2027
ERIE COUNTY DEPARTMENT OF MENTAL HEALTH

ADULT SINGLE POINT OF ACCESS (A-SPOA) GUIDANCE MANUAL

COUNTY OF ERIE

(Revised: 9/18/2026)

Purpose of this Guidance Document

The purpose of this Guidance Document is to provide the purpose and function of the Erie County Adult Single Point of Access (A-SPOA), the services available, referral process, and information for contract agencies related to reporting requirements.

Overview:

The Adult Single Point of Access (referred to as "A-SPOA" or "Adult SPOA") is a New York State (NYS) Office of Mental Health (OMH) initiative designed to provide a more cohesive and coordinated system. The Erie County Adult SPOA Referral system has established a uniform process for receiving and evaluating referrals for individuals with a serious mental illness (SMI) diagnosis. The goal was to create a system that promotes recovery-oriented services that are flexible, personally tailored and responsive to an individual's needs.

The A-SPOA Referral system's function is to assess/screen those referred and facilitate connection to the services that best meet the consumer's needs and the community's priorities. The centralized referral system facilitates linkage to services, allows for triaging for high needs individuals, and is used for monitoring outcomes. Referrals are made through an online system at: www.eriespoa.org. This website provides instructions for users to complete and submit an A-SPOA referral, which is done in the Single Point of Access Management Information System (SPOA-MIS). A signed A-SPOA consent from the individual to be served must be submitted to process the referral.

A-SPOA Eligibility Requirements:

Each service that the A-SPOA refers clients to has unique eligibility requirements. Many services are based on the diagnosis of Serious Mental Illness (SMI). The definition of Serious Mental Illness according to the New York State Office of Mental Health "**Definition of Serious and Persistent Mental Illness (DSM-V)**," follows below.

Definition of Serious and Persistent Mental Illness (DSM-V):
Source: https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html

In order to be considered an adult with a serious mental illness, "1" below must be met, in addition to either "2", "3", or "4":

1. **Designated Mental Illness**
   The individual is 18 years of age or older and currently meets the criteria for a psychiatric diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.

And

2. **SSI or SSDI due to Mental Illness**
   The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

Or

3. **Impairment in Functioning due to Mental Illness**
   a. 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:
      i. Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care, or complying with medical advice).
      ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
      iii. 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).
      iv. 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

4. **Reliance on Psychiatric Treatment, Rehabilitation and Supports**
   A documented history shows that the individual at some prior time met the threshold for 3 (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.

The Erie County A-SPOA team presumes those with diagnoses of schizophrenia; schizoaffective disorder; psychotic disorder (not substance-induced); delusional disorder; major depressive disorder; bipolar 1, 2, or unspecified disorder; and post-traumatic stress disorder meet the criteria of SMI due to the severity of these diagnoses. Other diagnoses will be considered on a case-by-case basis of how the individual experiences them and whether the circumstances involved meet the criteria of an SMI.

Services Available Through Adult A-SPOA:

Care Management:

General Case Management/Care Coordination:
To be eligible for Case Management/Care Coordination, a consumer's needs must be chronic in nature and their mental health issues must require enhanced community services Referrals are made directly to the A-SPOA via www.eriespoa.org and the A-SPOA will assign the referral to a Care Management Agency. An individual may be eligible for health home plus (HH+) depending on level of need. Criteria for health home plus is located here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/hh_plus.htm . In rare circumstances where agencies are at capacity, a referral may be put on a waitlist.

Assertive Community Treatment (ACT):
If an individual has shown inability to remain linked with traditional mental health treatment and health home care management, they may be appropriate for Assertive Community Treatment (ACT). ACT is a treatment model where an individual is seen in their home for all treatment services. These services include therapy, medication management, care management, and more. **Referrals are made directly to the A-SPOA via** www.eriespoa.org.
See ACT eligibility criteria at: https://omh.ny.gov/omhweb/act/act-program-guidelines.pdf

Assisted Outpatient Treatment (AOT):
AOT is meant for individuals who meet the specific criteria under Kendra's Law and may need mandated services after other alternatives have been diligently attempted. **See AOT eligibility criteria and additional information at:** https://my.omh.ny.gov/analyticsRes1/files/aot/Outpatient_Treatment_Brochure_Revised.pdf

Housing Programs:

Non-Licensed Housing

Supportive Housing Programs (SHP):
These programs provide a partial rental subsidy for a private apartment selected by and leased by the consumers themselves. The supportive housing programs provide rental payment assistance and supportive services. Staff provide services designed to assist consumers to obtain or refine skills necessary for more independent living and increased self-sufficiency. Staff generally meet with the consumer at a minimum of once a month depending on individual needs of the consumer.

Consumers are expected to develop individual goals which focus on living more independently. Referrals are coordinated through the A-SPOA. The NYS OMH-funded supportive housing programs require verification of significant impairment in functioning due to a mental disability.

Federal Housing and Urban Development (HUD)-funded permanent supportive housing programs also require verification of homelessness at the time of admission. HUD defines homelessness as being in a place not meant for human habitation, in an emergency shelter or transitional housing program exclusively intended for people who are homeless or fleeing domestic violence or human

trafficking.

The demand for these programs typically exceeds the availability of open beds; therefore, referrals are placed on a wait list prioritized by a risk score that is auto-generated by the circumstances entered into the A-SPOA referral. The Erie County Housing Coordinator and Assistant Housing Coordinators facilitate this process.

Supportive Housing Program Agency Providers Include:

- Transitional Services, Inc.;
- DePaul Community Services (Living Opportunities of DePaul);
- BestSelf Behavioral Health;
- Spectrum Health & Human Services;
- Southern Tier Environments for Living;
- Buffalo Federation of Neighborhood Centers;
- Restoration Society, Inc.; and
- WNY Veterans Housing Coalition.

Critical Time Intervention (CTI):
CTI are goal-oriented case management programs that support the transition into housing out of an institutional setting such as a hospital, prison, jail, substance abuse treatment facility, or homeless shelter. CTI offers one (1) month of financial assistance towards the cost of housing. The following months are then focused on helping participants build their support system and accomplish person-centered goals. A six-month (6-month) program is offered for people who experienced homelessness and are transitioning from an institution. There is also a twelve-month (12-month) program for those who are transitioning from a substance abuse treatment facility. Restoration Society, Inc. facilitates the CTI program for homeless individuals and BestSelf Behavioral Health operates the CTI program for people transitioning from substance abuse treatment facilities.

Emergency Housing Services (EHS):
EHS is a ten-bed (10-bed) setting for people with serious mental illness (SMI) who are also experiencing homelessness. Services are focused on transitioning people who are experiencing homelessness into permanent housing. Transitional Services, Inc. facilitates this program.

Licensed Housing:

Supervised Community Residences (SCR):
SCR are congregate care facilities (group homes) which house eight (8) to fourteen (14) residents age eighteen (18) years or older. These programs are considered transitional and rehabilitative in nature. The goal for the resident is to move to a less restrictive living environment within twenty-four (24) months. Bedrooms are often shared but some of the programs do have single bedrooms. Residents participate in the upkeep of the house which includes meal planning and preparation, and recreational activities are also provided. Some group homes (provided by Transitional Services, Inc.) include an attached training apartment for residents ready to test independent living skills where staff are on site 24/7. SCR services are facilitated by Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, and Transitional Services, Inc.

Supervised Senior Community Residences (SSCR):
SSCR operate the same way as Supervised Community Residences (SCR) but are for consumers who are aged fifty-five (55) years or older. SSCR are encouraged to identify independent living goals but there is less emphasis placed on moving into an apartment. SSCR are facilitated by Southern Tier Living Environments and Transitional Services, Inc.

Treatment/Supervised Apartments (TSA):
TSA provides transitional housing in shared (one (1), two (2) or three (3) bedroom) apartments within the community. These apartments are either located at a single site that has staff onsite 24/7, or there are scattered site apartments where the staff visit them anywhere from once (1) to seven (7) days per week and remain on-call for emergencies 24/7. Staff provide services that are designed to assist residents in either obtaining or refining the life skills necessary for independent living. Cash allowances for groceries and clothing are provided by some of the programs. TSA residents are expected to develop individual goals with the focus on them living more independently. The typical length of stay is eighteen (18) to twenty-four (24) months. TSA housing services are facilitated by Buffalo Federation of Neighborhood Centers; DePaul Community Services; and Transitional Services, Inc.

COD Housing (Co-Occurring Disorders):
COD (Co-Occurring Disorders) are Group Home and Treatment Apartment Programs capable of providing specialized staffing and services, for consumers who are diagnosed with an addictions disorder as well as a psychiatric disability. COD Group Homes are facilitated by Transitional Services, Inc., which operates a ten-bed (10-bed) supervised apartment program. Single bedrooms are available.

Young Adult Housing (YAH)
YAH is a group home and supported housing program, providing specialized services for individuals aged eighteen (18) to twenty-five (25), who are transitioning from Residential Treatment Facilities or congregate living environments for adolescents. The services provided are similar to other group settings. YAH has the staffing capacity to provide more intensive services for individuals participating in the supported housing component of the program. YAH services are facilitated by Transitional Services, Inc.

Single Room Occupancy (SRO):
SRO provides housing that is specifically designed to offer permanent housing in a service-enriched setting. These programs are intended to provide housing and services for individuals that are capable of living independently. A social service team provides services on-site which include case management, interactive groups, activities, medication management, money management, and vocational linkage. SRO housing is facilitated by DePaul Community Services.

Information for Agencies Providing A-SPOA Linked Services

Agencies that are providers of A-SPOA linked services should adhere to the following guidance as applicable. The following sections cover AOT Reporting Guidance and A-SPOA Housing Language.

AOT Reporting Guidance

The following reporting is required for all HH + Care Management agencies and ACT teams that serve AOT clients:

Weekly Reports:
AOT weekly reports are to be submitted via A-SPOA MIS no later than the Tuesday following the reporting week. A weekly report is to be submitted for each individual that is on a court ordered AOT plan or on an Enhanced Voluntary Agreement. Reporting is required for each category of service listed on the court ordered or diversion treatment plan. The weekly report is designed to capture compliance (or non-compliance) for each category of service.

Clinical Risk Information:
Sound, clinical decision-making requires accurate risk specific information. It is widely recognized that past violent behavior is a significant predictor of future behavior. Comprehensive, risk specific information promotes the development of treatment plans that are attentive to both the management of risk and the quality of clinical services.

Coordination of Care:
Coordination among providers is critical to the successful delivery of the array of services offered to AOT recipients. All providers involved in the individual's care, such as ACT teams, housing programs, and hospital personnel must work together to support the individual. This coordination is meant to lower risk, improve quality of care, and work towards positive clinical outcomes for the individual.

Discharge Planning:
It is critical that discharge planning and implementation commence at admission. Intensive, intentional and proactive discharge planning with the consumer, and in close coordination with the community provider and supports, and significant others should occur throughout the process to enable a successful transition from AOT in the shortest duration possible.

Significant Event Reports:
As per the AOT statute, the OMH AOT regional coordinator must ensure a mechanism exists for the agency serving the individual to report compliance/non-compliance, and other significant events to the county's AOT program. In Erie County, ACT teams and care management programs have access to a significant reporting form which is located in the SPOA MIS system. This form is used to report non-compliance and other significant events, which are described in the reporting form, to the Erie County AOT program. coordinator. The information reported will be used to complete the quarterly AOT report sent to OMH by county AOT coordinator and to inform decisions on a renewal of the AOT order or disenrollment at the expiration date. The Significant Report form is located at eriespoa.org under the providers' client list.
Link to the Significant Event guidance from OMH:
https://my.omh.ny.gov/analyticsRes1/files/aot/AOTGuidanceforReportingSignificantEvents11012017.pdf

Missing Persons Guidance

Analysis of the AOT data set related to persons designated as missing indicates a significant correlation to previous violent incidents and homelessness. AOT is a strategy to reduce risk and every effort must be made to locate individuals who are deemed missing while under the AOT court order. Missing person for AOT is defined as a person who has had no credible contact within the last 24 hours or cannot be located within a 24-hour period.
Link to Missing Persons Protocol:
https://my.omh.ny.gov/analyticsRes1/files/aot/AOTGuidanceforProgramOperation2017.pdf

Physician Availability Guidance

Agencies that provide medication management and/or psychiatric treatment to individuals enrolled in Assisted Outpatient Treatment must have a Board-Certified Physician available. This physician must be prepared to complete AOT renewal evaluation and complete an AOT treatment plan. This physician will also be required to testify at a hearing to the treatment plan and need for AOT when a hearing is requested. The associated testimony must be in accordance with the requirements and deadlines of the court.

A-SPOA Housing Language Definitions and Instructions

To promote communication among all contracting agencies, the following definitions have been established for reporting to the Erie County Department of Mental Health A-SPOA office:

Engagement:
Begins once the provider agency receives a referral from A-SPOA and extends until the individual has been permanently housed. All engagement activities should be documented in the Housing Engagement section of the referral including activity type, the client or collateral contact with whom the housing agency's engagement is with and a detailed note related to the activity and the next plan of action.

72-Hour Bridger Housing:
It is an expectation that the individuals who are referred to unlicensed housing will be screened and housed, at least within a suitable safe and temporary setting other than the street or a shelter, within 72 hours of receipt of the referral. 72-hour Bridger Housing notification will be located under Housing Engagement in the "Type" drop down box.

No Decline Admission Policy:
Housing acceptance and enrollment in unlicensed programs is not contingent on compliance with the following: treatment, substance abuse history, participation in services, criminal conviction (including arson, assault), poor financial management, ability, and/or rental history. All disengagements must be cleared with A-SPOA who will then collaborate with coordinated entry.

The Screening Process:
Once the A-SPOA referral is received, the receiving agency should contact the referring person and the client to initiate the screening intake appointment within 24-hours of receiving the referral from A-SPOA. This should be indicated in the "Housing Engagement" section of the A-SPOA-MIS referral.

All engagement activities should be documented in the Housing Engagement section of the referral including activity type, who the engagement is with (client, collateral, or other), and a detailed note related to the activity and next plan of action.

- An email notification will be sent to program intake supervisors indicating that an A-SPOA referral has been sent for your review.

Disposition:
Once the screening disposition is made by the housing agency, the decision must be posted in A-SPOA within one (1) business day.

Disengagement:
This includes referrals in which the client refuses services, client is unable to be found (the ECDMH standard of time spent looking is for at least ninety (90) days if someone is experiencing chronic homelessness, less if not), client needs a higher level of care, referrer withdraws the referral, client is currently with another housing provider, client found other housing, etc. The ECDMH should be notified when a housing disengagement is needed as ECDMH A-SPOA is the only entity that has the ability to disengage referrals. The disengagement reason should be provided so the SPOA team can document the circumstance. To maximize capacity, A-SPOA is to be notified as soon as a referral is accepted, housed, discharged, denied, or disengaged.

Denial:
Denial refers to when an agency is not accepting the A-SPOA referral. If an agency denies an individual, a formal letter needs to be submitted to the ECDMH A-SPOA via email identifying the client's name with the specific reason for denial. As a reminder, HUD providers have a "No Decline Policy."

Enrollment:
Enrollment means that the individual has been housed. It is expected that an individual will be enrolled in housing within forty-five (45) days of receipt of the referral. Once the individual is housed, the provider agency needs to document this in the A-SPOA MIS System by clicking "Enrollment" located below the A-SPOA Notes section in the referral.

- **Please do not enroll unless the client has actually moved into the unit.**

*****It is mandatory that the A-SPOA-MIS is updated as each disposition event occurs to reflect the current activity on the assigned case.**

A-SPOA Capacity Table:
Agencies need to ensure that their Capacity Table is accurate and reflective of the individuals that are in each phase related to the status of the referral. A-SPOA sends referrals to providers based on the information provided by the agency in the A-SPOA Capacity Table.

Running of Reports:
A-SPOA will regularly compile reports that will measure the following:

- Length of time from agency receiving referral to enrollment in housing;

- Reasons for disengagements and denials; and
- Capacity based on capacity table.

The Erie County Department of Mental Health maintains an online web portal to receive, assign, and keep statistics on utilization of services that are referred through the SPOA. The terms of service are attached.

SPOA-MIS Terms of Service

These Terms of Service ("Terms") govern access to and use of the website, the Single Point of Access - Management Information System (SPOA-MIS), which facilitate referrals to services such as care coordination, Assertive Community Treatment (ACT) teams, Assisted Outpatient Treatment, and mental health residential programs. By accessing SPOA-MIS, all users agree to be bound by the below Terms (the "Terms").

1. Acceptance of Terms

By creating an account, accessing, or using any part of the SPOA-MIS, user signifies unreserved acceptance of the Terms. The Terms constitute a legally binding agreement between user and Erie County by and through the Erie County Department of Mental Health ("ECDMH") concerning user use of SPOA-MIS.

2. Description of Service

The Erie County Department of Mental Health provides the SPOA-MIS platform designed to connect individuals seeking mental health support with mental health services. SPOA-MIS is a referral tool and does not provide medical advice, diagnosis, or treatment.

3. User Responsibilities

All users agree to:

- Provide accurate, current, and complete information in the referral.
- View and use information about individuals' circumstances only for the coordination of care.
- Maintain the confidentiality of account credentials (user account and password). The user is responsible for all activities that occur under that account.
- Refrain from sharing login credentials with anyone else.
- Make referrals only for those who are consenting and cooperating with this process and for those who have signed the Erie County SPOA Redisclosure Consent forms.
- Use professional credentials and contact information (as applicable).

- Notify the SPOA team or SPOA System Administrator if and when user leaves its current professional position so that the account can be deactivated.
- Refrain from accessing previously submitted referrals after separating from previous employment.
- Use the service only for lawful purposes and in a manner that does not infringe upon the rights of others.
- Understand that the account will be deactivated after one year from the last login or upon leaving the current professional role, whichever occurs first. For users not employed by a participating organization, the user account will be deactivated after one year from the last login.
- Use the SPOA-MIS only for its intended purposes.

4. Privacy and Data Handling (PII and PHI)

User privacy is paramount to ECDMH. This section outlines how ECDMH handles Personally Identifiable Information (PII) and Protected Health Information (PHI).

4.1. Collection of Information

To provide effective referral services, ECDMH may collect PII for individuals referred to SPOA-MIS (such as your name, contact information, date of birth) and PHI (such as your mental health history, symptoms, treatment preferences, and other health-related information) that users voluntarily provide.

4.2. Use of Information

The PII and PHI collected are used exclusively for the following purposes:

- Facilitating Referrals: To match individuals with appropriate mental health service and residential providers based on the stated needs and preferences.
- Service Improvement: To analyze usage patterns and improve the functionality and relevance of our referral system.
- Internal Operations: For administrative purposes, security, and compliance with legal obligations.
- Coordination of Care: Update collaborative partners of status of enrollment, and to reassign referrals where appropriate

4.3. Outside Disclosure

ECDMH is committed to protecting personal information. We will NOT disclose PII or PHI to any third party outside of our direct operational needs for the coordination of care, without explicit consent, except in the following limited circumstances:

- With Client Express Written Consent: If client explicitly authorizes us to share their information with a specific third party (e.g., a particular mental health professional) by completing a release of information form.
- Legal Requirements: If required by law, court order, or governmental regulation (e.g., subpoena, warrant). In such cases, ECDMH will make reasonable efforts to notify user and client unless legally prohibited from doing so.
- To Prevent Harm: If ECDMH believes it is necessary to prevent imminent and serious harm to client or others.
- De-identified Data: ECDMH may use and share aggregated or de-identified data (data from which all PII and PHI have been removed) for research, analysis, or service improvement, as this data cannot be linked back to any individual.

4.4. Data Security

ECDMH maintains robust technical, administrative, and physical safeguards designed to protect PII and PHI from unauthorized access, use, disclosure, alteration, or destruction. These measures include, but are not limited to, encryption, and access controls.

4.5. HIPAA Compliance

SPOA-MIS complies with the Health Insurance Portability and Accountability Act (HIPAA) and its associated regulations concerning the handling of PHI.

5. Disclaimers

- No Medical Advice: SPOA-MIS does not provide medical advice, diagnosis, or treatment. The information provided on this website is for informational purposes only and should not be considered a substitute for professional medical advice.
- No Guarantees: ECDMH does not guarantee the availability, quality, or suitability of any mental health service or residential program found through our service. ECDMH is not responsible for the actions, omissions, or services of any third-party professionals.
- "As Is" Basis: The service is provided on an "as is" and "as available" basis, without any warranties of any kind, either expressed or implied.

6. Limitation of Liability

To the fullest extent permitted by law, Erie County by and through the Erie County Department of Mental Health, its affiliates, officers, directors, employees, agents, and licensors will not be

liable for any indirect, incidental, special, consequential, or punitive damages, including but not limited to, loss of profits, data, use, goodwill, or other intangible losses, resulting from (i) user access to or use of or inability to access or use the service; (ii) any conduct or content of any third party on the service; (iii) any content obtained from the service; and (iv) unauthorized access, use, or alteration of user transmissions or content, whether based on warranty, contract, tort (including negligence), or any other legal theory, whether or not we have been informed of the possibility of such damage.

7. Intellectual Property

All content, trademarks, service marks, trade names, logos, and intellectual property displayed on the SPOA-MIS are the property of ECDMH or its licensors and are protected by copyright and other intellectual property laws. User may not use, reproduce, distribute, or create derivative works from any content on this website without express written permission from ECDMH.

8. Termination

ECDMH may terminate or suspend user access to SPOA-MIS immediately, without prior notice or liability, for any reason whatsoever, including without limitation if user breaches the Terms. Upon termination, user right to use the service will immediately cease.

9. Governing Law

The Terms shall be governed and construed in accordance with the laws of the State of New York, and the United States.

10. Changes to the Terms

ECDMH reserves the right, in its sole discretion, to modify and/or replace the Terms at any time. By continuing to access SPOA-MIS after those revisions become effective, user agrees to be bound by the revised terms.

11. Contact Information

Questions regarding the Terms can be directed to support@eriespoa.org.