Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Directions: To apply for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF), complete and submit the C-SPOA Part 1 and this Part 2 application to the applicant's C-SPOA of origin.

Note: If an update to the information provided in the application occurs within 90 days of the initial submission, updates can be provided by re-submitting the form, with updates to relevant section(s) and selecting "check this box if no information has changed" for all others.

Section 1: Referral Type ☐ If resubmitting within last 90 days, check this box if no information has changed.

Select the program type(s) to which the youth applicant/family is pursuing access:

☐ OMH Youth Assertive Community Treatment (ACT)

Not available statewide. Confirm applicant resides in one of the following catchment counties:

- ☐ Albany/Schenectady
- ☐ Bronx
- ☐ Brooklyn
- ☐ Broome
- ☐ Chemung/Steuben
- ☐ Cortland/Chenango
- ☐ Erie/Niagara
- ☐ Fulton/Montgomery
- ☐ Manhattan
- ☐ Monroe
- ☐ Nassau
- ☐ Oneida
- ☐ Onondaga
- ☐ Orange
- ☐ Queens
- ☐ Saratoga/Warren/Washington
- ☐ Staten Island
- ☐ Suffolk
- ☐ Westchester

☐ OMH Children's Community Residence (CCR)

☐ OMH Residential Treatment Facility (RTF)

For OPWDD use only: ☐ Referral for OLV ITP RTF

Section 2: Reason for Referral ☐ If resubmitting within last 90 days, check this box if no information has changed.

What are the current symptoms which require treatment and support? Describe the frequency, intensity, duration, and risk of harm for each symptom present.

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

What are the youth applicant/family's presenting needs? How do these needs impair the youth applicant's ability to function in the home, school, and community?
What are youth applicant and family strengths?
Is the youth applicant/family currently connected to community-based services? If so, please describe the type of service(s), frequency, duration, and coordination of services.
What challenges have impacted the ability of home and community-based services to meet the youth applicant and their family's needs?

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Section 3: Education Program Information

☐ If resubmitting within last 90 days, check this box if no information has changed.

Home School District	School Name	Grade

Has a CSE determined the applicant has a Special Education Disability or Condition? ☐ Yes ☐ No ☐ Pending

If yes, please list all that apply (e.g., Learning Disability, Emotional Disturbance, Multiple Disabilities, etc.):

Is there a current IEP or 504 Plan? ☐ No ☐ Yes, IEP ☐ Yes, 504	Has a CSE found the applicant eligible for New York State Alternate Assessment? ☐ No ☐ Yes	Date of Last CSE meeting Date:_____ ☐ N/A

CSE Contact Name	CSE Phone	CSE Email

Section 4: System and Service Involvement ☐ If resubmitting within last 90 days, check this box if no information has changed.

System and Service Categories	Involvement	Describe Reason for Involvement and the Timeframe *If additional space is needed, please attach narrative to the application.*
Office for People with Developmental Disabilities (OPWDD)	NY START/CSIDD connected? ☐ Yes ☐ No ☐ Unknown	(*If applicable, indicate current status of pending eligibility or referrals.*)
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Child Protective Services (CPS) Involvement	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
DSS/ACS Custody	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Family Court	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
PINS/PINS Diversion	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Probation	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
Criminal Court	☐ Past ☐ Current ☐ Unknown	(*if applicable, indicate if charges pending*)
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	
OCFS Division of Juvenile Justice (OCFS DJJOY Custody)	☐ Past ☐ Current ☐ Unknown	
	If current involvement: Contact Name _____ Title _____ Phone _____ Email _____	

Section 5: Residential or Inpatient Service Utilization (Over the past 2 years) If no history of residential or inpatient admission, indicate N/A. If additional space is needed, please attach narrative.
☐ If resubmitting within last 90 days, check this box if no information has changed.

Name of Facility	Date of Admission	Date of Discharge (or Anticipated Date of Discharge)

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Section 6: Discharge Planning ☐ If resubmitting within last 90 days, check this box if no information has changed.

Detail a proposed plan for discharge. Include a discharge setting and the services that may be needed. Identify potential barriers.

Section 7: Discharge Planning Partner(s) Identify individuals, in addition to the parent/legal custodians and guardians, to be engaged in discharge planning discussions. If there is DSS, or an ACS Case Planning Agency involvement, the case worker and supervisor must be listed as discharge planning partners.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Name	Relationship to Youth Applicant/Family	Contact Information (Email and Phone Number)

Section 8: Primary Provider Contact For Clinical Updates. Complete if different than referrer.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Name	Agency Name
Phone Number	Fax Number
Relationship to Applicant (PCP, Therapist, Etc.)	Email Address
Signature	Date

Section 9: Supporting Documentation Guidelines and Checklist ☐ If resubmitting within last 90 days, check this box if no information has changed.

The following documentation is required to be completed and submitted with the C-SPOA Part 1 and this Part 2 application in order for the referral to be considered "complete" and processed by C-SPOA.

☐ **C-SPOA Application Part 1**
☐ **Required Consent For Release Of Information For C-SPOA** completed by parent/legal guardian
☐ **C-SPOA Application Part 2** (this form)
☐ **Verification of Serious Emotional Disturbance** completed by Licensed Behavioral Health Practitioner -OR- a psychiatric, psychosocial, or psychological evaluation which includes a SED determination

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

☐ **For referrals initiated in an inpatient setting**, **a current summary of the hospitalization is required**.
The summary of the hospitalization should address: course of treatment since time of admission (including use of increased observation (e.g.,1:1 5 min. observation), intramuscular medication for agitation, aggressive, or self-injurious behavior use of restraint) response to treatment, *current* status (e.g. overall behavior on unit, ADLs), and anticipated LOS.

☐ **For referrals initiated by Youth ACT, CCR or an RTF, submit**:
- ☐ Psychosocial which includes current course of treatment and response to treatment in the program.
- ☐ Current treatment plan

Subsection A: Required For Youth ACT Referrals Only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Any documentation to support the following ACT eligibility criteria**:
- Youth and/or family has not adequately engaged or responded to treatment in more traditional settings.
- High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year)
- High use of psychiatric emergency or crisis services
- Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues)
- Residing or being discharged from in an inpatient bed, residential treatment program, or in a CCR, or being deemed eligible for RTF, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. This may also include current or recent involvement (within the last six months) in another child-serving system such as juvenile justice, child welfare, foster care etc. wherein mental health services were provided.
- Home environment and/or community unable to provide necessary support for developmentally appropriate growth required to adequately address mental health needs.
- Clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., children's community residence, psychiatric hospital, or RTF) without intensive community services

Subsection B: Required For CCR and RTF Referrals Only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Psychiatric Evaluation**
- A full psychiatric evaluation must have been performed within the past 12 months, with an update within the past 90 days of the time of referral, verifying that the psychiatric evaluation accurately reflects the youth applicant's current level of functioning.
- The psychiatric evaluation may be signed by the treating Physician, or Nurse Practitioner.
- The psychiatric evaluation should address the following:
  - Current mental status
  - History of prior psychiatric care and treatment
  - Brief summary of past and present psychotropic medication, response to medications, reasons for changes/discontinuation, effectiveness, and side effects

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

- Diagnostic formulation with clear examples that substantiate clinical conceptualization
- DSM-5 diagnosis

☐ **Psychosocial Assessment**

- A psychosocial assessment must have been performed within the past 12 months.
- The psychosocial assessment must assess both youth applicant AND family and address the following:
  - Developmental History & Needs: Include pre-natal, peri-natal, and post-natal periods, developmental milestones and problems, any services and related progress, current status and needs across domains.
  - Treatment History: Indicate current and historical therapeutic interventions and response to the course of treatment. include treatment outcomes, engagement, problems with approaches, barriers to progress.
  - Family/Community History: Include family developmental/psychiatric/medical history and current status, constellation and dynamics of family members and other natural supports, past and current family problems, socioeconomic status, religious, cultural, ethnic, and other important youth and family affiliations. Note if there are visiting restrictions, loss of rights, or other special information.
  - Educational/Vocational History: Indicate current grade, academic, social, behavioral, and emotional functioning, special education needs and supports. Note employment history and vocational interests as appropriate. Note family's involvement in school/vocational interests and achievement.
  - Skills, Talents, Interests and Strengths: Describe youth applicant/family's special interests, skills/talents, recreational interests, and other assets.
  - Court involvement, if applicable: Indicate any involvement with family/criminal court, department of probation or any such mandated treatment and level of compliance. Include last court date with outcome and next court date.
  - Other co-morbid special needs: Please include any concurrent needs including substance abuse, sexual problematic behavior, etc. If applicable, be sure to include assessments indication risk to self and others, engagement in treatment and related progress.

☐ **Psychological Assessment (Required for RTF ONLY. For CCR, only required if youth has an IEP.)**

- The psychological assessment must have been performed within the last 3 years.
- The psychological assessment must be completed signed or co-signed by a Licensed Psychologist verifying that the psychological assessment accurately reflects the youth applicant's current level of functioning.
- The psychological assessment should address the following:
  - Mental status
  - Instruments used and dates of testing. Testing completed by JD/MHS licensed psychologist is acceptable. An ACTUAL copy of the testing administered should accompany the referral; it is not sufficient to reference someone's past psychological assessment in a new document without new testing.
  - Assessment of cognition (including FSIQ verbal and nonverbal/performance IQ). Standardized adaptive testing (e.g., Vineland, ABAS) is recommended if FSIQ is below 70.

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

- Evaluation of language, social-affective functioning, sensory-motor functioning, and adaptive behavior (may be based on standardized testing, interview, history, and observation, as appropriate)
- Where available and appropriate, personality assessment
- Case formulation with clear descriptive examples that substantiate clinical conceptualization

☐ **Physical/Medical Exam Documentation**

- Documentation of physical exam performed within last 12 months, unless there is an ongoing physical problem, in which case a summary within 90 days of referral is required
- Physical Exam documentation must include:
  - Statement regarding youth applicant's current health & medical history
  - Indicate any allergies, chronic and/or severe needs, potential risk factors that may interact with medications
  - Test results, prescribed treatment, and response to treatment.

☐ **If youth applicant has been reviewed by a CSE, attach**:

☐ CSE recommendations

☐ The IEP or 504, if established

☐ **If high risk behavior for sexualized behavior or fire-setting have occurred in the past two years, attach a risk assessment.** Contact C-SPOA for list of acceptable risk assessments.

☐ **If chronic/severe physical/medical needs are identified**, attach any relevant information (e.g., neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tine test report, nutritional assessment and any other physical findings.)

IF FOUND ELIGIBLE, the following documents will be requested for admission.

Please indicate which of the following are currently available

☐ **FOR CCR ONLY:** An authorization for Children's Community Residence rehabilitation services

☐ **Proof of US Residency as evidenced by:**

☐ Copy of Birth Certificate, and

☐ Copy of Social Security Card; **OR**

☐ Copy of Permanent Residency Card; **OR**

☐ Description of current U.S. residency status from Immigration Attorney

☐ **Copy of Immunization Record**

☐ **Copy of Health Insurance Card** (front and back)

☐ If the youth applicant is DSS/ACS involved or if in the youth is in DSS/ACS custody: Any restrictions to family contact (e.g., Order of Protection)

Subsection C: Required For RTF Referrals only

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Statewide OMH RTF Authorization Review Process Consent** completed by parent/legal guardian

☐ **Statewide Request for Medicaid Childhood Disability Determination** completed by parent/legal guardian

Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

Youth Applicant's Identifying Information			
Legal Last Name	Legal First Name	MI	Date of Birth

Section 10: Be advised the following additional documents may be requested in order to determine eligibility for Youth ACT, CCR or RTF.

☐ If resubmitting within last 90 days, check this box if no information has changed.

Please indicate which of the following are available upon request:

- ☐ If the youth applicant/family is DSS/ACS-involved or if in the youth applicant is in DSS/ACS custody: Family Court Order, Permanency Plan, Psycho-social
- ☐ Records related to involvement in other systems of care (e.g., juvenile justice, child welfare, disability services) that provide examples of functional impairment in home and community
- ☐ Other clinically relevant evaluations (psychiatric, psychological, neurological, occupational therapy, chemical dependency, etc.)
- ☐ Discharge summaries from previous inpatient, residential and outpatient treatment providers

Section 11: Referrer Attestation

☐ I attest that the information in this application, accurately reflects the youth's level of functioning at the time of application.

Referrer Signature	Date

Referrer Name	Title/ Agency

--------For C-SPOA Use Only----------

C-SPOA Name	Email	Phone	Date Received

Notes regarding application (e.g. completeness, resubmission, updates).

Are less restrictive services documented to be insufficient to meet the individual's severe and persistent clinical needs? ☐ Yes ☐ No ☐ Unable to determine

Provide additional information regarding the youth applicant's utilization of less restrictive treatment and support services and C-SPOA recommendation(s). If known and applicable, include any barriers encountered by the youth/family.

Is referral for access to Youth ACT? ☐ Yes ☐ No	Date deemed complete for Youth ACT	Does the applicant meet eligibility criteria for Youth ACT? ☐ Yes ☐ No	Date youth/guardian agreed to proceed with Youth ACT referral
Is referral for access to CCR? ☐ Yes ☐ No	Date deemed complete for CCR	Is the applicant appropriate for CCR per the *CCR LOC Recommendation Guide*? ☐ Yes ☐ No	Date youth/guardian agreed to proceed with CCR referral
Is referral for access to RTF? ☐ Yes ☐ No	Date deemed complete for RTF	Date youth/guardian agreed to proceed with referral for RTF services	Date application for RTF services submitted to OMH
Is referral from OPWDD for the ITP? ☐ Yes ☐ No			

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

Youth Applicant's Name (Last) (First) (M.I.)	Youth's Date of Birth

Youth's Permanent Address

Referring Source Name

Referring Source Address

I, or my authorized representative, request that health information regarding the above-named youth's care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- A specific authorization is required to use or disclose drug or alcohol diagnoses or treatment information or confidential HIV related information.
- I have the right to know what information about the youth has been shared, and why, when, and with whom it was shared.
- I have the right to cancel my authorization to release information by notifying the referring agency or the Office of Mental Health (OMH) Residential Treatment Facility (RTF) Authorization Coordinator in writing, or to withdraw from the OMH RTF Authorization Review Process any time before it is released. This will stop OMH from sharing information after my consent has been withdrawn.
- I also understand that the OMH RTF Authorization Review Process may be composed of reviewers from the youth's local Children-Single Point of Access (C-SPOA) and Office of Mental Health (OMH.) As applicable, reviewers may also include representatives from the Office for People with Developmental Disabilities (OPWDD), Office of Children and Family Services (OCFS), and State Education Department (SED.)
- I authorize the release of clinical and educational information to OMH regarding the above-named youth. I understand that the OMH RTF Authorization Review Process will review and evaluate this information to determine the youth's eligibility and medical necessity for authorization to apply for admission to RTF(s) and will maintain the confidentiality of this information. I understand that the information will be shared in written form, in meetings, by phone, or by computerized data.
- I authorize the OMH RTF Authorization Coordinator(s) to release the above information to RTF(s). I understand that this information will be used to evaluate the youth for possible admission to the RTF(s) and that the RTF(s) will maintain the confidentiality of this information.
- This consent to release information will expire: a) one year from the signed date if the youth is not admitted into an RTF or b) when the youth is discharged from an RTF.

This authorization must be completed by the parent/legal guardian to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. **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.

_____ _____
Signature of Parent Relationship

_____ _____
Print Name Signed Date Signed

_____ _____
Signature of Legal Guardian * Title

_____ _____
Print Name Signed Date Signed

*Legal documentation indicating authority to sign in lieu of parent(s) listed on birth certificate must be submitted with this form.

_____ _____
Signature of Witness Title

_____ _____
Print Name Signed Date Signed

FOR OMH USE ONLY

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:
- ☐ Letter (Attach Copy)

DATE REQUEST RECEIVED:_____

OMH REPRESENTATIVE RECEIVING REQUEST:

(OMH REPRESENTATIVE'S FULL NAME AND TITLE)

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

REQUEST FOR DISABILITY DETERMINATION

Name of Youth Applicant: _____

Youth's Date of Birth: _____

This is to request that the Office of Mental Health (OMH) determine whether the above-named youth applicant is disabled for the purposes of the Medical Assistance Program, as designated by the Department of Social Services.

I authorize OMH to review and evaluate any mental health, health, or educational information it has received to assess whether the above-named youth is disabled. I also authorize OMH to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that OMH will be determining whether the above-named youth is disabled but not whether he/she is eligible for Medical Assistance.

_____

Signature of Parent/Legal Guardian

_____

Relationship to Applicant

_____

Date Signed