

**Wyoming County Department of Mental Health
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 the use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508©, this form is not an "Authorization" under the federal HPPAA 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 disclosed includes (check all that apply):

- Mental Health Records
- Health Records
- Alcohol/Drug Records
- School or Education Records
- 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 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.

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 Wyoming County.

This includes:

- Living Opportunities of DePaul (LODP)
- Wyoming County Community Hospital
- DePaul Community Services
- Wyoming County Department of Mental Health
- Peers Together of Wyoming County
- Wyoming County Department of Social Services
- Rochester Psychiatric Center
- Wyoming County Probation Department
- Wyoming County Public Defender
- GV BOCES Wyoming County Jail Case Manager
- RPC-Mobile Integration Team (MIT)
- Clarity Wellness Community
- Spectrum Health & Human Services
- Monroe Plan
- Independent Living of the Genesee Region
- And, any other SPOA participant pertinent to the interests of signee

OR

- The following organizations only:

6. The purposes for which this information may be used and disclosed include:
- Evaluation of eligibility to participate in a program supported by the Wyoming 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.
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 NOT OTHER PURPOSE.
8. This permission expires (check applicable choice)
- 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 also 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

Single Point of Access (ADULT SERVICES)
Application Form

PLEASE COMPLETE ENTIRE FORM. PLEASE ATTACH A COPY OF A RECENT PSYCHOSOCIAL EXAM, ANY AVAILABLE ASSESSMENTS OR MENTAL STATUS EXAM.

1. REFERRAL INFORMATION	Referral is for: <input type="checkbox"/> Care Coordination <input type="checkbox"/> Housing <input type="checkbox"/> Both <input type="checkbox"/> Other: _____ If referring for care coordination, preferred agency: <input type="checkbox"/> Spectrum Health <input type="checkbox"/> Monroe Plan Type of Service Requested: _____	
Client Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Specify: Pronouns in Use:	Date of Referral:
Client Street Address:	Referring Person:	
City/State/Zip:	Referring Agency and Address:	
Client Phone Number:	Cell phone #:	Referral Contact Telephone #:
Client SSN:	Client DOB:	
Client Medicaid # (include Sequence #) _____ Seq. _____ Private Insurance Name and Policy	Name and Phone Number of Current Outpatient Provider:	
Alternate Contact, Address and/or Phone # for Client:	Emergency Contact Name, Address & Phone #:	

<i>AXIS</i>	<i>DESCRIPTION</i>	<i>CODE</i>
Mental Health DX		
SUD DX		
Medical DX		
Significant Life Stressors		XXXXXXXX

Primary Referral Organization Affiliation:

- | | | |
|--|---|---|
| <input type="checkbox"/> Self, Family, Friend | <input type="checkbox"/> State Psychiatric Ctr (inpt) | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Mental Health Outpatient | <input type="checkbox"/> General Hospital ER | <input type="checkbox"/> Family Court |
| <input type="checkbox"/> Local MH Practitioner | <input type="checkbox"/> General Hospital (inpt) | <input type="checkbox"/> Criminal Court |
| <input type="checkbox"/> Mental Health Residential | <input type="checkbox"/> Substance Use Program | <input type="checkbox"/> Probation/parole |
| <input type="checkbox"/> CSP Mental Health Program | <input type="checkbox"/> Other Medical Provider | <input type="checkbox"/> Jail |
| <input type="checkbox"/> Emergency Non-residential Program | <input type="checkbox"/> MR/DD Facility | <input type="checkbox"/> Shelter for the homeless |
| <input type="checkbox"/> Other (specify) _____ | | |

2. PERSONAL & DEMOGRAPHIC INFORMATION

- | | | |
|---|--|--|
| Race/Ethnicity: | Primary Language | English Proficiency |
| <input type="checkbox"/> 1. White, Non-Hispanic <input type="checkbox"/> 4. Asian
<input type="checkbox"/> 2. Black, Non-Hispanic <input type="checkbox"/> 5. American Indian or Native
<input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 6. Other (specify) _____
<input type="checkbox"/> 4. Other _____ | <input type="checkbox"/> 1. English
<input type="checkbox"/> 2. Spanish
<input type="checkbox"/> 3. American Sign Language | (if primary language is other than English)
<input type="checkbox"/> 1. Does not speak English
<input type="checkbox"/> 2. Poor
<input type="checkbox"/> 3. Fair
<input type="checkbox"/> 4. Good – does not need translator |

3. LIVING ENVIRONMENT/SUPPORT SYSTEM

Does this individual currently receive case management or care coordination? No Yes
 If yes, agency name: _____

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 older than 18yrs
- 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:

- | | |
|--|--|
| <input type="checkbox"/> Lives alone
<input type="checkbox"/> Lives with spouse
<input type="checkbox"/> Lives with parents
<input type="checkbox"/> Lives with other relatives | <input type="checkbox"/> Assisted /supported living (specify) _____
<input type="checkbox"/> Nursing home/medical setting (specify) _____
<input type="checkbox"/> Supervised Apartment Program (specify) _____
<input type="checkbox"/> Supervised group home (specify) _____
<input type="checkbox"/> Psychiatric hospital (specify) _____ |
|--|--|
- Correctional setting (specify)** _____

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
- Master’s degree
- Other: _____

Current Employment Status

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

5. NEED FOR SERVICE(S)

Item	
<p>Please comment on each of the following areas of your life.</p>	<p><i>Living Situation:</i> In 1 year, where would you like to be living?</p> <p><i>Learning:</i> In 1 year, would you like to be in school or a training program? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what would you like to do?</p> <p><i>Working:</i> In 1 year, would you like to be working? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what would you like to do?</p> <p><i>Socializing:</i> In 1 year, would you like to have more connections with others? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who or where would you like these connections?</p>
<p>What kind of support and guidance would help you (applicant) through this time in your life?</p>	

REFERRAL INFORMATION SPOA- Adult		NAME: Last First MI				
PAGE FOUR						
Item	1	2	3	4	5	Details
Mental Health Services <i>* Name of Outpatient Treatment Provider:</i> Score:	Stable, linked with mental health services or no mental health issues identified	Needs information to link to mental health services; has the skills to complete independently	Needs linkage to mental health services and does not have the skills to initiate	Linked to mental health services but not engaging; multiple emergency room visits to manage mental health issues	Multiple mental health issues; refusing or unable to address issues	<input type="checkbox"/> Individual has had at least 2 inpatient psychiatric hospitalizations in the last 2 years <u>OR</u> any 1 hospitalization in the last year * If known, how many: _____ <input type="checkbox"/> Individual has had at least 2 or more ER visits in the last year * If known, how many: _____
Substance Use Services <i>* Name of Outpatient Treatment Provider:</i> Score:	Stable, linked with substance use services or no substance use issues identified	Needs information to link to substance use services; has the skills to complete independently	Needs linkage to substance use services and does not have the skills to initiate	Linked to substance use services but not engaging	Multiple substance use issues; refusing or unable to address issues	<input type="checkbox"/> Individual has had at least 1 inpatient detoxification or rehabilitation admission in the last year *If known, how many: _____ <input type="checkbox"/> Individual has had at least 2 or more ER visits in the last year *If known, how many: _____
Physical Health/Wellness <i>*Name of Current Outpatient Treatment Provider(s):</i>	Stable, linked with medical services or no medical issues identified	Needs information to link; has the skills to complete independently	Needs linkage and does not have the skills to initiate	Linked but not engaging; multiple emergency room visits to manage medical issues	Multiple medical problems; refusing or unable to address issues	<input type="checkbox"/> No significant medical issues <input type="checkbox"/> Incontinent <input type="checkbox"/> Impaired walking <input type="checkbox"/> Requires special medical equipment <input type="checkbox"/> Hard of Hearing/ Deaf <input type="checkbox"/> Impaired Vision/Blind <input type="checkbox"/> Lung Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Weight Problems <input type="checkbox"/> Other:

Item	1	2	3	4	5	Details
Medication Use * Name, dosage, frequency of medications: Score:	Medication not prescribed	Takes medication exactly as prescribed	Takes medication as prescribed most of the time	Takes medication as prescribed sometimes	Takes medications as prescribed rarely or never; refuses medications	<input type="checkbox"/> Mental illness interferes with taking prescribed medications <input type="checkbox"/> Prescribed oral medications <input type="checkbox"/> Prescribed injectable medications
Danger to Self or Others Score:	No apparent history or risk indicators	No apparent risk factors in at least the last 12 months	Possible risk factors for danger: there have been risk factors in the last year however the individual seems to be managing them well	Probable risk factors for danger; there have been risk factors in the last year and the individual does not seem to be managing them well	Imminent risk factors for danger; action for safety needs to take place	<input type="checkbox"/> suicidal ideation <input type="checkbox"/> history of arson <input type="checkbox"/> suicidal attempt (s) <input type="checkbox"/> perpetrator of abuse <input type="checkbox"/> violence towards others <input type="checkbox"/> destruction to property <input type="checkbox"/> currently involved in domestic violent relationship <input type="checkbox"/> other: <input type="checkbox"/> Triggers: please specify:
Legal *Name of Current Legal Contact (s): Score:	No legal charges or arrests in the last year	Charges pending; family and friends have legal involvement	Legal history and needs monitoring but following through; legal history is over a year old	On probation and continues to involve self in illegal activity; sporadic arrests; released from jail/prison in the last 30 days	Multiple and continuous arrests in the last year; currently incarcerated	Involved with: <input type="checkbox"/> Treatment Court <input type="checkbox"/> Involved with Child Protective Services <input type="checkbox"/> Involved with Adult Protective Services <input type="checkbox"/> Involved with Assisted Outpatient Treatment (AOT) <input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> CPL <input type="checkbox"/> Other:

Item	1	2	3	4	5	Details
Housing <i>* Current Housing Provider:</i> Score:	Stable housing for over six (6) months; no current housing concerns	Stable housing for three (3) to six (6) months	Stable housing for three (3) months	Unstable housing; evictions; temporary shelter or housing; unsafe or substandard housing; concern for eviction	Homeless; living on street; living in a shelter	
Education and Employment Score:	Engaged in competitive employment without supports; actively engaged in training or education full time	Engaged in competitive employment, training or education with ongoing supports	Engaged in non-paid work experiences (ie: volunteer); have begun training or education	Temporary or sporadic employment; thinking about training or education	No history of employment of any kind; has no desire to move towards goals in either of these areas	
Economic Status <i>* Current Financial Contacts:</i> <input type="checkbox"/> Representative Payee: Score:	Manages money without assistance; never in financial crisis	Manages money independently with assistance; rarely in financial crisis	Has some difficulty managing money with assistance; occasionally in financial crisis	Money is not managed most of the time; frequently in financial crisis	Money is not managed at all; regularly is in financial crisis	<input type="checkbox"/> Social Security <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Public Assistance <input type="checkbox"/> Veteran’s Benefits <input type="checkbox"/> Food Stamps <input type="checkbox"/> Pension <input type="checkbox"/> Wages/Earned Income <input type="checkbox"/> Worker’s Compensation <input type="checkbox"/> Unemployment <input type="checkbox"/> Sanctioned by Social Services <input type="checkbox"/> Other:

REFERRAL INFORMATION SPOA- Adult PAGE SEVEN	NAME: Last	First	MI
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Item	1	2	3	4	5	Details
Community Living Skills Score:	Has not required assistance for more than six (6) months	Has not required assistance in the last three (3) to six (6) months	Requires assistance to maintain basic needs	Basic needs are minimally met	Basic needs are not met	
<i>ADL's (eating, hygiene, grooming, dressing, toileting)</i>	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
<i>Transportation/Use of public transportation and other community resources</i>	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
<i>Plan, shop, prepare meals, clean</i>	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
<i>Social Relationships (ability to establish or maintain satisfactory relationships)</i>	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
<i>Self direction (impulse control, decision making, judgment, etc)</i>	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	

I am aware of this application and the services I am requesting:	
Signature of Individual: _____	
Signature/Title/Agency of Person Completing Application:	Date:

Mail or fax completed application and release to:
Sue Gagne, Fax (585) 786-8874
460 North Main St., Warsaw, NY 14569