2017 Onondaga County Adult SPOA Application

Send with **Records** and signed **SPOA Permission Form to SPOA Fax: 315-435-3279**

Referral Information			
Referral is for: *See OMH SMI High Priority Eligibility Criteria	☐ OMH Residential Services; Congregate or Apartment Treatment ☐ OMH Supported Housing ☐ Non Medicaid CM for SMI* Eligible ☐ Forensic Case Management ☐ ACT Team ☐ SRO ☐ To be determined ☐ Other__________		
Date of Referral:		**Applicant Gender:**	☐ **Male** ☐ **Female**
Applicant Name:		**AKA:**	
Social Security Number, last 4 digits:	**Applicant DOB:**		
Home Street Address:			
(City, State, Zip)			
Current Location:			
If inpatient, anticipated release date:__________			
Alternate Contact, Address and/or Phone # for Client when in the community: May we leave a message? ☐ Yes ☐ No		Emergency Contact Name, Address & Phone #:	

Referring person contact information: **Provider Type:** __________

Name: __________ **Role**__________

Agency: __________

Address: __________

Phone: __________ **Fax:** __________

Email Address: __________

Legal Status

Involved with: **If incarcerated, anticipated release date**__________

☐ Parole ☐ County Probation ☐ Federal Probation/history

PO name and phone: __________

Reason/charges/convictions__________Restrictions? __________

☐ CPL _______ ☐ Court Order or Diversion ☐ Town Court ☐ Treatment Court

☐Adult Protective Services ☐Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other: __________

Medicaid Status

Client Medicaid #: __ __ __ __ __ __ __ __

Managed Care Company:__________

Medicaid active? Yes_____ No______ HARP eligible? Yes ____ NO_____ Not known ______

Name__________

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) __________________	☐ Does Not Speak English. ☐ Poor ☐ Fair ☐ Good - Does Not Need Translator ☐ Literacy level:

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 clients custody, ages:__________ ☐ Have children - older than 18 years ☐ Minor children not in client's custody but have access ☐ Minor children no custody - no access

Prior Living Situations: **Section 8 Status:**

If planning to live with family/friend, please list other members of the household:

Current Educational Level	Employment/Vocational
☐ No formal education ☐ Some grade school (1-8th grade) ☐ Completed grade school ☐ Some HS (9-12th grade, but no diploma) ☐ HS diploma or GED ☐ Vocational, business training ☐ Some college, no degree ☐ College degree ☐ Master's degree ☐ Other:______________________________	☐ If has employment history, describe: ☐ Other vocational training, describe: Recommendations: ☐ Access-VR involvement ☐ Other:

Representative payee history?	☐ No ☐ Yes ☐ Recommended? Debts, if any: ___________________
Representative Payee Name:	
Agency:	
Phone:	**Address:**

Name____

Clinical Information

	Diagnoses	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 health supports:		

Number of ER Visits For Psychiatric Reasons in the in last 12 Months:______
Number of Psychiatric Hospitalizations in the last 24 Months:______

Date	Hospital	Length of Stay
________	________	________
________	________	________

Substance Use

Drugs of Choice:

☐ None ☐ Any IV Drug Use ☐ Alcohol ☐ Marijuana/Cannabis

☐ Crack ☐ Heroin/Opiates ☐ PCP ☐ Hallucinogens

☐ Cocaine ☐ Sedative/Hypnotic ☐ Benzodiazapines ☐ Spike, Synthetic Marijuana

☐ Prescription drugs ☐ Amphetamines ☐ Inhalant: Sniffing Glue/Other Household Product

☐ Other:______________________________Inpatient Rehab?______________

Physical Health/Wellness

Check off any of the following that apply:

☐ Incontinent ☐ Impaired Walking ☐ Requires Special Medical Equipment

☐ Hard of Hearing/Deaf ☐ Impaired Vision/Blind ☐ Lung Problems

☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure

☐ Chronic Pain ☐ Weight Concern ☐ Cognitive Impairment

☐ Speech Impairment ☐ Developmental Disorder ☐ Traumatic Brain Injury

☐ Learning Disability ☐ Other: ______________________________

Financial Section: Income And Insurance Status

Income and Insurance	Now Receives	Income and Insurance	Now Receives
No Income	☐	Wages/Earned Income	☐
SSI	☐	Unemployment/Amount___________	☐
SSD	☐	Child Support Owed or Received $________	☐
Temporary Assistance	☐	Worker's Comp	☐
Veterans benefits	☐	Social Security Retirement	☐
Medicare	☐	Pension/Amount:______ Source	______________
Medicaid	☐	Trust Fund	☐
Food Stamps	☐	Special Needs Trust	☐
Other, Describe:____________________		Private Insurance/Third Party Payer	☐

Name__________________________________

Alerts Related To Risk To Self Or Others

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

Reason For Referral

Precipitating Events Leading up to Referral:

____

____

Current Symptoms:

____

Desired Outcome of Care Coordination or Residential Services:

____

____

Strengths:

____

____

Please Specify Discharge Linkages:

____

____

Please Note Anything You Have Questions About Regarding Your Plan:

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**

Individual, i.e. Applicant's Signature: ______________________________
Date: ______________

Onondaga County SPOA Team
Call: 315-435-3355 x4695;
Valerie Flanagan, x4695, Jennifer Feliciano x4997, Jan Moag x4696

Name______________________________

LISTING OF RESIDENTIAL/HOUSING PROVIDERS WITHIN ONONDAGA COUNTY
FOR PERSONS CONNECTED TO MENTAL HEALTH SERVICES

OMH licensed Community Residences

Access CNY, Community Residences
1010 James Street
Syracuse, New York 13203 — **Phone:** (315) 478-4151
Susan Bonzagni, Residential MH Admit/Discharge Specialist — **Fax:** (315) 478-3118

St. Joseph's Hospital Health Center, Community Residence
742 James Street
Syracuse, New York 13203 — **Phone:** (315) 703-2812
David Mihajlovski, Coordinator — **Fax:** (315) 457-1086

Central New York Services, Community Residence Program (for men only)
375 West Onondaga Street
Syracuse, New York 13202 — **Phone:** (315) 478-0610 x328
Sherry Fuller, Central Intake — **Fax:** (315) 295-2031

Loretto Community Residences, Inc. (for people 45 and older) — **Phone:** (315) 413-3592
750 East Brighton Avenue, 4th Floor — **Fax:** (315) 469-6891
Syracuse, New York 13205 — **Phone:** (315) 492-0896
Michele Rita Gottschalk, Executive Director — **Fax:** (315 492-6830

OMH licensed Treatment Apartments

Access CNY, Treatment Apartments
1010 James Street
Syracuse, New York 13203 — **Phone:** (315) 478-4151
Susan Bonzagni, Residential MH Admit/Discharge Specialist — **Fax:** (315) 478-3118

St. Joseph's Hospital Health Center, Treatment Apartments
742 James Street
Syracuse, New York 13203 — **Phone:** (315) 703-2812
Sarah June, Coordinator — **Fax:** (315) 703-2744

Central New York Services, Treatment Apartments
375 West Onondaga Street
Syracuse, New York 13202 — **Phone:** (315) 478-0610 x328
Sherry Fuller, Dana Ontoveris, Central Intake — **Fax:** (315) 295-2031

Enriched Services Single Room Occupancy (SRO)

Central New York Services, Enriched Services Single Room Occupancy
518 James Street Suite 280
Syracuse, New York 13203 — **Phone: (315)-565-4199 x 339**
Sherry Fuller, Central Intake — **Fax:** (315) 214-3205

LISTING OF RESIDENTIAL/HOUSING PROVIDERS WITHIN ONONDAGA COUNTY
FOR PERSONS CONNECTED TO MENTAL HEALTH SERVICES

Young Adult Program

Salvation Army, Young Adult Program, State Street Apartments
1480 South State Street
Syracuse, New York 13205 — **Phone:** (315) 475-7663
Nicole Semmens, Program Director — **Fax:** (315) 474-7577

OMH funded Supported Housing

Access CNY, Independent Living Program
1010 James Street
Syracuse, New York 13203 — **Phone:** (315) 478-4151
Cameron Hudson, Independent Living Program Director — **Fax:** (315) 478-3118

Central New York Services, Supported Housing and Recovery Permanent Supported Housing Programs
518 James Street
Syracuse, New York 13203 — **Phone:** (315) 478-0610
Donna Cruz, Supported Housing Coordinator — **Fax:** (315) 214-3205

Salvation Army, Supported Housing Initiative
677 South Salina St (Red door)
Syracuse, New York 13202 — **Phone:** (315) 479-3626
Pamela Alderman, SHI Coordinator — **Fax:** (315) 479-1366

Department of Health licensed Adult Homes and Residences

Rescue Mission, Crossroads, Adult Home
120 Gifford Street
Syracuse, New York 13202 — **Phone:** (315) 701-3845
Debbie Carter, Intake Coordinator — **Fax:** (315) 474-0891

Kalets's Adult Residence
504 Delaware Street
Syracuse, New York 13204 — **Phone:** (315) 479-7514
Diane Kalet, Administrator — **Fax:** (315) 479-1058

Erie Enriched Housing Program
1207 Almond Street — **Phone:** (315) 428-8562
Syracuse, NY 13210 — **Fax:** (315) 425-0529

Transitional Residences (partially HUD funded for individuals experiencing homelessness)

Chadwick Residence, Transitional Residence (for women and women with up to 2 children up to 7yo)
335 Valley Drive
Syracuse, New York 13207 — **Phone:** (315) 476-6554
Jennifer Gratien, Intake — **Fax:** (315) 476-6555

YWCA Women's Transitional Residence
300 Burt Street, 9th Floor
Syracuse, NY 13202 — **Phone:** (315) 471-9480
Tammie Steele or Felicia Hall, Intake — **Fax:** (315) 471-9478

COUNTY OF ONONDAGA
Department of Adult and Long Term Care Services

John H. Mulroy Civic Center
421 Montgomery Street, Syracuse, NY 13202
SPOA Adult (315) 435-3355 Ext. 4695
SPOA Adult FAX (315) 435-3279
www.ongov.net

Joanne M. Mahoney, County Executive

Lisa D. Alford, Commissioner
Barry L. Beck, LMSW, Deputy Commissioner

Onondaga County Department of Mental Health SPOA (Adults) Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.
2. The person whose information may be used or disclosed is:

   Name: ______________________. **Date of Birth:** ______________

3. The information that may be used or disclosed includes (check all that applies):

   ☒ Mental health records
   ☒ Alcohol/Drug Records
   ☐ School or Education Records
   ☒ Health records
   ☒ Health Home Application
   ☐ All of the records listed above

4. This information may be disclosed by:

   ☒ Any person or organization that possesses the information to be disclosed
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations that provide services to me:

   ______________________ ______________________
   ______________________ ______________________

5. This information may be disclosed to:

   ☒ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations:

   ______________________ ______________________
   ______________________ ______________________

6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Onondaga County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and

- Health Care Operations such as quality assurance.

Onondaga County Department of Mental Health SPOA
Permission to Use and Disclose Confidential Information (con't.)

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. This permission expires (check applicable box):
   - ☐ On ________________________
   - ☐ Upon the following event: ____

9. This permission is limited as follows:
   - ☐ Permission only applies to records for the following time period: ____________________ to ______________
   - ☐ Other limitation: ____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. 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 records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

____ ________________________

Signature **Date**

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is___ ____. I give permission to use and disclose my records as described in this document.

____ ________________________

Signature Date

____

Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Onondaga County.

Altamont
ARISE
Auburn Memorial Hospital
Catholic Charities
Central New York Services
Chadwick Residence
CNY Developmental Services Office
Community General Hospital
Conifer Park
Contact
Crouse Hospital.
Health Homes of Upstate NY
Hillside Children's Center
Huntington Family Center
Hutchings Psychiatric Center
Interfaith Works of CNY
Jewish Family Center
Kalet's Adult Residence
Legal Aid Society of CNY
Liberty Resources and the Brownell Center
Loretto Community Residences
Mental Health Association in Onondaga County
Mental Hygiene Legal Services
Newark Wayne Hospital
Onondaga Case Management Services
Onondaga County: DSS, Adult Protective Services, Dept of Aging and Youth
Onondaga County Department of Mental Health
Onondaga Nation Healing Center
Oswego Hospital
Salvation Army
Spanish Action League
St. Joseph's Hospital Health Care
Syracuse Behavioral Health
Syracuse Community Health Center
Syracuse Housing Authority
Syracuse Rescue Mission
Syracuse Veteran's Administration
Transitional Living Services
Upstate Medical University
Vera House
VESID
YWCA
YMCA

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Department of Mental Health
ADULT SPOA

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CONFIDENTIAL
AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: For substance abuse information, use a cover sheet referencing Federal Law 42 CFR Part 2.
HIV: Use form DOH-2557. Do not send HIV related information with this form.

Participant Name:	**DOB:**
I authorize the following person/agency to provide and/or receive the disclosure of my health information:	
Agency	
Dates of Treatment:	**From:** **To:**
Contact Person	
Address	
City, State, Zip	
Phone	
Fax	

(Each person/agency requires a separate consent form)

Staff Person Requesting/Releasing: **Jennifer Feliciano**	**Phone: (315) 435-3355 x 4997**

Nature or Extent of Information to be Released (please check all that apply):

- ☒ Services Desired
- ☒ Involvement in Program
- ☒ Evaluation/Assessment
- ☒ Progress, Treatment, Goals and Service Plans
- ☒ Psychosocial Evaluation
- ☒ Psychiatric Evaluation
- ☒ Medical History and Physical Examination
- ☒ Medication Record
- ☒ Financial and Demographic Information
- ☒ Psychological Testing Results
- ☐ Results of Laboratory and Diagnosis Tests
- ☒ Vocational History/Assessments
- ☒ Legal/Criminal Justice History
- ☒ Discharge Summary/Cont. Care Plan
- ☒ Recommendations
- ☒ Axis I, II, III, IV and V Diagnosis
- ☐ Verification of Health Insurance and Income
- ☐ Other:

Reason for Release of Information (check all that apply):

- ☒ To assist in assessment/service planning
- ☒ To refer for services
- ☐ Care Coordination
- ☒ SPOA Meeting & Planning
- ☒ To establish program eligibility
- ☐ To permit discharge planning
- ☐ Other (please specify):

I consent to the release of information described above. This authorization (check one):

☐ Is for a one-time release
☒ Will expire on: ☐ 90 days following signature for release ☒ 1 year following signature for services release
☐ Discharge from OCMS Inc.

I may revoke my consent at any time by verbal or written notice to these agencies. Revocation will be effective upon the date the notice is received. Revocation does not apply to information furnished before that date. Re-disclosure of record information to any other party is prohibited.

______________________________ ______________
Client Signature **Date**

______________________________ ______________
Witness Signature Date

This information has been disclosed to you from records protected by federal and New York state laws and federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Address	
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Fax	

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Client Signature ______________________ **Date** __________

Witness Signature ______________________ Date __________

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Client Signature _______________ **Date** _______________

Witness Signature _______________ Date _______________

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☒ Will expire on: ☐ 90 days following signature for release ☒ 1 year following signature for services release
☐ Discharge from OCMS Inc.

I may revoke my consent at any time by verbal or written notice to these agencies. Revocation will be effective upon the date the notice is received. Revocation does not apply to information furnished before that date. Re-disclosure of record information to any other party is prohibited.

Client Signature **Date**

Witness Signature Date

This information has been disclosed to you from records protected by federal and New York state laws and federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.