Chautauqua County Department of Mental Hygiene
Single of Point Access (ADULT SERVICES)
Referral Form

Please complete entire form and forward to: fadalet@chqgov.com, or Fax to 716-753-9724. Attach copy of recent psychosocial exam, any available assessments and/or mental status exams.
Please call 716-661-8857 for assistance.

1. REFERRAL INFORMATION

Referral is for: BestSelf Behavioral Health ACT ☐ Non-Medicaid Care Management ☐

Housing ☐ STEL ☐ COI ☐ ROME ☐ Case Review ☐

Client Name: Gender: ☐ M ☐ F	Date of Referral:
Client Street Address: City/State/Zip:	Referring Agency and Address:
Client Phone Number:	
Client SSN: Client DOB:	Referral Contact Telephone #:
Client Medicaid # (include Sequence #) _____Seq._____ Private Insurance Name and Policy #_____	Referring Person:
EMERGENCY CONTACT, ADDRESS & PHONE #:	Alternate Contact, Address and/or Phone # for Client

Primary Referral Organization Affiliation:

☐ Mental Health Outpatient	☐ General Hospital ER	☐ Family Court
☐ Local MH Practitioner	☐ General Hospital (inpt)	☐ Criminal Court
☐ Mental Health Residential	☐ MR/DD Facility	☐ Probation/parole
☐ State Psychiatric Ctr (inpt)	☐ Substance Abuse Program	☐ Jail
☐ CSP Mental Health Program	☐ Other Medical Provider	☐ Shelter for the homeless
☐ Emergency Non-residential Program	☐ Social Services	☐ Self, family, friend
☐ Other (specify) _____		

Reason for Referral: _____

_____

_____

2. PERSONAL & DEMOGRAPHIC INFORMATION

Race/Ethnicity:

☐ 1. White, Non-Hispanic
☐ 2. Black, Non-Hispanic
☐ 3. Hispanic
☐ 4. Asian
☐ 5. American Indian or Native
☐ 6. Other (specify)_____

Primary Language

☐ 1. English
☐ 2. Spanish
☐ 3. American Sign Language
☐ 4. Other_____

English Proficiency
(if primary language is other than English)

☐ 1. Does not speak English
☐ 2. Poor
☐ 3. Fair

Additional Information/Comments: _____

_____

_____

_____

REFERRAL INFORMATION SPOA- Adult PAGE TWO	NAME: Last First MI

3. LIVING ENVIRONMENT/ SUPPORT SYSTEM

Current Marital Status

- ☐ Single, never married
- ☐ Currently married
- ☐ Cohabiting with significant other/domestic partner
- ☐ Divorced/separated
- ☐ Widowed

Custody Status of Children

- ☐ No children
- ☐ Have children all > 18yrs.old
- ☐ Minor children currently in client's custody
- ☐ Minor children not in client's custody but have access
- ☐ Minor children not in client's custody-no access

Living Situation at Time of Referral:

- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with parents
- ☐ Lives with other relatives
- ☐ Assisted /supported living (specify) _____
- ☐ Nursing home/medical setting (specify) _____
- ☐ Supervised Apartment Program (specify) _____
- ☐ Supervised group home (specify) _____
- ☐ Psychiatric hospital (specify) _____
- ☐ Correctional setting (specify) _____

IS THERE ANY ADULT HISTORY OF HOMELESSNESS? ☐ ***Yes*** ☐ ***No***

4. EDUCATION & EMPLOYMENT VOCATIONAL STATUS

Current Education Level

- ☐ 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
- ☐ Masters degree
- ☐ Other:_____

Current Employment Status

- ☐ No employment
- ☐ Full-time
- ☐ Part-time
- ☐ Sheltered workshop
- ☐ Has job coach
- ☐ VESID involvement
- ☐ Other _____

Additional Information, Support Networks, Comments: _____

_____

_____

_____

REFERRAL NFORMATION SPOA-Adult PAGE THREE	NAME: Last First MI

5. ENTITLEMENTS & INCOME *(check all that apply)*

Benefits or Insurance	Currently receives (Enter amount)	Pending - application submitted	Eligible - no application submitted	Ineligible	Unknown	Caseworker
Social Security						
SSI/SSD						
Public Assistance						
Veteran's Benefits						
Medicare/Medicaid (inc. #)						
Food Stamps						
Pension						
Wages/earned income						
Worker's Compensation						
Unemployment						
Private insurance (inc. #)						
Trust Fund						
Medication Grant						
Alimony						

Representative Payee

☐ Yes (Name): _____

☐ No

☐ Needs

Ability to budget money

☐ Independently

☐ Needs help

☐ Unable

☐ Unknown

6. PSYCHIATRIC INFORMATION

AXIS	*DESCRIPTION (include primary and secondary dx)*	*CODE*
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Current or last services *(check all that apply)*:

☐ **No prior service**

	HISTORIC	*CURRENT*	*LOCATION*	*DATES*	*CIRCUMSTANCES*
State Psych. Center (inpt)					
General Hospital					
Mental Health Residential					
Mental Health Outpatient					
CSP Mental Health Program					
Emergency Mental Health (non-residential)					
Prison, jail, court					
Local mental health practitioner					
Case management (specify type)					

REFERRAL NFORMATION SPOA-Adult PAGE FOUR	NAME: Last First MI

Current medications (psychiatric and medical) ***LIST ALL KNOWN ALLERGIES***

_____

_____

Prescribing doctor: _____

Number of psychiatric hospitalizations in past 12 months: _____

Number of psychiatric ER visits in the past 12 months: _____

Current case management/ACT ☐ No ☐ Yes, specify _____

Current AOT investigation/court order ☐ No ☐ Yes, specify _____

Compliance with treatment ☐ No ☐ Yes, specify _____

Compliance with medications ☐ No ☐ Yes, specify _____

7. LETHALITY/DANGEROUSNESS/ RISK FACTORS *(check all that apply)*

	History	Current	Date of most recent event	Dates of previous attempts	Method
Suicidal ideation					
Suicidal attempts					
Violence to others					
Arson					
Destruction of property					
Victim of abuse					
Perpetrator of abuse					

8. LEGAL
(Current Criminal Justice Status)

☐ None

☐ Released from jail/prison in last 30 days

☐ Currently incarcerated – prison

☐ Currently incarcerated-jail

☐ Other _____

☐ Alternative to incarceration (any voc. or addictions treatment)

☐ PPL 33.20

☐ Parole, Officer: _____ ph # _____-_____

☐ Probation, Officer: _____ph # _____-_____

Number of arrests in past 12 months: _____

Number of incarcerations in past 12 months: _____

REFERRAL INFORMATION SPOA-Adult PAGE FIVE	NAME: Last First MI

9. SUBSTANCE ABUSE HISTORY

☐ **None**

Drug **Frequency**

	Not in last month	Daily	1-2x/week	1-3x in the last month	3-6x/week
Any IV drug use					
Alcohol					
Marijuana/Cannabis					
Cocaine					
Crack					
Heroin/Opiates					
Hallucinogens					
Amphetamines					
PCP					
Sedative/hypnotic					
Benzodiazepines					
Prescription drugs					
Inhalants (sniffing glue, other household products)					
Other					

Longest period of sobriety: _____

History of chemical dependency treatment: ☐ **Yes** ☐ **No**

IF YES…

☐ Inpatient (specify where and dates) _____ # of treatment episodes _____

☐ Outpatient (specify where and dates) _____

10. MEDICAL

Functional medical problems (check all that apply)

☐ None
☐ Impaired ability to walk
☐ Requires special medical equipment
☐ Incontinent
☐ Hearing impairment
☐ Deaf
☐ Impaired vision
☐ Blind
☐ Other medical problem/condition: _____

_____

Primary Physician: _____

Address: _____Phone #: _____-_____

REFERRAL INFORMATION SPOA-Adult PAGE SIX	NAME: Last First MI

11. COMMUNITY SURVIVAL SKILLS

SKILL	INDEPENDENT (requires no assistance)	NEEDS HELP	UNABLE	REJECTS
ADL's (eating, hygiene, grooming, dressing, toileting)				
Personal safety (crossing streets, not getting lost, respond appropriately in an emergency)				
Use of public transportation and other community resources				
Plan, shop, prepare meals and clean				
Use/engagement with mental health services (taking medications, making appts, adherence to regimen/programs)				
Use/engagement in medical services (annual physical, and if applicable, taking meds, making appts, adherence to regimen, special diets, etc.)				
Social relationships (ability to establish or maintain satisfactory relationships with peers)				
Self-direction (impulse control, decision-making, judgment and value system)				

12. ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

13. SIGNATURE OF CLIENT:	Email, mail, or fax completed referral and release to: **Single Point of Access** Chautauqua County Department of Mental Hygiene 333 E. 5th Street, Jamestown, NY 14701 **Email: fadalet@chqgov.com Phone: 716-661-8850 Fax: 716-753-9724**
Signature/Title/Agency of Person Completing Referral:	**Date:**

Chautauqua County Department of Mental Hygiene

OBTAINING AND RELEASING OF PSYCHIATRIC AND/OR SUBSTANCE ABUSE INFORMATION for SINGLE POINT OF ACCESS PROGRAM for ADULTS

Client Name: _____

Date of Birth: _____

Client consent form:

Single Point of Access Program For Adults is hereby granted permission to release and/or obtain information from my referral to and from the Committee Representatives of and/or Records Departments from: **the referral source, Aspire WNY, BestSelf Behavioral Health ACT Program & Outpatient Mental Health; Buffalo Psychiatric Center; Lakeside Clinic; The Resource Center; Southern Tier Environments for Living (STEL); Evergreen Health Services; Hillside Family of Agencies; INTANDEM; Monroe Plan; Person Centered Services; UPMC Chautauqua Hospital Inpatient and Outpatient Mental Health Programs, UPMC Chemical Dependency; Mental Health Association; Recovery Options Made Easy, Inc.; Chautauqua Opportunities Inc.; The Chautauqua Center; Chautauqua County Department of Mental Hygiene (CCDMH), CCDMH Case Management, CCDMH Outpatient Mental Health, CCDMH Child SPOA Program, CCDMH AOT Program and Forensic Services; Chautauqua County Department of Mental Hygiene & Social Services; Chautauqua County Department of Health; Chautauqua County Office for Aging; and Chautauqua County Probation Department, Chautauqua County Sheriff's Office; CARES; Venture Forthe; Veteran Affairs.**

OTHER: _____ EXCEPTIONS: _____

(to above)

I understand that information in my referral may contain information about my identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis. I understand the only information disclosed will be pertinent and necessary to determine housing and case management needs. I further understand I have the right to attend the SPOA committee discussion regarding the appropriate level of care for my needs.

The purpose or need for disclosing and obtaining information is:

To allow the SPOA Committee to determine appropriate level of care and coordinate treatment.

I am not giving permission for any re-disclosure of this information other than specified above.

INSTRUCTIONS: Client or person acting for client **must** sign **A *and* B** to give permission for the release of information and to authorize permission for review by the SPOA Committee. **C is signed *only* when there is *denial* of permission.**

A. *My consent will expire when discharged from the SPOA Program* ***OR*** *on this date _____/_____/_____. I hereby grant permission for the exchange of information to the parties authorized. I also understand that I have the right to cancel my permission to release or obtain information at any time.*

Signature of client/person acting for client	Relationship	Date	Signature of Witness	Title	Date

B. *I hereby authorize the SPOA Committee review of my SPOA application and all relevant records obtained by the Single Point of Access Program, for the purpose of determining eligibility for services and level of care. I understand the Committee is comprised of representatives of various human service agencies in Chautauqua County, and that Committee members will hold all information in confidence.*

Signature of client/person acting for client	Relationship	Date	**Signature of Witness**	Title	Date

C. *I hereby refuse to authorize the release of information to the person/organizations, facilities, or programs above.*

Signature of client/person acting for client	Relationship	Date	Signature of Witness	Title	Date

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

Consent Form

Chautauqua County Department of Mental Hygiene SPOA

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 1 box only.*

☐ **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.

☐ **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 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

1 **How providers can use your health information.** They can use it only to:

- Provide medical treatment, care coordination, and related services.
- Evaluate and improve the quality of medical care.
- Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2 **What information they can access.** If you give consent, Chautauqua County Department of Mental Hygiene SPOA can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4 **Who can access your information, with your consent.** Chautauqua County Department of Mental Hygiene SPOA 's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Chautauqua County Department of Mental Hygiene SPOA. Staff members who perform the duties listed in #1 above also can access your information.

5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:

- the Chautauqua County SPOA Coordinator at 716-661-8857, or
- the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6 **Sharing of your information.** Chautauqua County Department of Mental Hygiene SPOA may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Chautauqua County Department of Mental Hygiene SPOA, 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 and submitting a Withdrawal of Consent Form to the Chautauqua County SPOA Coordinator. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling the SPOA Coordinator Office at 716-661-8140. Please note, providers who get your health information through Chautauqua County Department of Mental Hygiene SPOA while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

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