MATTHEW GACEK
CHAIRPERSON, COMMUNITY SERVICES BOARD

TEISHA COOK, LCSW-R
DIRECTOR

Madison County Mental Health Department

VETERANS MEMORIAL BUILDING
NORTH COURT STREET, P.O. BOX 608, WAMPSVILLE, NY 13163-0608
(315) 366-2327
FAX (315) 366-2599

Madison County Adult Single Point of Access (SPOA)

Madison County Mental Health Department
SPOA & AOT Coordinator: Samantha Ratnour, LMSW
138 North Court St. Wampsville, NY 13163
Phone: 315-366-2327 Fax: 315-366-2599
Email: SPOA@madisoncounty.ny.gov

The Single Point of Access (SPOA) programs help providers connect people with severe and persistent mental illness (SPMI) to mental health services that can accommodate them. This can include but is not limited to connection to treatment, supportive housing, and care management services.

Please note that all referrals for OMH Housing (Venture House, Apartment Treatment Program, Supportive Scattered-Site apartments, and Venture House Respite Bed), Health Home + Care Coordination, and non-Medicaid Care Coordination require a SPOA application. Please contact the SPOA coordinator directly for additional applications

To be eligible for A-SPOA services through Madison County, applicants must be:

- At least 18 years of age
- Meet the diagnostic criteria for severe and persistent mental illness
- In need of the service because the SPMI significantly impairs his/her ability to access housing or other services.
- At risk for out-of-home or psychiatric placement without additional services
- Have service and support needs that cannot be met by just one agency
- Can be served in the community if provided appropriate access to services

Examples of a qualifying diagnoses include:

- Major Depressive Disorder, recurrent, severe (not from substance use or medical condition)
- Bipolar I or II Disorder, severe, may be with rapid cycling or psychotic features
- Schizophrenia Spectrum Disorder (Schizophrenia, Schizoaffective) and Psychotic Disorder) not from substance use.

Non-Qualifying diagnoses:

Primary Diagnoses due to alcohol/drug use, dementia, organic brain syndromes, developmental disabilities, neurocognitive disorders, general medical conditions or social conditions.

TO MAKE A REFERRAL: Submit the below check list with the following forms to the address, email, or fax listed above. If you require assistance with completing the necessary forms, contact the SPOA coordinator directly at 315-366-2327.

☐ **Completed referral form.** Asterisked (*) sections or items **must be completed.**

☐ **Signed SPOA consent form.** *Please note that a missing consent form **will** delay the referral process.

☐ **Sign or obtain Authorization form(s)** specifying the provider(s) who can provide clinical information or who will be directly involved in the assessment and planning process so that **confirmation of diagnosis and functional assessment may be obtained from the most current provider.**

☐ **Supporting documentation**, such as:

- ☐ Psychiatric evaluation,
- ☐ Comprehensive psychosocial assessments, or
- ☐ Other documentation indicating that the individual meets the criteria for a **primary** mental illness diagnosis signed by a Psychiatrist, Medical Doctor, Nurse Practitioner, LMSW, LCSW, LMHC, or LMFT dated within the past 12 months.

MADISON COUNTY MENTAL HEALTH DEPARTMENT
Adult Single Point of Access (SPOA)
AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant Information			
Legal Last Name	Legal First Name	MI	Date of Birth

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 govern the release of drug and alcohol records for the purposes of care coordination, delivery of services, and health care operations. This authorization complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal confidentiality rules for alcohol and drug records (42 CFR Part 2), and the Family Educational Rights and Privacy Act (FERPA) (20 USC 1232g).

I hereby authorize communication with, and the exchange of Personally Identifying Information (PII) and PHI between:

- The SPOA Team (comprised of County and state employees and local service providers),
- Referral Source: (Person, Title, Agency/Facility) _____.
- AND the agencies/provider(s) as indicated below:

Madison County:	The Madison County Council on Alcoholism & Substance Abuse, Inc. - BRiDGES
-Mental Health Department	Children's Home of Wyoming Conference (CHOWC)
-Department of Social Services	ACT Team
-Probation Department	Integrated Community Alternative Network (ICAN)
-Corrections Department (Jail)	LifePlan CCO NY
-Madison County Treatment Court	Monroe Plan for Medical Care
Liberty Resources: ATP - Venture House Apartments - Scattered Sites - ESSHI	Consumer Services of Madison County - PROS Clinic
Liberty Resources: Care Management	Pathways Wellness Center
Liberty Resources: Mobile Crisis	Helio Health
Liberty Resources: Crisis Respite	Mohawk Valley Housing & Homeless Coalition
Liberty Resources: Maxwell House and Next Step	Salvation Army
New York State Office of Mental Health (OMH)	Rescue Mission
Family & Children's Counseling Services	St. Joseph's Health Hospital – Comprehensive Psychiatric Emergency Program (CPEP)
Community Action Partnership for Madison County	Upstate University Hospital
Central New York Health Home Network (CNYHHN)	Wynn Hospital
	Rome Hospital

Description of Information to be used, disclosed and re-disclosed (*check all that apply*):

☐ Health Records
☐ Mental Health Records
☐ Alcohol/Drug Records
☐ School or Education Records
☐ Other: _____
☐ *All of the above*

If any of the following apply, please **initial** next to each category to authorize their disclosure (required by law):

_____ Mental Health Records
_____ Substance Use Treatment Records
_____ HIV/AIDS-related Information
_____ Psychotherapy Notes (separate authorization required)

[continued the following page]

MADISON COUNTY MENTAL HEALTH DEPARTMENT
Adult Single Point of Access (SPOA)
AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Purpose of Authorization: The purpose of this authorization is to allow the Madison County SPOA Team obtain and share information necessary for coordinating care, making appropriate referrals, arranging services through healthcare or mental health providers, reviewing the quality and appropriateness of services received, and facilitating collaborative treatment planning through the SPOA Committee.

I UNDERSTAND AND ACKNOWLEDGE that:

- I may revoke this authorization at any time by submitting a written request. Revocation will not affect any disclosures made prior to receipt of the revocation.
- This authorization remains in effect unless otherwise specified below.
- Information disclosed under this authorization may be re-disclosed by the recipient(s). While most healthcare providers and health plans are required to follow privacy laws, not all recipients may be legally obligated to do so.
- If this authorization includes the disclosure of sensitive information—such as HIV/AIDS-related status (NYS Public Health Law §2782), substance use disorder treatment records (42 CFR Part 2), or mental health treatment records (NYS Mental Hygiene Law §33.13)—I understand these records are subject to additional protections and may not be re-disclosed without my written permission, unless otherwise permitted or required by law.
- Verbal disclosures may be made during SPOA Committee meetings for the purpose of care planning and coordination.
- Written records will be shared only with providers directly involved in care coordination.
- Information may also be disclosed to oversight agencies, including the New York State Office of Mental Health and the New York State Commission on Quality of Care, as necessary.

Expiration of Authorization: I 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 (*choose one*):

☐ When the individual named herein is no longer receiving services from the County SPOA;
☐ One (1) from the date of signature;
☐ Other: _____

By signing below, I acknowledge that I have read and understand this authorization. I authorize the use and disclosure of my PHI as described above. The facility, its employees, and physicians are released from any legal responsibility or liability for the release of information as authorized herein.

Applicant Signature _____ Date _____

Witness Signature _____ Date _____

Withdrawal of Request

I, _____, voluntarily withdraw the request for an initial screening of my eligibility for these services. I understand that this withdrawal does not jeopardize my current treatment or any future requests for screening. All information forwarded for review will continue to be maintained in a confidential manner.

Client Signature _____ Date_____

Witness Signature _____ Date_____

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Madison County Adult SPOA Application

Send with Records and signed SPOA Permission Form to SPOA Fax: 315-750-3424

Referral Information		
Referral is for: *See OMH SMI High Priority Eligibility Criteria	☐ OMH Residential Services (Select one): ☐ Congregate ☐ Apartment Treatment ☐ Non-Medicaid CM for SMI* Eligible ☐ Assertive Community Treatment	☐ OMH Supported Housing ☐ Crisis Respite ☐ To be determined ☐ Other

Date of Referral:	Applicant Gender: ☐ Male ☐ Female ☐ X	
Applicant Name:	AKA:	
Social Security #, Last 4 Digits:	Applicant DOB:	
Home Address:		
City:	State:	Zip:
Current Location:	Applicant's Phone Number:	
If inpatient, anticipated release date:		

Alternate Contact	Emergency Contact
Name:	Name
Address:	Address:
Phone # for Client when in the community:	Phone Number:
May we leave a message? ☐ Yes ☐ No	
Referring Person Contact Information:	
Provider Type:	Agency:
Name:	Role:
Address:	
Phone Number:	Fax:

Legal Status:			
Involved with: ☐ Parole ☐ County Probation ☐ Federal Probation/History	PO Name _____ Phone: _____ If incarcerated, anticipated release date: _____		
Reason/charges/convictions:		Restrictions?	
☐ CPL	☐ Court Order or Diversion	☐ Town Court	☐ Treatment Court
☐ Adult Protective Services		☐ Child Protective Services	
☐ Assisted Outpatient Treatment (AOT)		☐ Other:	
Prior Living Situations: _____		Section 8 Status: _____	
If planning to live with family/friend, please list other members of the household:			

Personal And Demographic Information

Race / Ethnicity	Primary Language	English Proficiency (If primary language is not English)
☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian ☐ American Indian or Native ☐ Other (specify): _____	☐ English ☐ Spanish ☐ American Sign Language ☐ Other (specify): _____ Translator: _____	☐ Does Not Speak English ☐ Poor ☐ Fair ☐ Good – Does Not Need
	Literacy Level: ☐ Below Basic ☐ Basic ☐ Intermediate ☐ Proficient	

Veteran Status

Veteran or served in military? ☐ Yes ☐ No	Branch/ type of discharge: _____
Service-Connected Disability? ☐ Yes ☐ No	If Service Connected: _____%

Current Marital Status	Custody Status of Children
☐ Single, never married ☐ Currently married ☐ Divorced/separated ☐ Widowed	☐ No children ☐ Minor children in client's custody, ages: _____ ☐ Have children - older than 18 years ☐ Minor children not in client's custody but has access ☐ Minor children no custody - no access

Applicant Name: _____

Clinical Information

	Diagnosis	CODE
DSM 5 MH		
DSM 5 SUD		
DSM 5 Other		
Disability Level		
Chronic health conditions		
Other health conditions		
BH Treatment type:		
Clinician		
Psychiatrist:		
Other behavioral supports:		

Hospitalizations

Number of ER Visits for Psychiatric Reasons in the last 12 months:	
Number of Psychiatric Hospitalizations in the last 24 months:	

Date:	Hospital:	Length of Stay:

Physical Health/Wellness

Check all that apply:

☐ Asthma	☐ Breathing or Lung Problems	☐ Traumatic Brain Injury
☐ Hard of Hearing/Deaf	☐ Impaired Vision/Blind	☐ Impaired Walking
☐ Diabetes	☐ Heart Problems	☐ High Blood Pressure
☐ Chronic Pain	☐ Weight Concern	☐ Cognitive Impairment
☐ Speech Impairment	☐ Developmental Disorder	☐ Incontinent
☐ Learning Disability	☐ Requires Special Medical Equipment	☐ Other: _____

Event	Response	Date of most recent episode
History of Homelessness	☐ Yes ☐ No	
Victim of Physical/Sexual Abuse	☐ Yes ☐ No	
History of Domestic Violence in Home	☐ Yes ☐ No	
Chronic Self-Harm/Self-Mutilation	☐ Yes ☐ No	
History of Suicidal Ideation	☐ Yes ☐ No	
History of Suicide Attempts / Self Harm	☐ Yes ☐ No	
Elaborate on Other Serious Attempts	☐ Yes ☐ No	
Arson or fire starting	☐ Yes ☐ No	
Physically Abusive and/or Assaultive of Another	☐ Yes ☐ No	
Sexually Assaultive Behavior	☐ Yes ☐ No	
Destruction of Property	☐ Yes ☐ No	
Current Access to Firearms	☐ Yes ☐ No	
Criminal Justice Involvement	☐ Yes ☐ No	
AOT Order	☐ Yes ☐ No	
AOT Enhanced	☐ Yes ☐ No	

Applicant Name: _____

Reason for Referral		
Please include all relevant information such as reason for referral, current symptoms, desired outcome, etc. If there is a significant change from a previous referral, please state it here.		
Does the individual have a case manager, or other support such as Adult Protective Services housing worker, etc.?		☐ Yes ☐ No
If yes, please state name and program:		
The individual requesting services agreed to submit this application		☐ Yes ☐ No
The individual requesting services agreed to review by the SPOA Team and potential Providers.		☐ Yes ☐ No

Applicant Signature _____ Date _____

Madison County SPOA & AOT Coordinator, Samantha Ratnour, LMSW | Call 315-366-2327