment And/or progress of the above named person.
X Court orders and/or other relevant legal documents.
X HHUNY Referral Form and Consent Form
X Completed CSS Eligibility Form
___ Other information to be obtained or released (please specify): _____

Purpose or need for the disclosure:

X For obtaining access to client records in order to evaluate and/or facilitate SPOA referral.
X Review client's level of care
___ For court/legal evaluation of the above named person.
___ Other (please specify): _____.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42, Part2, of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records an/or Section 33.13 of the Mental Hygiene Law. and/or federal privacy regulations (HIPAA), Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.
"Pursuant to Section 33.25 of the Mental Hygiene Law, the attached records and reports shall not be further disseminated, except that you may share the report with (i) A Health Care Provider, (ii) a Behavior Health care Provider, (iii) Law Enforcement, if you believe a crime has been committed, or (iv) your attorney."

I have the right to revoke this authorization at any time. My revocation must be in writing on this form (see back). I understand that I may revoke this authorization except to the extent that action has ready taken based on this authorization.

I further understand that SPOA of Tioga County includes: Tioga County Mental Hygiene, Tioga County ADS (Alcohol and Drug Services), Finger Lakes ICM (Intensive Case Management) Program, RSS (Rehabilitation Support Services), Tioga County DSS (Department of Social Services), ACT (Adult Assertive Community Treatment Program), Tioga County Forensic Project, Family Care Homes (Elmira Psychiatric Center), Health Home of Upstate NY (HHUNY), Southern Tier Mobil Integration Team (MIT), Southern Tier Care Coordination, and a consumer representative.

Time period, event or condition replacing period specified above: for duration of SPOA support services

Note: Any information released through this form will be accompanied by "Prohibition on Re-disclosure of information".

Client Signature: _____

Client Signature: (Printed): _____ Date: _____

Signature of Parent/Guardian: _____

Witness: _____ Title: _____ Date: _____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke my authorization to use/disclose information indicated on the front of this form, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

I hereby refuse to authorize the use/disclosure indicated on the front of this form, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Signature Date

Tioga County Department of Mental Hygiene
Single Point of Accessibility (SPOA) Release of Information
PO Box 177 - 1062 State Route 38
Owego, NY 13827

Owego (607) 687-4000
Waverly (607) 565-9594/2800

Owego Fax (607) 687-6396
Waverly fax (607) 565-7194

Consent for Release of Information

Client Name: _____ **DOB:** _____

Concerning: (choose only one) _____**Alcohol/Drug Records** _____**Mental Health Records**

Grants permission to the **Tioga County Single Point of Accessibility Committee**, or a representative thereof, to obtain information from and/or release information to the following:

Name of Organization/Agency or person: _____ (no abbreviations)
(A separate consent form must be completed and signed for each individual or group exchanging information with SPOA and/or attending the SPOA meeting.)

Extent or Nature of Information to be disclosed:

X Any Assessments, Evaluations, Discharge summaries or other information regarding history, treatment And/or progress of the above named person.
X Court orders and/or other relevant legal documents.
X HHUNY Referral Form and Consent Form
X Completed CSS Eligibility Form
___ Other information to be obtained or released (please specify): _____

Purpose or need for the disclosure:

X For obtaining access to client records in order to evaluate and/or facilitate SPOA referral.
X Review client's level of care
___ For court/legal evaluation of the above named person.
___ Other (please specify): _____.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42, Part2, of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records an/or Section 33.13 of the Mental Hygiene Law. and/or federal privacy regulations (HIPAA), Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.
"Pursuant to Section 33.25 of the Mental Hygiene Law, the attached records and reports shall not be further disseminated, except that you may share the report with (i) A Health Care Provider, (ii) a Behavior Health care Provider, (iii) Law Enforcement, if you believe a crime has been committed, or (iv) your attorney."

I have the right to revoke this authorization at any time. My revocation must be in writing on this form (see back). I understand that I may revoke this authorization except to the extent that action has ready taken based on this authorization.

I further understand that SPOA of Tioga County includes: Tioga County Mental Hygiene, Tioga County ADS (Alcohol and Drug Services), Finger Lakes ICM (Intensive Case Management) Program, RSS (Rehabilitation Support Services), Tioga County DSS (Department of Social Services), ACT (Adult Assertive Community Treatment Program), Tioga County Forensic Project, Family Care Homes (Elmira Psychiatric Center), Health Home of Upstate NY (HHUNY), Southern Tier Mobil Integration Team (MIT), Southern Tier Care Coordination, and a consumer representative.

Time period, event or condition replacing period specified above: for duration of SPOA support services

Note: Any information released through this form will be accompanied by "Prohibition on Re-disclosure of information".

Client Signature: _____

Client Signature: (Printed): _____ Date: _____

Signature of Parent/Guardian: _____

Witness: _____ Title: _____ Date: _____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke my authorization to use/disclose information indicated on the front of this form, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

I hereby refuse to authorize the use/disclosure indicated on the front of this form, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Signature Date

NEW YORK STATE OF OPPORTUNITY | Office of Mental Health | PSYCKES

Consent Form

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to www.psyckes.org, and click on About PSYCKES, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

"I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.

- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES — or get it from another provider — when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check I box only.*

O I GIVE CONSENT for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

O I DON'T GIVE CONSENT for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

NEW YORK STATE OF OPPORTUNITY | Office of Mental Health | PSYCKES

Consent Withdrawal Form

Provider/Facility Name

What you need to know

You previously signed a Consent Form, giving this health care provider permission to access your Medicaid and other health information available in the Psychiatric Services and Clinical Enhancement System (PSYCKES) online database.

You must complete and sign this Consent Withdrawal Form if you no longer want this provider, and their staff who provide your care, to see your information. When you complete, sign and return this form to them:

- This health care provider won't be able to access your health information through PSYCKES. The exceptions are: • in an emergency, or
  - when state and federal confidentiality laws and regulations allow it. For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.[1]
- Your provider may be able to access your medical information in other ways. For example, the same laws and regulations may allow them to get information needed to treat you from another provider.
- This Withdrawal of Consent will not affect the health information shared while your Consent was in effect.
- Your access to medical care and health insurance coverage won't change because you withdrew consent. Your health care providers will still submit claims to your insurer for the services you receive.
- You can complete a new PSYCKES Consent Form at any time. Forms are available from your provider and, once completed and signed, should be returned to them.
- You'll get a copy of this form when you sign and submit it.

What you need to do

Provide the information requested below and give this form to your provider.

Print Name of Patient	Patient's Date of Birth
Patient's Medicaid ID Number	
Signature of Patient or Patients Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will Be Used.** Your electronic health information will be used by **only** to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care to all patients

Note: The choice you make in this Consent Form does *not* allow health insurers to have access to our information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included?** If you give consent, RSS may access **all** of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. Your health records may include history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
    - Mental Health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Sexually transmitted diseases
3. **Where Health Information About You Comes From.** Information about you in PSYCKES comes from the New York State Medicaid program.
4. **Who May Access Information About You, if You Give Consent.** Only those people may access information about you: doctors and other health care providers who serve on RSS'S medical staff who are involved in your medical care; health care providers who are covering or on call for RSS's doctors; and staff members who carry out activities permitted by this Consent Form as described about in paragraph one.
5. **Penalties for Improper Access to or Use of Your Information.** These are penalties for inappropriate access to or use of your electronic health information. IF at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Denise Brown at (607) 687-7468 ext 103; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.
6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.
7. **Effective Period.** This Consent Form will remain in effect until three (3) years after the last date you received any medical services, or until the day you withdraw your consent, whichever comes first.
8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to RSS. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling (607) 687-7468. Note: Organizations that access your health information through RSS while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.
9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.